THE ENVIOUS LOVER

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Case Presentation

After nearly a year of psychotherapy, Ian comes to a session wearing a cutaway shoe and a cast on his toe. He looks as though he just lost a street fight. His face is puffy and shows recent cuts. His account of his weekend reveals a pattern of alcohol abuse and acting out under its influence that the therapist has been unaware of until this moment. When Ian first came into therapy, at age twenty-nine, he presented himself as an earnest, overly polite young stockbroker. His clothing was perfectly matched, the grays accented with burgundy and everything pressed and buttoned down. The therapist gathered that Ian's articulate sales pitches and solicitous voice had gained him a substantial clientele for his age. In his initial consultation, he admitted only to "drinking an occasional beer with friends," but after his wild weekend, he acknowledges "getting smashed" with his friends at irregular intervals

about every six weeks. These binges often include some public rowdiness, especially on Ian's part, and sometimes visits to prostitutes.

Ian grew up on a farm, the eldest of three boys. His parents were unhappy with each other. His mother, regarded as the most attractive woman in the county, was vain and exhibitionistic. Her extramarital affairs, including one with her husband's brother, were major items of local gossip.

Mother tried (and partly succeeded) to keep Ian from growing up, indulging his immature ways and making fun of him when he rebelled. She insisted that he come directly home from school to look after his younger brothers while she was out and that he remain home to keep her company when she was home. Ian did not often get to join his classmates at play.

Ian felt (and to some extent still feels) responsible for her. As a young boy, he often asked her why she did not leave his father, since she was so unhappy with him.

Ian's first account of his father, a mechanic and inventor of farm equipment, made him out to be a macho brute. But in time, Ian himself realized he was describing a man who was merely a resigned weakling. The father seems to have given up approaching his wife sexually after he learned of her affairs. He appears to have lived an asexual life except when it amused

his wife to invite him to bed. Infrequently, he beat the boys with a belt, but Ian does not seem to hold that against him. Ian does resent that his father not only never showed affection to him but also was typically scornful toward Ian and the prospect that he might ever amount to anything. His father forbade his sons from inviting their classmates home, which Ian feels wrecked whatever chance he might have had to develop socially.

By the time Ian reached adolescence, he was fifty pounds overweight, a hopelessly backward "blob" (Ian's word). He could not take part in sports, had no pals, and no hope of ever finding a girlfriend.

Ian was saved from despair by a talent for mathematics that enabled him to earn scholarships to college and business school. After sexual initiation by a woman professor fifteen years older, he was able to lose weight and "stop masturbating every six minutes." Their affair, which lasted five years until Ian left the university town to seek his fortune, was marked by his frequent hostility to her followed by his abject apologies. In most ways, she dominated the immature young man.

When Ian sought therapy, he mentioned that he was not following up on opportunities at work, was not doing his homework on the stocks he was selling, and was deliberately annoying his boss by pretending to be stupid. He had made friends with a few colleagues, but he noted a peculiar way he had of

waiting for them to call him. “I want them to court me like a girl,” he observed, “and I’m always afraid they’ll figure that out.”

Ian worked out in the gym every day, dieted, and became quite handsome. Nevertheless, he was still afraid to approach young women. Another affair with a much older woman followed the pattern of that with the professor. He came late for their dates and insulted her figure and everything about her—including her affection to him—and then, becoming terrified, he abased himself and promised to be good.

In the early months of therapy, following a hint by the therapist, Ian began to ask young women for dates. His good looks and emotional intensity made him highly attractive, and for a season or two he “fell in love” with another woman about every two weeks. He also went to prostitutes, to whom he felt superior, but they humiliated him. Because of the AIDS danger to Ian and his numerous sexual partners, the therapist adopted an unwontedly directive stance; he ordered Ian to cut out going to prostitutes entirely.

The pattern of Ian’s love life at this stage was to have sex immediately with a new date, then to "move in” for three or four nights in a row of intense sex and emotional involvement, then a hysterical fight and breakup over the young woman’s alleged attempt to possess and control him, and then a few days of recriminations, telephone calls, reconciliation, and final breakup—just

in time for a sex-love binge with a new woman.

Probably again influenced by his therapist, who hinted that an ongoing relationship could be more rewarding, Ian decided that he wanted a long-term relationship with his current woman friend. Jill was a wealthy art dealer five years older than Ian. Soon after he moved into her apartment, Ian began to inquire about her previous relations with men. At first he acted as though knowing each other's past was a casual diversion, but then it became a test of her honesty to tell him everything. Ian imagined himself inferior sexually to all the men she had slept with, despite her assurances to the contrary. He envied her experience as more extensive than his, and he fantasized being a woman like her and sleeping with many men. He tried to get her to describe her sexual life in detail, but she declined. Notwithstanding his recent promiscuity, Ian accused Jill of having been too available to men. When she yelled at him in retaliation, he abused her physically, twisting her arm and pushing her about, and then stormed out.

After Ian roughed Jill up on Friday evening, she changed the locks the next morning. When Ian discovered that he was locked out, he kicked the door, breaking his big toe, as he later learned. He was already drunk and, limping from bar to bar, became much drunker. He went to Jill's art gallery, drank some complimentary champagne, shouted obscenities, terrified the patrons, and broke a tray of stem glasses. Jill began to dial the police, so Ian

left, snapping off car antennas as he limped down the street. He wound up at a house of prostitution, where he was unable to get an erection because of his drunkenness and intermittent awareness of the pain in his toe. He offended the management by refusing to leave (at this point he had nowhere to go) and took a couple of punches in the face, after which he saw the management's point of view. He checked into a hotel, left an incoherent message on his therapist's answering device, and slept for twelve hours.

By the time Ian arrived at his therapist's office, his toe was in a cast and he was all sobered up, expressing more earnestly than ever his desire to change.

Formulations and Treatments

Gerald C. Davison (Cognitive-Behavioral)

Even for a cognitive-behavioral therapist cum humanist like me, who focuses primarily on the present and future, it is impossible to overlook the importance of Ian's past relationship to his mother, who slept around, humiliated Ian's father, and dominated Ian. It is conceivable that Ian may have carried his fury at her into adulthood, generalizing it to all women. Ian is described as having been hostile to the woman professor who initiated him into sex (probably no accident that she was fifteen years his senior), making

snide comments to another older woman he dated, going to prostitutes to whom he felt superior, and abusing his current lover physically.

His seeming fear of women, then, I would construe as a cover for his extreme anger at them. His problem in establishing intimate and honest relationships is consistent with a deep-seated mistrust and dislike of women.

I would not see the allusion to his occasionally wondering what it would be like to be a woman as a homosexual or transsexual inclination, but as a kind of escape from the pain that being a heterosexual male has been. After all, how enjoyable can his life be if he is raging at half the people around him? What is not evident from the case report data is what his male-to-male relationships have been. Has he had close male friends? Or has his anger at his mother and other women generalized to all people? That generalized anger is suggested by his passive-aggressiveness, as in not doing his homework on the stocks he sells and deliberately annoying his boss by pretending to be stupid.

The alcohol abuse I regard as secondary to Ian's core anger problem. As is often the case, alcohol is probably an anesthetic for his strong negative feelings about women and about himself—feelings that arise in large measure from the stressful situations he constructs for himself.

In the most general terms, I would set as the main agenda item a change in his extreme hatred for women. What is less clear is how I would go about the task. A principal choice would entail whether to work on his current relationships with women or to work on his earlier and maybe also current one with his mother. If the mother is available, I might raise with Ian the possibility of inviting her in for a few sessions to help him express to her his hurt and anger at how she treated him and his father when Ian was a child. This encounter might also give her a chance to explain what life was like for her in a way that might enable Ian to forgive or at least to understand her from his current adult perspective. Children can seldom appreciate what emotional pain their parents endure but can often do so when they themselves are grown up. They may still not like very much what their parents did, but they may at least be able to empathize with them and forgive them for shortcomings. If I could help Ian and his mother in this way, perhaps his current anger at women would diminish.

Alternatively or in addition, I would work with Ian on his present relationships. Perhaps, as Ellis would say, some of his anger and remoteness could be construed as arising from the unrealistic, unproductive belief that others must be exactly as he wants them to be, that things absolutely must go as he wants them to. If such a belief is part of Ian's view of women, perhaps it can be detected in other parts of his life, such as work. His meticulous way of

dressing may be part of the need to be perfect.

His being "overly polite" may be a defense against his rage and in turn may perpetuate that rage through cyclical psychodynamics (Wachtel, 1982). Ian's excessive politeness might be associated with lack of assertiveness and hence with being taken unfair advantage of, which could well lead to others abusing him or at least not taking his wants and needs adequately into account. Assertiveness training might be called for; it might help Ian to realize that he can express anger or hurt to others without injuring others or himself. Appropriate assertiveness can alter the kinds of interpersonal situations he finds himself in; if he is not taken advantage of, he will have less to rage against.

In addition to the usual behavioral what and when mode of interviewing, I might use a Gestalt empty chair technique to help him better discover and express his feelings. For example, I would have him imagine his mother in the chair—and probably also his father, at whom he might harbor anger for the childhood beatings and ridicule as well as anger for the father's failure as a man in accepting the emotional abuse and neglect by Ian's mother. Ian's attitudes toward and feelings about other important people in his life, past and present, might well be plumbed with this procedure. Also, if he were amenable, I might try to hypnotize him to help him express thoughts and feelings that he is reluctant to own up to. A person's merely believing that he

or she is hypnotized can act as permission to think and say what is unthinkable and unutterable. In Ian's case, just allowing someone to hypnotize him might be beneficial as a model for trusting someone and not having that trust betrayed or abused.

There are social-skill deficits that I would approach via structured in-session behavior rehearsal, which (as part of the assertiveness training mentioned earlier) would also serve as an assessment instrument. Especially in initial sessions, it might help him and me see his hostility toward women, and toward all people as well. I might also assess his "self-talk" by a modification of my paradigm of articulated thought during simulated situations (Davison, Robins, & Johnson, 1985), a sort of stimulus-bound free association. I would construct a situation for him to imagine himself in, and then I would encourage him to think aloud. For example, I might have him imagine an attractive woman declining an overture from him: Does he verbalize only hurt, fear, and expressions of low self-esteem? Or does he, as I would expect, articulate thoughts and feelings of anger and rage?

There is much else in this richly textured, densely packaged case material, but these are the clinical hypotheses I would initially entertain and use as guides to further assessment and cognitive-behavioral treatment planning. In the midst of my directiveness and behavioral focus, I would try to remain sensitive to the subtle messages most patients send, particularly those

signaling that sensitive areas are being touched.

Carlo C. DiClemente (Integrative)

Ian is an individual with multiple problems and a self-defeating cycle of relationships. Initially I would evaluate these problems along several levels of change. At the symptomatic level, his alcohol abuse, violent explosive episodes, and dysfunctional sexual relations would all be primary foci of concern. The self-statements about wanting to be courted like a girl and his fantasies about being a woman represent significant issues at the level of maladaptive cognitions. These symptoms would need greater elaboration. On the interpersonal level, Ian is experiencing interpersonal conflicts with women as well as with colleagues and seems unable to approach an intimacy of equals. Family of origin, social network, and employment systems are sources of conflict and confusion at the family-systems level. Finally, Ian seems to have problems with sexual identity, self-image, self-esteem, and individuation at the intrapersonal level.

Whenever I see a person with this variety and extent of problems at the various levels of change, a personality disorder diagnosis usually is most appropriate. Ian is best understood in terms of diagnostic classification as having a borderline personality disorder highlighted by intense anger, identity disturbance, impulsiveness, affective instability, and unstable

interpersonal relationships. The levels of change, however, offer a more functional and practical perspective for intervention than does the *DSM-III-R* Axis II diagnosis of borderline personality.

The current crisis in Ian's life raises interesting questions and offers unique opportunities for the course of his therapy. We need to know more about the pattern of Ian's drinking— frequency, duration, precipitating factors, and consequences. Are there other drugs involved? What emotions, thoughts, and behavior does he express when he is under the influence? Alcohol's loosening of inhibitions supports the ancient phrase *in vino veritas* (in wine—truth). I would bet that some of the more destructive and dysfunctional parental behaviors were facilitated by alcohol; and I would like to know about parental and sibling drug and alcohol use.

Ian's ambivalence toward women, involving rage and idealization, would also lead to a whole line of questioning about sexual abuse, sexual identity, and sexual preference. Homosexual fears and activities would be another line of inquiry. In addition, an exploration of self-destructive or suicidal thoughts or behaviors as well as feelings of emptiness and abandonment would be of interest.

In working with this type of client, I have found that a firm, authoritative, empathic-but-not-overly-involved approach, which enables me

to be open without being manipulated, works best (Prochaska & DiClemente, 1984). The process of developing a therapeutic relationship is a critical pathway to change for borderline individuals, so I would avoid being too directive with Ian, since he is likely to blame the therapist if things do not work out. Idealization and devaluation will be part of the picture as Ian attempts to get close to the therapist, and issues of trust and abandonment will emerge often. The therapist should be clear about expectations and should warn Ian well in advance of any shifts in schedule or absences.

I would expect the therapy with Ian to proceed from one personal crisis to another, indicating loss of control in one or more aspects of life. Problems at each of the levels would need to be examined and dealt with in a thoughtful and empathic manner. Training in problem-solving skills, assertiveness, and cognitive-behavioral anger control techniques, as well as employing rational-emotive strategies, would be useful to handle specific problems as they emerge—provided Ian is ready for action in these areas. The issue of what to do and when with Ian would depend on his stage of change with respect to the problems at each level. So far, he and his therapist appear to have focused on relationship issues. At this point in the therapy, Ian may be able to move toward contemplation or action regarding his drinking and anger control problems. I would certainly focus on the symptom- situational level at this time of crisis.

I would also consider a medication evaluation if Ian became depressed. Especially after the recent disruptive events, Ian might experience a serious depressive episode. Medication could help stabilize him and allow the work of psychotherapy to proceed.

Clearly, Ian would not be considered a short-term therapy case. That he has been able to remain in therapy for a year is a good sign. But given the multiplicity of his problems, he requires intensive and extensive therapy to accomplish characterological change. While dealing with current issues and problems, I would attempt to address underlying themes at the system and intrapersonal levels. In a nonconfrontational manner, I would encourage consciousness raising, self-reevaluation, and environmental reevaluation, and I would explore his individuation and differentiation from his dysfunctional family. In many ways, Ian is living out his family legacy. I would relate current issues to his roles as surrogate spouse, mother, and father in his family of origin. The current incidents provide a wonderful opportunity to explore Ian's dichotomous thinking; contrasting the dapper and polite Ian with the rebellious, angry, and acting-out aspects would help to address identity issues. Idealization and devaluation of self and others would be another critical theme that I would weave throughout our sessions as the therapy moved from crisis to crisis. If both Ian and his therapist can handle discouragement and disappointments, significant changes can be made at

many of the problem levels. Maintaining these changes and integrating them into Ian's sense of self will be the long-term challenge.

Shridhar Sharma (Psychoanalytic)

Ian, a handsome, educated, and intelligent stockbroker, grew up in an atmosphere of prolonged parental conflict and inadequate opportunities to socialize. Before commencement of therapy, it would be necessary to determine whether Ian's problem is chiefly one of personality disorder causing difficulty in interpersonal relations and sexual relationships or whether his interpersonal difficulties and sexual problems are independent of each other.

More details are required about Ian's alcohol abuse—pattern and severity and use of other drugs concurrently with alcohol. Earlier reports of depressive symptoms and anxiety attacks need to be verified. These patterns would indicate whether any medication would be necessary.

Ian's case seems to fit into the passive-aggressive type of personality disorder. His background of disturbed childhood with parental conflicts, personality problems with both his parents, and his continued maladaptive behavior at work and in his personal life support this diagnosis.

Another diagnosis to be considered would be substance or alcohol abuse disorder. Ian's work performance seems mediocre. Substance abuse may account for his multiple difficulties ranging from street brawls to breakups in his relationships. But Ian's own perception is that he "deliberately acts stupid" to annoy his boss, suggesting a personality problem rather than substance abuse.

Therapy should concentrate on exploring the interpersonal difficulties and behavior patterns that are the cause of his recurrent difficulties.

A supportive, nondirective approach seems to be most suitable for Ian. From the case report, it appears that Ian uses the therapist's suggestions in a passive-aggressive manner. Clear, attainable therapeutic goals should be established to help Ian realize and accept responsibility for the self-defeating nature of his actions and to change his behavior to a more adaptive style.

Ian's long-term relationships with two older women and his temporary affairs with women of his age group have been superficial and unfulfilling. The interpersonal context of these relationships needs to be examined in light of his love- hate relationship with his mother. Ian must come to appreciate mutually satisfying and rewarding involvement and learn not to exploit his relationships.

Ian's alcohol problem has been discovered late in the therapy. This may indicate that Ian is poorly committed to the therapeutic contract. Group therapy is likely to be less threatening to Ian, and his self-defeating behavior patterns can be handled in a group; hence, group therapy also appears to be indicated.

James F. T. Bugental (Existential-Humanistic)

My approach to life-changing therapy rests on the belief that there is a fundamental division of responsibility between therapist and patient. Patients are the only ones who can know their own lives and are, therefore, the only ones who can guide their lives. The therapist is a coach who observes and comments on how patients use their capabilities for life direction. This position implies that I do not try to solve patients' problems, advise on courses of action, discover so-called causes of symptoms or problems, or work out psychodynamic formulations to teach them. I do pay close attention to the immediacy (in the hour) and genuineness of patients' concerns for how their lives are going. I observe and offer feedback on the many ways patients avoid immediacy and genuineness. I insist that patients are responsible for what they say and do, that there are always more alternatives available than those the patients describe as the only possibilities; that their route to better self-guidance and reduction of distress (pain, anxiety, repetitive failures) lies

in intensive and extensive exploration of their perceptual worlds.

I am less interested in learning about Ian than I am in persuading him that he needs to learn a great deal more about himself. I do not make a formal diagnosis except as insurance forms may require. Long before this point, I would have satisfied myself that Ian had no major thought disorder, that his ego strength was sufficient to accommodate depth explorations, and that he could make a commitment to come at least two times a week and to hang in over a period of at least one and preferably two years. Since the case synopsis suggests the work with Ian has been going on for some time, I assume those desiderata have been satisfied.

The fact that Ian has these drinking and fighting episodes as often as at six-week intervals and that the therapist has never picked up at least some clue to this highly significant aspect of his life is important in itself. For this to be the case, it seems that either the therapist has been too much in charge of what was talked about or Ian is a remarkable actor (psychopath?).

The history of Ian is so totally focused on Ian that there is no cue to the relation with the therapist or to how the alliance was evolving. It is also evident that the personality, style, and emotional receptivity of the therapist are not deemed sufficiently important to be included.

I would insist on a therapeutic relation in which Ian discovered his responsibility for his own life. This relationship would come about from my refusal, for the most part, to enter into discussions of his motives or to offer interpretations of his dynamics and from my repeated identification of the ways in which Ian avoids taking responsibility.

I would depart to a limited extent from my position—somewhat as did Ian's therapist—to insist that his frequenting of prostitutes during the AIDS epidemic was resistance in that it put our work at risk. Whether I would say to Ian that it was also acting out with suicidal potential would depend on the state of our alliance.

Considerations in conducting this first interview when Ian arrives physically and emotionally battered are represented by the following questions: How ready is he to be present genuinely and to work to explore the meanings of the previous night's debacle? Is he reenacting with me the guilt-and-reconciliation script he has so often played out before? What are my reactions and impulses to the presentation he makes? Am I moved to sympathy, to anger, to take satisfaction, or to want to reassure? I would not likely act on any of these impulses, but I need to know the answers to these questions to recognize what Ian is pulling for and how my responses may be adulterated.

Assuming that Ian has some amount of (desirable) apprehension arising from the episode, I would attempt to bring it forward so that he truly and strongly experiences alarm at what is happening to his life. I would do this by spotlighting the ways in which he might seek to downplay or explain away the events of the night. Here are some examples: (1) You are trying to persuade yourself and me this is really not very serious. (2) It seems as though it would be overwhelming to you to recognize just how far out of control you can get.

You want to be the sad, repentant sinner here so that we won't get into what this episode really means for you. That way you can go out and pull another one when you need to.

All told, I would regard this situation as a window of opportunity to require Ian to renew his commitment to our work and to gain genuine direction in his life.

The foregoing is suppositional and brief. To carry it further, I would need more information about the previous course of the therapeutic alliance and Ian's sophistication about inward searching.

Points of Contention and Convergence

Gerald C. Davison

Beginning with DiClemente, I did not employ a *DSM-III* diagnosis and was interested to see his reference to borderline personality. I can see how Ian could be given this Axis II diagnosis, and yet I would not materially change my therapeutic approach to him if I too had labeled him in this way. DiClemente's approach raises in my own mind the interesting question of what benefits are achieved by employing the borderline personality diagnosis. Like the narcissistic personality a few years ago, the borderline seems to have become a popular rubric, in spite of a paucity of evidence on the validity or utility of the diagnosis.

DiClemente's allusion to the Latin aphorism *in vino veritas* assumes that what comes out from Ian when he is drunk is somehow more valid than what one sees of him in the sober state. I would caution against assuming this. Consider, for example, that sexual arousability generally declines when considerable alcohol (as Ian would ingest) is consumed. Would one then conclude that the person is sexually hypoactive? I doubt it.

I like DiClemente's comments about the general approach he would take with someone like Ian. Concern about being overly idealized and then damned by the client is well taken. Moreover, there are commonalities between us in the specific approaches that we might take—assertiveness

training, for example—although my own focus would be more clearly on Ian's anger toward women.

It is noteworthy that Sharma uses an Axis II diagnosis different from that of DiClemente—passive-aggressive personality. His reasons make sense and are consistent with recent data pointing to considerable overlap among personality disorder diagnoses. There seem to be very few "clean" cases, and this paucity constitutes an argument against the typological *DSM* approach in general. Sharma's specific therapeutic suggestions are too vague for me to comment upon substantially; basically, I cannot tell what he would actually do with Ian, aside from being supportive and nondirective. However, the caution that Ian may use therapist suggestions in a passive- aggressive manner does suggest that a paradoxical approach may be needed. Such an approach would drastically change the cognitive-behavioral suggestions I made. I would want to watch for this potential conflict with my generally directive and prescriptive approach.

I am probably in clearest disagreement with Bugental's suggestions. My sense is that if Ian could operate as autonomously and responsibly as Bugental assumes he can, his clinical picture would be much different and less serious than it is. I would agree on such behavior as goals, of course. It is noteworthy that Bugental would directly insist that Ian not go to prostitutes because of the AIDS crisis. While I would do the same, I contend that this

negates the ultra-nondirective approach he advocates. Ian's going to prostitutes is not "resistance" that puts the therapy at risk; it is behavior motivated by reasons the therapist should investigate, behavior which until recently was relatively common among men.

Carlo C. DiClemente

My training and background ally me with both the cognitive- behavioral and humanistic perspectives. The integrative trans- theoretical approach that I currently use to direct my therapy allows me to integrate these perspectives with my experience to make clinical decisions. Reviewing the responses of my fellow panelists renews my commitment to developing an integrative approach. While I can resonate with the clinical recommendations of Davison and the philosophical stance of Bugental, I disagree with them and Sharma on several points.

Readiness for change and taking responsibility for one's life are similar. The model of the stages of change that I work from focuses on intentional change but does not assume that clients are ready for action on any one problem when they enter or remain in therapy. Bugental assumes Ian to be in action or close to action, and he assumes that focusing on Ian's experience of the night of chaos by offering genuine feedback about responsibility will be therapeutic. Although I agree that intentional, responsible activity is needed

for change, there may be many times when Ian will be at earlier stages of change—times when he may be too unaware, unable, unconvinced, or unskilled to assume responsibility. Self-regulation involves not only commitment but also cognitive and behavioral processes applied or encouraged at specific stages of change.

Bugental also seems to concentrate on the interpersonal and intrapersonal levels. I concur that there are serious problems at both of these levels. However, the failure to address the alcohol abuse as a serious and separate (but not completely separable) issue is problematic from my perspective. Many aspects of Ian's life and problems significantly reduce his capacity for intentional, responsible action. These aspects must be addressed if we are going to be able to offer him a comprehensive treatment program.

Davison's plans for intervention are probably most similar to mine, but I am somewhat distressed by his brushing aside of the alcohol abuse as simply a medication for emotional pain. My focus on Ian's alcohol abuse represents a major difference in approach. Etiology of a problem behavior is often quite different from the maintenance of that behavior and from the issues to be addressed to change that behavior. Whether Ian began using alcohol to self-medicate, to mimic mother, or to release anger, current patterns of use, benefits, and consequences are much more relevant for change. Unless the therapist focuses on the alcohol problem, gains made in the sober state will

not transfer to these binge drinking episodes. The alcohol-as-symptom perspective, a pet peeve of mine, is partially responsible for the current rift between psychotherapists who focus on emotional problems and alcohol treatment personnel who focus almost exclusively on the substance abuse (Prochaska & DiClemente, 1984). A truly integrative perspective would allow for the importance of each domain and also acknowledge the interrelatedness.

Davison would focus on the interpersonal level by prescribing assertiveness training. Again, I concur but feel that this would be the most difficult level at which to get substantial change quickly. The importance of the cognitions and their role in producing and maintaining the problem behavior are key points of convergence between Davison and me. Cognitions are alluded to by both Sharma and Bugental but are more directly and explicitly addressed by Davison and me. However, I would not use hypnosis or free association with Ian. It seems to me that those techniques would be counterproductive. Issues of trust, rebelliousness, and unclear personal boundaries would make hypnosis and free association difficult. To avoid such difficulties, I would offer a rather structured interpersonal approach and cognitive intervention.

Sharma seems to evaluate the case diagnostically in a manner similar to mine; however, he sees the diagnostic classification as giving more direction

to his intervention than I do. Diagnostic levels are helpful for insurance reimbursement and have implications for treatment as they become more specific and specified. However, the current *DSM-III-R* system does not allow for a more functional and problem-oriented perspective like that of the levels of change. A more descriptive, functional diagnosis of problems seems most useful in this case. The personality diagnosis can help in deciding the characterological traits that will be encountered and that will influence the therapeutic relationship. However, simple Axis I and II labels do not often yield clear directives for treatment.

Sharma assumes that Ian's failure to disclose his alcohol problem is indicative of his lack of commitment to therapy. Since individuals can be at various stages with respect to problems at various levels of change, I do not think it is helpful to overgeneralize attributions of resistance (Miller, 1985). It seems to me that Ian has been ready to work on relationships with women during his year in therapy while being less willing to work on or admit an alcohol problem. This behavior does not indicate a lack of commitment, but a limited commitment.

It is not surprising that I would find my perspective more useful and compelling than those of the other authors. This case does point out that, as therapists, we are directed by our own theoretical frames, however broad or limited they are. While I see a good deal of consensus among the four of us in

our approach to Ian, there are both major and minor points of divergence. The field of psychotherapy continues to elude formal consensus and integration while becoming more homogenous at the level of practice.

Shridhar Sharma

I will begin with the points of convergence. There is basic agreement in the diagnostic impression that Ian is experiencing a personality disorder that is causing both interpersonal problems and drug and alcohol abuse. It appears that Ian is the major source of available information, but his mother or girlfriend might also provide additional information helpful in forming a well-knit psychodynamic formulation.

A few indicators suggest the presence of parental conflict and an abnormal parent-child relationship. These have probably triggered Ian's problems, both in relation to his sexual conflict and his poor interpersonal relationships. Ian appears to be lonely, searching for a lasting and satisfying relationship with the opposite sex—a relationship he is unable to accomplish due to his psychopathology. Probing is needed regarding possible homosexual tendencies and early sexual traumas.

Despite general agreement on the diagnostic formulation, there are points of conflict on therapeutic interventions—conflict due to different

perceptions and approaches to resolving the same problem. From the available history, it is difficult to suggest that Ian has any homosexual inclination, but to conclude that his behavior is an escape from the pain that a heterosexual male may suffer is also not clear and evident.

I believe that individual psychotherapy alone may not be sufficient. Ian would benefit from being placed in a therapy group involving his mother and, if possible, his girlfriend. The emotional support and understanding on the part of his girlfriend and his mother would enhance understanding of the problem and would help in establishing a more positive therapeutic process. I totally agree with the idea to involve Ian's mother in a few therapeutic sessions, which may also help in understanding some of his conflicts and in establishing positive emotional relationships. The results in such cases are usually difficult without adequate social and emotional support from the family.

James F. T. Bugental

The response of Gerald Davison is ingenious, multifaceted, and dynamic, but somehow it is almost totally therapist focused. He lists hypotheses about Ian and then proposes things he (the therapist) might do to and for Ian. Only the very last sentence mentions the possibility of being tuned in to Ian and to what is happening to Ian. It is as though Ian is to be regarded as an object, a

puzzle box to be speculated about from the outside.

DiClemente's approach initially is diagnostic with much emphasis on identifying issues or symptoms and on acquiring information about Ian. Sensitive speculations about the likely therapeutic relation and how it should be modulated still retain the strong flavor of objectification of Ian. The mobilization of many possible therapeutic instrumentalities suggests the implicit question in the therapist's mind, "What shall I do to this person?" Again, the last sentence is revealing in that, for the first time, it shows some sharing with Ian—"If both Ian and his therapist can handle discouragement and disappointments . . ."

Sharma, not recognizing therapy has gone on for a year, begins by saying a diagnostic judgment must be made "before commencement of therapy." Again, the history is disregarded with the observation that "Ian's work performance seems mediocre," despite the report saying that Ian had gained "a substantial clientele for his age." These points are only important to show how the center of gravity is in the therapist, not in Ian.

The other three psychotherapists and I part company most markedly in terms of the stance from which we approach the work with Ian. Each of the others tends to look on Ian as an object to be diagnosed, explored, helped, treated, and impacted in a variety of ways. Information is to be collected,

collated, and reduced to various diagnostic judgments and treatment strategies. This approach is very much in the current mainstream of American psychological therapy (cf. Zeig and Munion, 1990). I recognize, therefore, that mine is a radically contrasting point of view (Bugental, 1978, 1987, 1988).

My perspective can be most economically set forth in a set of beliefs that forty years and many disappointed efforts to work from other bases have brought home to me. I believe that Ian, and only Ian, is the possessor of whatever knowledge about himself is going to be needed for him to change his life. I believe that only if Ian genuinely and vividly experiences his present life as something he does not want to continue will he begin to go through the misery that lies between him and a changed life experience. I also believe that Ian is continuing this self-defeating pattern because of the way he has implicitly come to define himself and his world; and changing this self-defeating pattern means to Ian (at some level) a kind of death. Thus he does well to avoid it. And I believe that I, the therapist, can bring essential aid to Ian by doing three things—and, for the most part, by doing only these three things: (1) developing an alliance with Ian in which it is firmly established that he is in charge of the content of what we deal with but that I am insistently attending to and calling on him to attend to how he deals with whatever he does talk about, (2) focusing on how Ian avoids being totally, genuinely present in the therapeutic hour, and relentlessly confronting him

with his evasions, and (3) standing steadily by Ian as he encounters the feared, agonizing, tragic, irrevocable, and heretofore suppressed and repressed elements within himself.

It appears to me that the other psychotherapists commenting on Ian's case manifest informed and, doubtlessly, caring concern. Still, our current implicit metaphysical foundation for therapy devalues and disregards the subjective in the client and, indeed, in the therapist as well. We are taught that objectivity is the highest virtue, so we often fail to consider that the core of psychotherapy is, and must be, the subjectivity of the client. Treating the client as an object only reinforces one of the pathogenic tendencies of our time.

I read into statements of Davison and DiClemente an underlying empathy for the client. In keeping with so much of our training, the greater parts of what they propose focus on objective aspects of Ian, his history, and what the therapists might do; however, each at the end of his statement suggests something not expressed earlier. Davison said, "In the midst of my directiveness and behavioral focus, I would try to remain sensitive to the subtle messages most patients send, particularly those signaling that sensitive areas are being touched." And DiClemente said, "If both Ian and his therapist can handle discouragement and disappointments, significant changes can be made at many of the problem levels." Is it too presumptuous

to speculate that they felt it not quite proper to bring in such subjectivity but that their deeper feelings slipped out before they stopped writing?

Psychology, seeking to be a science on the model of nineteenth-century physics or early twentieth-century medicine, avoids subjectivity in both client and therapist as it would sepsis. The consequence is an overvaluing of detached diagnosis and overt technique and an underestimate of what clients can and must do if they are to make major life changes.

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