THE RETURNING HERO AND THE ABSENT WIFE

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Case Presentation

A marital crisis erupts after a few sessions in the therapy of Carl and Trudy, and Trudy expresses her readiness to quit the marriage and the therapy.

Carl is thirty-eight, a large man with impressive muscular development of chest and arms. He walks with a cane because of injuries sustained in Vietnam, for which he volunteered out of a sense of duty. He lived his childhood in an orphanage where no one had time for the children. “The food was handed in under the door,” Carl said, “and the bigger boys got most of it. You had to fight for your share.” Three times a year, he was allowed out to visit an aunt, who was affectionate. But when he was nine, he was told he would not be getting out for Easter; that was how he learned his aunt had married and moved away.

Trudy is thirty-two, a tall, slender woman with dark eyes and curly black hair. She was raised by her mother, a former Miss Arizona. Trudy's father was an Air Force test pilot who adored her. He died flying an experimental plane when Trudy was ten years old. Before his death, the family was transferred to a different base every few months; she has sparse memory of her childhood. Trudy learned not to make friends, because the family always expected to be moving again. Trudy's mother drank heavily and was (or became) irresponsible, but she demanded obedience and affection from her child. She married a man who claimed to be a minister, but Trudy guessed that he wanted to live off her mother's pension. As she became an adolescent, her stepfather sexually abused her and threatened to kill her if she told. Trudy hinted about it to her mother, who eventually caught them in bed. Her mother's first reaction was to take Trudy away. The stepfather came after them, and Trudy, believing (probably accurately) that her mother wanted to go back to him, ran away and got work as a waitress. She passed for eighteen, but in reality, she was a tall, precociously developed fourteen-year-old.

Carl eventually became an engineer, responsible for research and development of high-tech products. Aggressive on behalf of his company, Carl is never assertive for himself. He enjoys sex but is not at all affectionate to Trudy except in bed. He has severe hypertension and consented to go to

psychotherapy at his physician's insistence. Trudy says that everyone takes advantage of him, that his boss manipulates him, and that his subordinates get him to do their work for them. Carl is strongly self-controlled, compulsive, ethical, laconic, and at least in our consultations, passive.

Trudy was first married at seventeen to a man who did not believe in birth control, but who discovered he was not ready for fatherhood and left her with three children when she was twenty-two. Carl married unwisely, too, and was left with two boys. Trudy and Carl also have a young child in common to complete the household.

Trudy has read widely to make up for her lack of formal education. She believes she fell into motherhood because of her insecurities. She describes herself as "street smart," but also as "scatterbrained," and as having "jumbled emotions," jealous rages, painful feelings of inadequacy, and numbness (terror). She says she cannot ever get out of her mind what her stepfather did to her. Often, she is sexually unresponsive to Carl because she is angry at him or because she just wants to be held, which he does not understand. She would like someday to have a career or small business of her own, "if I could handle it."

After a few sessions, Carl announced he would be out of town and would miss at least one session. Trudy said she would come to the session by herself,

but she did not. Instead, she called afterward to say that she would not be coming back to therapy. She moved out of the family apartment, as she had done many times in the past, but vowed that this time she would not return. Leaving her young teenagers to fend for themselves, she dropped Carl's children with his ex- wife's family and took their baby with her to the apartment of some girlfriends. I talked Trudy into coming back for at least one final session, during which she expressed anger at Carl's lack of consideration in not calling her when he was on business trips, even to say when he would be back. From her voice and body language, and from her flight itself, I knew she was deeply frightened. She was so extremely angry and scared at once that it was hard to talk with her.

Trudy remarked that Carl thinks she ought to be glad to see him whenever he walks in the door. His fantasy is that she will drop whatever she is doing and that they will make love at once. Trudy hates this scenario. What actually happened the last time (and it had happened before) was that when Carl arrived home, Trudy and his children were gone, and hers were dirty, ill-fed, and "swinging from the ceiling."

Carl never expresses any emotion. One can see that he is suffering, but if one says that to him, he hardly responds—as though "it doesn't compute." Upon being asked why he does not call Trudy when he is away (and reminding him that he is extremely responsible in every other way), he gives

only rationalizations. It appears that he avoids the pain of separation by cutting off and pretending to be emotionally self- sufficient.

Carl is willing to work at therapy because it is a medical necessity to lower his blood pressure. He wants Trudy to come back, but when he says without any feeling in his voice that he needs her, she retorts, “Get a maid!” She says she wants to stay in the marriage “only if Carl changes a lot,” and she doubts therapy can do that.

If our panelists had conducted the first sessions themselves, they would have inquired more deeply along some of these lines or along different lines, as they have noted. The following *DSM-III* diagnoses were suggested, but the panel was invited to amend them or add other categories as they felt warranted.

Carl

Axis I: Psychological factors affecting physical condition

Axis II: Compulsive personality disorder, with masochistic tendencies

Axis III: Hypertension

Trudy

Axis I: Posttraumatic stress disorder

Formulations and Treatments

Jeremy D. Safran (Cognitive)

In considering the establishment of a therapeutic relationship, I find Ed Bordin's (1979) distinctions among the goal, task, and bond components helpful. I would want from the outset to establish whether the goal of therapy was to work on the relationship or on specific issues with either Carl or Trudy independently. It is not clear how Carl's referral due to hypertension led to relationship counseling, nor how willing either is to work on the marriage. The information provided on Trudy suggests that she may not be motivated to work toward improving the marriage at present.

Granted that Carl, because of his need to lower his blood pressure, may be more motivated than Trudy, it remains unclear what type of therapeutic task he would perceive as relevant to that goal. Does he want to work on the relationship as well as reduce his hypertension? Would he see the type of self-exploration common to insight-oriented therapies as relevant to whatever goals he decides are worth pursuing? Depending on the answers, I might

wind up seeing one of them, both of them, or neither of them in psychotherapy.

In what follows, I will assume that both Carl and Trudy are interested in improving their relationship and that they both perceive some form of self-exploration as relevant to that goal.

From a cognitive-interpersonal perspective, psychological problems are maintained by a cycle. Individual expectations shape perceptions of interactions and influence behavior in a way that elicits behaviors from others confirming an individual's dysfunctional expectations. A corollary is that a two- person system can be understood as the complementary integration of individual cognitive-interpersonal cycles through which the dysfunctional patterns of the two individuals elicit and maintain one another, reciprocally confirming their associated dysfunctional beliefs.

To treat Carl and Trudy, I would want four interdependent pieces of information: (1) What is the primary, repetitive dysfunctional pattern that characterizes their relationship? (2) How can this interactional pattern be understood as the integration of specific interpersonal patterns characteristic of each of the spouses? (3) What are the key pathogenic beliefs linked to Carl's and Trudy's respective, dysfunctional interpersonal patterns? (4) How does their interactional pattern confirm each spouse's dysfunctional beliefs

about relationships?

I have some information already. Carl has difficulty expressing intimate, warm, and caring feelings toward Trudy, and Trudy appears to interpret his behavior as exploitative and possibly rejecting. She expresses her anger both by withholding sexual intimacy and by threatening to abandon Carl. This response discourages emotional openness in anybody who has difficulty expressing feelings of need and vulnerability in the first place. Carl's lack of emotional openness, in turn, confirms Trudy's belief that she is being exploited.

From the biographical information available at this point, I can form only tentative hypotheses about what the important subjective construing processes and tacit beliefs might be for Carl and Trudy, and how these might be related to important developmental experiences. I might conjecture that Carl may have a fear of abandonment because of his early experiences in an orphanage and that he has learned not to express his feelings and needs because of his belief that to do so would be futile or would lead to rejection. Similarly, I might conjecture that Trudy's traumatic sexual experience with her stepfather might contribute to a general sensitivity to exploitation by men.

The truly important information would have to come from a detailed,

emotionally live and experiential exploration of both clients' subjective interpretations of the interaction that constitutes the fabric of their relationship. I would obtain this information from both partners' moment-by-moment interpretations either of specific dysfunctional interactions that have taken place between the two of them in the recent past or of a dysfunctional marital interaction taking place in my office. The specific interactions I would want to focus on would be those that are most characteristic of their relationship. The more concrete, specific, and immediate the interaction, the greater the likelihood that both clients would be able to explore their actual feelings and thoughts in the situation. Hence, a dysfunctional marital interaction occurring in my office would be particularly useful for assessment purposes.

Recall the situation in which Carl tells Trudy in my office that he needs her, but without any feeling in his voice. Trudy responds, "Get a maid!" and starts talking about leaving him. This simple interactional sequence would provide a perfect opportunity to explore whether Carl is aware of the lack of emotion in his voice. If not, I could point it out to him or simply have him listen to himself. I would then help him explore how he inhibits his expression of feelings and what beliefs, expectations, and fears lead to the difficulty he has in expressing his desires and needs to Trudy. This process would gradually help Carl to become more aware of his feelings and needs and to be

able better to express them. It might also help

Trudy to understand the fears and vulnerabilities that underlie Carl's difficulty in expressing his needs spontaneously. This understanding might help to disconfirm her belief that she is being exploited by Carl and to soften her feelings toward him.

I would also explore Trudy's fears and feelings of vulnerability that underlie her angry response to Carl. It may be that Carl's lack of emotional expressiveness in the present context confirms Trudy's dysfunctional belief that people are out to exploit her. It may be that she believes herself to be ultimately unlovable and that she interprets Carl's lack of tenderness toward her as confirmation.

As Trudy becomes aware of and is able to articulate some of the fears and vulnerable feelings that underlie her anger and threats of abandonment, Carl may begin to feel somewhat safer about expressing his feelings and needs.

Ultimately, both partners must assume responsibility for the roles they play in their dysfunctional interactions and come to see the ways in which their own fears and beliefs about intimate relationships contribute to their own behavior. In addition, learning to see and understand fears and

vulnerabilities that underlie the other person's characteristic behavior will help each of them to disconfirm his or her own dysfunctional beliefs about relationships.

Carl and Trudy must learn to communicate their underlying fears and vulnerabilities. Either partner, on encountering the other's expression of vulnerability for the first time in the relationship, would be confronted with new, powerful, and irrefutable evidence about the other.

This process will help to disconfirm the dysfunctional or pathogenic beliefs about intimate relationships that both spouses have. As these beliefs become disconfirmed, their behavior with respect to one another will continue to change. Carl will find it easier to communicate his feelings to Trudy as he realizes how his beliefs and fears inhibit his expression and as he is moved by Trudy expressing the vulnerable feelings underlying her anger. Trudy will soften her anger toward Carl as she becomes aware how her own fears and beliefs maintain her anger and as she begins to see that Carl does care about her and is not trying to exploit her.

At some point, it may be useful for Carl and Trudy to explore the role that various experiences played in the development of their respective beliefs about intimate relationships. This exploration may not be an essential component of the treatment process, but it can serve two useful functions.

First, it can facilitate the acceptance of responsibility as both partners develop a clearer sense of their own contributions to the dysfunctional interaction and the influence of their own histories. Second, such an exploration can help both clients appreciate that the beliefs they hold about relationships, while perhaps accurate and functional in a certain historical context, may be dysfunctional and subject to revision in the context of the present relationship.

Martin R. Textor (Systems and Integrative)

To formulate a treatment plan for Carl and Trudy, I would need much more information. I would ask Carl and Trudy about their parents; their development in childhood and puberty; their first sexual experiences; Carl's time in the orphanage; Trudy's past relationship to her parents and present one to her mother; her assessment of the impact of the sexual abuse on her later fears, sexual experiences, and attitudes toward men; Carl's experiences during the war; the earlier marriages (including similarities and differences between old and new partners); their marital relationship and sex life; their relationships to the children; the development of the children and their problems; and involvement in the marital conflicts.

Lacking this information, I can only speculate on the individual and marital dynamics. Carl appears to have developed an identity as a lone wolf in

the orphanage and in Vietnam. I surmise that he lost fights with older orphans. His experience was that when he expressed his needs and wishes, they were rarely or never satisfied. On the one hand, his self-assertiveness became impaired, and he allows others to take advantage of him. On the other hand, he became laconic and self-controlled. He might regard the expression of emotions, wishes, and needs (such as his need for Trudy and the pain of separation) as a weakness that will be exploited. His experience that he cannot rely on others and that they do not really come for him was reinforced by the sudden loss of his affectionate aunt, his divorce, and the short-term abandonments by Trudy.

Trudy's development led to her sense of herself as a homeless child. Because her parents were always moving, she did not feel at home anywhere; she felt like an orphan. She might regard her present marriage as another phase in an endless sequence of brief episodes that leave her anxious, insecure, and emotionally uninvested. Having had no friends in childhood and early adolescence, she did not learn to get involved with others and to trust them. Her mother's unreliability and failure to protect her from her stepfather reinforced her expectation that people will let her down. Like Carl, Trudy had to fend for herself from early on, but unlike him, she was not successful in the practical world, and she developed feelings of inadequacy, low self-esteem, and a poor self-image. She was afraid of getting a job and perhaps of Carl's

expectations. Despite Carl's evident success, she did not have high regard for him, and she viewed him as exploited by others. She might have been comparing him to an idealized image of her courageous and loving father. Could there be object conservation and unresolved mourning?

Thus, we have two extremely lonely and untrusting individuals living together. Both are unable to express their feelings, thoughts, needs, and wishes. Moreover, Trudy cannot differentiate between emotions and often has no evident reasons for them (her jealous rages, for example), while Carl has strong defenses against emotions, cuts off his own, and avoids Trudy's. He wears the mask of the "super-reasonable" (Satir, 1972), while Trudy acts like an "irrelevant person" who talks a lot but says little of importance. Both suffer from disturbances in communication, such as exclusion of topics, ineffective verbal expression, and lack of feedback. These disturbances also impair their problem-solving capabilities.

Their unresolved conflicts are acted out in the sexual sphere, and Trudy probably fails to communicate how much she needs love and affection because of an incorrect assumption that her partner will know by himself.

Carl may feel that the world owes him a lot since nobody cared for him in childhood and because he was wounded fighting for his country. According to his "merit accounting" (Boszormenyi-Nagy & Spark, 1973), he no longer

has to give, and he deems it fair to take. He expects a lot from Trudy, including her being ready for sex from the moment he enters the apartment. However, Carl's expectations are not fulfilled as Trudy's merit accounting shows she has given a lot and now has the right to take: she lost her father, and she had to meet the demands of her mother, to submit to the sexual urges of her stepfather, and to relinquish her self-fulfillment by caring for her children on her own after her first husband deserted her. Thus, she may be making Carl responsible for her happiness.

Carl is self-controlled, pretends to be emotionally self-sufficient, and tends not to say what he wants, and Trudy lacks self-control, is impulsive, immature, and extremely needy. Sometimes she acts like an anxious child who wants to be held and comforted. Since Carl does not show love or consideration, she becomes, at the same time, deeply afraid (that she will be left again or that the marriage is just another episode in her life) and extremely angry (because of not receiving her just share or because she feels unloved and exploited). She tries to escape from this situation, thereby punishing Carl for not giving to her. However, this step increases her fear and her anger, for Carl does not show his pain and suffering and does not express a strong need for her or beg her to return. He cannot allow himself to be dependent on her or to show weakness.

Their marital system suffers from a lack of restorative mechanisms. It is

an “unstable unsatisfactory relationship,” in the words of D. D. Jackson (1968). Their system is not well- defined because expectations and wishes are not verbalized, and since there is little problem solving, conflicts can easily get out of hand. Both spouses married unwisely (at least the first time) and do not fulfill their marital roles well. There is no information given on how Carl behaves as a father; Trudy, however, seems to follow the example of her irresponsible mother. She did not use birth control, thereby allowing herself to become pregnant for secondary reasons, and she does not care for her children consistently. She seems to be unsatisfied with her role as mother, and she wants a job.

Carl and Trudy are still willing to undergo psychotherapy. Since both individual and marital problems are of great importance, I would suggest continuing in one of two ways. The first possibility is *parallel psychotherapy.* If Trudy is still unwilling to return to Carl, I would offer her individual therapy. She accepted the suggestion to return for at least one session. I would use this opportunity to motivate her to discuss with me, or with a female cotherapist, the loss of her father, the sexual abuse, and her strong, undifferentiated feelings. Carl is motivated by the necessity to lower his blood pressure, and I would offer to treat him separately from Trudy, focusing on his experiences in the orphanage, in Vietnam, and on the job, as well as on his love life. Ideally, the parallel psychotherapy would lead to marital therapy in which common

problems could be discussed.

The second possible method is *collaborative or serial psychotherapy.* If Trudy returns to Carl, I would offer them a sequence of individual and conjoint sessions. The individual sessions would be to discuss important events in their lives and their intrapsychic conflicts, and the conjoint sessions would be to discuss marital problems and child-rearing issues. I would prefer these sessions to be conducted with a woman cotherapist, an arrangement that permits role modeling and perhaps greater empathy by each therapist for the client of the same sex. Moreover, the relationship between the therapists can serve as a symbolic marriage in which marital and parental behaviors, joint problem solving and decision making, the acceptance of individual differences, and mutual respect are modeled.

I think that Trudy will be hard to keep in psychotherapy because she has not learned to sustain longer-lasting relationships. If she gets a lot of support, positive regard, and warmth, she may continue the treatment. Carl is better motivated but may be hard to activate, especially with respect to expressing feelings and needs. Thus, I would act as a role model trying to help him learn how men express emotions and show affection and how they can be open without getting hurt.

Carl will also need some warmth and affection to help him stay in

treatment; he needs help in making contact with inner experiences. I would often ask what he feels, thereby making emotions conscious, fighting defense mechanisms such as rationalization, broadening the range of his feelings, and increasing his sensibility. By modeling, shaping, and role playing, he could learn much about congruently expressing his thoughts, feelings, and wishes, and in the course of participating in these therapeutic processes, he may become more trusting. If it is true that he is exploited by his boss and subordinates, assertiveness training is indicated.

Trudy needs to learn to differentiate emotions and to identify unreasonable ones. I would help strengthen her self-control by showing that she is responsible for her feelings and that she can decide how to react emotionally. I would also challenge her negative self-concept by emphasizing her strengths and uniqueness. I would ask her to close her eyes and remember the traumatic events of losing her father and of being sexually abused—an exercise that would foster catharsis, interpret feelings, terminate unresolved mourning, and diminish object conservation.

Conjoint sessions would provide an opportunity to foster open and honest communication between Carl and Trudy. I would facilitate a dialogue about emotions, needs, attitudes, and expectations; ask Carl and Trudy to express everything they feel at a given moment; and encourage each partner to explore the other's inner world. Thereby, I would identify communication

disturbances such as incongruence while teaching them listening skills and empathy. I would also clarify signals about sex, further the nonverbal expression of love and affection (maybe prescribing sensate-focus exercises), and attempt to enhance intimacy.

I would ask Carl and Trudy to discuss their so-called merit accounts and the resulting expectations that cannot be fulfilled. This discussion would lead to a more appropriate definition of their marital relationship—one that takes only realistic desires into account. I would also attempt to increase the stability of the marriage by teaching Carl and Trudy problem-solving and conflict-resolution skills. After they have taken responsibility for their marriage, family sessions might be indicated for the discussion of their relationships to their children and their child-rearing methods.

Robert N. Sollod (Integrative)

A core tenet of an integrative, pluralistic approach to psychotherapy is the acceptance of the validity of a number of experiential and therapeutic domains. In application to the presented case, this approach would require additional probing, especially of Carl. I would need more information about the couple's courtship, the positive aspects of their marriage, the couple's sexual behavior, the level of functioning of their children, the family dynamics, Carl and Trudy's patterns (if any) of use or abuse of drugs or

medications, and any aggressive, violent, homicidal, or suicidal behavior they may exhibit. Information about these areas would help determine the appropriate types of therapeutic intervention.

Additional information on Carl's presenting problem, hypertension, should be obtained from both Carl and his physician. Is there a family history of cardiovascular problems? What is the history of Carl's hypertension? Has its severity been related to specific events or situations in his life? If there is a correlation, a chart summarizing it could be constructed. What medication, if any, has been prescribed? What side effects are present? (Common side effects of drugs that lower blood pressure include erectile dysfunction and mild to moderate depression.) Are there treatment compliance issues? What life-style and nutritional factors may contribute to

Carl's hypertension? How much fat, cholesterol, and salt does he ingest? Does he smoke? What patterns of physical activity and exercise does he engage in? Minnesota Multiphasic Personality Inventory (MMPI) results and assessment of Type A behavior might reveal personality patterns related to hypertension. Based on thorough, detailed information, I would decide whether hypertension should be a focus of treatment, how urgent the problem is, and what other factors might be addressed. Treatment modalities such as biofeedback, relaxation training, cognitive restructuring, reduction of Type A behavior through behavior modification, encouragement of emotional

expression, and catharsis could all be helpful. I might refer Carl to other professionals for work in specific modalities or for obtaining assistance in diet and exercise.

Veterans who experienced combat in Vietnam have a high likelihood of distressing emotional sequelae. According to Laufer and Gallops (1983, p. 6), "Limiting of the emotional scope of the veteran is likely to limit his inclination to enter marriage or to find an acceptable partner ... or to satisfy his mate's emotional needs and maintain the relationship over time." Carl's emotional numbness, lack of responsiveness, and inability to connect emotionally with his wife are typical symptoms of posttraumatic stress disorder (PTSD) in Vietnam veterans. His possible victimization at work (as reported by Trudy) may be connected to his war experiences. Wilson, Smith, and Johnson (1985) state that the survivor of a traumatic event begins to perceive his or her destiny as shaped by external forces over which he or she has little or no control and to see the world as hostile, threatening to inflict more pain and suffering.

Carl's hypertension may result from a state of constant vigilance and accompanying automatic arousal, often a symptom of PTSD in Vietnam veterans. Recent research has indicated that the various symptoms of PTSD in war veterans are directly related to the type and severity of stressors experienced during the war, as well as to preexisting problems.

It is ironic that Carl is referred to in the title of the case history as "the returning hero," because the status of hero has been denied Vietnam veterans, who were often treated as outcasts. Not only Carl's war experience, but also the nature of his subsequent reintegration into society should be explored.

Trudy's relational dynamics are consistent with a diagnosis of PTSD. She is a grown-up, sexually abused child. Ideally, she should participate in group therapy with other grown-up incest victims. In such a therapeutic atmosphere, she could get in touch with the intensity of her feelings about her incestuous experiences and could develop insights into how these traumatic events have affected her current relationships. Analogously, if Carl is found to have a traumatic-stress-related disorder, there could be significant benefit for him in participating in a Vietnam veterans group. Both of these forms of PTSD could be addressed in individual therapy, but the group method with participants who have undergone similar stresses has proven preferable. Perhaps this group approach could be supplemented by individual therapy. Trudy and Carl also appear to need help in the development of parenting skills. This parenting area should be explored carefully and some sessions should be devoted to assisting Trudy in acquiring more competence as a parent.

I would suggest that Carl and Trudy delay any decisions on their

marriage. A moratorium—which could involve living together or apart—would give them the opportunity to deal with the tremendous emotional burdens that each is bringing to the relationship. They both need significant individual support during therapy, although Trudy appears to be the pivotal person at present regarding the continuation of the marital relationship. Developmentally, Trudy is struggling with issues at the trust-mistrust level, whereas Carl has not yet successfully resolved intimacy-isolation issues. The behavior of each reinforces the fears and suspicions of the other, and as a result of intrapsychic conflicts and preoccupations related to past traumas, both Trudy and Carl would likely discount positive changes in the other. To the extent that each is able to resolve his or her own issues enough to perceive the behavior of the other more objectively, couple counseling to resolve relationship issues would be warranted.

A beginning point in such couple counseling might well consist of aiding Carl and Trudy to become more sensitive to the emotional burdens that the other is carrying.

The case, as presented, leads one to consider strategies of treatment management rather than of therapeutic integration per se. Both clients would likely benefit from a combination of different therapeutic modalities. The primary therapist would have to provide Carl and Trudy with a clear rationale for the selection of therapeutic approaches, assess their impact, and

modify them as warranted. Both Carl and Trudy eventually need to make a decision about their marriage, but it would be premature to try to resolve this problem at the outset.

Points of Contention and Convergence

Jeremy D. Safran

My impression is that the most important point of convergence among the three orientations is our common recognition that Carl and Trudy are caught in a dysfunctional interaction of their individual maladaptive cognitive interpersonal cycles. There appears to be an agreement that Carl has difficulty communicating his feelings directly and that Trudy has a tendency to interpret Carl's behavior as exploitative, even when it is not. There also appears to be an agreement that Trudy's style of angry withdrawal further aggravates Carl's difficulty in being emotionally open and vulnerable.

Also, all three panelists appear to agree that change will take place through both partners' becoming aware of the roles that their respective issues play in the marital problem, learning to communicate their feelings in a more honest and direct way, and coming to see the hurt, fear, and vulnerability that lies underneath their partner's problematic behavior.

Both Textor and Sollod recommend supplementing couples therapy with individual therapy. While this is a recommendation that I did not make, it certainly seems to be a reasonable one, particularly given the apparent severity of the clients' individual problems.

The most important differences between Textor's and Sollod's orientations toward the case and my own is the source of the information on which we base our formulations and the relationship between formulation and treatment. As I indicated initially, I am reluctant to develop an elaborated formulation on the basis of the information available to me at this point. My formulation would only come from an in-depth exploration of the way in which both clients construe the present situation.

Textor has also indicated a reluctance to develop an elaborate formulation on the basis of the information available to him. The difference between his perspective and my own, however, appears to be that he would want more historical or biographical information to formulate a treatment plan, while I feel much more comfortable giving weight to the information that emerges through a careful phenomenological exploration of both clients' present construing processes. I am concerned that an overreliance on historical information would blind me to the subtleties of both clients' inner worlds as they reveal themselves in the here and now. For this reason, I feel at a disadvantage when the case material is presented in the present format; I

feel limited in terms of the inferences that I can draw and constrained to speak in tentative generalities.

Sollod appears to pay greater attention than either Textor or I do to diagnostic formulations. He reasons that if both Trudy and Carl are suffering from specific forms of posttraumatic stress disorder (sexual abuse in Trudy's case and war trauma in Carl's), assignment to relevant therapy groups would be helpful. I do not rule out the possibility of both partners benefiting from relevant groups. I am more inclined, however, to develop an evolving formulation of both partners on the basis of an ongoing assessment of the respective phenomenologies rather than to assign them to treatment modalities on the basis of my initial formulations.

The particular way in which the case is presented calls for a rather static portrayal of the formulation and treatment process, and hence Textor's and Sollod's accounts probably do not do justice to the way in which they work in practice. Both therapists, however, appear to me to feel more comfortable than I do in speaking about predestined treatment programs or modules on the basis of their initial formulations. To me, however, so much of what goes on in therapy involves moment-to-moment process considerations, so talking about specific treatment programs in advance does not make much sense. A so-called treatment program seems to be too large a unit of analysis.

Martin R. Textor

For me, all psychotherapy approaches are "personal theories" (Textor, 1985, 1988). They are not scientific theories based on empirical data and serving as models of reality; rather, they serve as "manuals" guiding a therapist in his or her work. Because the therapeutic situation is extremely complex, a therapist has to focus on a small number of selected variables and neglect the others. Otherwise he or she would be overwhelmed by the multitude of verbal and nonverbal responses, by intrapsychic and interpersonal patterns, and by situational factors, not all of which can be perceived, considered, and evaluated. Thus, each therapist has to limit himself or herself to a reasonable and manageable number of variables. The therapist thereby arrives at a unique personal theory, which is strongly influenced by biography, personality structure, view of people, and attitudes.

Accordingly, I can accept all approaches to psychotherapy as long as they are well-founded and work with the respective clients. Thus, I agree with nearly all of Sollod's and Safran's thoughts on how to treat Carl and Trudy. Moreover, I did not notice great differences from what I wrote. Sollod made me more aware of the medical and life-style aspects of Carl's hypertension and of the characteristics of posttraumatic stress disorder (which is little discussed in West Germany). In hindsight, I think it worthwhile to consider suggesting that Carl join a Vietnam veterans group and that Trudy join an

incest victims group. However, I might refrain from those suggestions for fear that Carl and Trudy might be overwhelmed by too many treatment formats (and therapists). Safran made me notice the importance of Carl's and Trudy's belief systems. In contrast to Safran, I would try another treatment format and put more emphasis on the life history of each client. I would also put more importance on improving the clients' (especially Trudy's) parental behaviors; but I assumed they would come around, so I did not mention it.

I believe that in each idiosyncratic case, hypotheses, strategies, and techniques from different schools of psychotherapy should be combined—those that best fit the characteristics of the case and that are most likely to be successful. Accordingly, in the case of Carl and Trudy, I refer to psychodynamic approaches (interpreting past relationships, traumas, and experiences as well as impact on the present), behavioral approaches (modeling, role playing, assertiveness training), Rogerian psychotherapy (furthering self-actualization, contact with inner feelings), and approaches of family therapy (merit accounting, improving communication and child-rearing skills).

While such personal, eclectic approaches in psychotherapy may always be the reality in practice, I also believe that we must achieve a theoretical framework for therapy more satisfying than is afforded by the present multitude of limited, one-sided conceptualizations. Therefore, I strive for the

integration of effective approaches. To the extent that these approaches concentrate on different variables and focus on certain aspects of the client and therapist situation, they are mostly complementary and compatible. An integrative theory (Textor, 1989), more comprehensive than personal approaches to psychotherapy, takes into account the multicausality of phenomena, the complexity of reality, and the complex interplay of biological, psychological, interactional, systems, and sociocultural variables.

Robert N. Sollod

My main disagreements with the initial responses of the panel, and on some points with my own position, concern the level of knowledge and understanding of the clients, our attitudes toward the clients, and the establishment of a therapeutic bond. The case history, with its allusions to various events in the lives of clients, has a two-dimensional feel— possibly inevitable as a result of space limitations. It is possible that the information as originally presented is colored by a therapeutic attitude that led to major difficulties getting therapy off the ground. Whatever the cause, the panelists, including me, may not have fully spotted the problem.

I admit that, based on the information provided, I do not genuinely know or understand either Carl or Trudy. Rather, the events in their lives and their reported behaviors lead to probabilities generated in my own mind that

these events or behaviors are connected to presumable personality characteristics. Carl was an orphan, Trudy had been sexually abused, Carl is a veteran, both were divorced, therefore, what?

Our psychological training and experience should have sensitized us to the proposition that such a series of facts in many cases can camouflage the true stories of the lives of people. Not all adults who were orphans as youngsters are alike, nor do they all have similar experiences and dynamics. Most of our conclusions are drawn from the questionable logic of reasoning from small parts to the whole. I wonder what we would think of clients who made major interpersonal commitments based on such a paucity of information.

It is difficult to escape this trap, both in the current endeavor and in actual practice, because we are often called upon to reach conclusions based on insufficient evidence (Sollod, 1982). Safran is more tentative and cautious in his conclusions than is Textor, who comes up with many speculations without adequately qualifying them. Until a clearer, fuller story emerges, the words of Socrates seem relevant— "One thing I know is that I know nothing."

One area of major disagreement I have with the other panelists is the likelihood of Carl's suffering from posttraumatic stress disorder, which I do not believe either mentioned. At the very least, I think there should be an

attempt to interview Carl regarding his adjustment to the Vietnam war and to assess him carefully for signs of posttraumatic stress disorder. If he does turn out to have PTSD, then the choice of Trudy as a partner becomes more understandable. Perhaps she is acting out the fear and turmoil that Carl is hiding from in himself.

None of the panelists, including me, emphasized the areas of growth that Trudy has demonstrated. Survival is, in such circumstances, a major achievement. We are informed that Trudy has read widely and has, in a sense, made up for a lack of formal education by her own efforts. She is also interested in psychotherapy. The case presentation suggests that both married "unwisely" the first time since their marriages ended in divorce, and they were each left with children. Positive aspects of the first marriages of each are not presented, and they just might be doing some things right in their difficult chores of parenting. Textor views Trudy as following the example of her "irresponsible" mother. Does he appreciate, I wonder, the struggles she might have undergone to keep her family together and the sense of helplessness that might underlie her potential decision to leave her older children with Carl? Is it merely a question of irresponsibility? In general, I found Textor's approach to reflect a pathologizing attitude that would be less likely to facilitate the development of a therapeutic relationship.

I have a strong impression that the breakdown that seems to be occurring at the beginning of therapy is somehow the result of vagueness or confusion in setting up the therapeutic contract. Safran addresses the issue of sorting out these issues at the beginning of therapy, but he does not give them the needed level of attention. Textor more or less tries to bypass these issues. In my rereading of the case, these complications regarding the development of the therapeutic relationship now seem paramount (Beitman, 1987).

Hellmuth Kaiser, according to Shapiro (1989), said that knowing what to do in therapy is much less important than the attitude of the therapist. An attitude of respect for the patient can emerge, according to Kaiser, only from understanding the patient. The lack of understanding and the paucity of indications of positives (Wiesen, 1977) in the narrative are both indications and continuing causes of the lack of a good, working therapeutic relationship with either client.

Assuming that a therapeutic contract could be negotiated and a good therapeutic relationship established, then one main question the case presents is that of sorting out each partner's lifelong difficulties, problems, and needs. Both Safran and Textor, I believe, are aware of this problem and address it well. Textor considers the possibility of different modalities as a partial solution. I suspect that much effort will be needed to help both Carl and Trudy resolve some of their own issues—prior to the possibility of a lot

of work on the relationship. It might turn out, however, that some solution of relational issues can be reached without much progress on individual issues. Issues of basic trust or intimacy can often be resolved, in part, through positive relational experiences.

I especially like Textor's concept of merit accounting, and I believe that it does hold promise for this couple. I agree with the approaches and tactics that Textor and Safran would use once therapy actually got under way. I agree with their emphasis on improving the relationship and, at the same time, their sensitivity to the needs and concerns of both Carl and Trudy. Safran is more of a therapeutic optimist than I am regarding this case, since I am more convinced that individual limitations may severely affect what they can reach in their relationship. I agree with Textor's options of parallel therapy, collaborative therapy, and serial therapy and with Safran's options of individual therapy, couple therapy, or no therapy. Less pressure on the couple will result from the availability of such options.

One final suggestion is that *cognitive decentering* regarding the relationship be promoted for both Carl and Trudy (Sollod & Wachtel, 1980). In this process, each should become more able to sort out his or her own experiences from the problems of the other. If this sorting can be accomplished, there will be a lower likelihood of downward interpersonal spirals whereby each partner's problems would trigger excessive reaction

from the other.

Author

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