A Dialogue Between Control-Mastery and Self Psychology

November 3, 1990

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Welcome

Jessica Broitman, Ph.D.

Hello. I am Jessica Broitman, coordinator of today's conference, and I'd like to welcome you to "A Dialogue Between Control Mastery and Self Psychology," sponsored by the San Francisco Psychotherapy Research Group and the Extension Division of the San Francisco Psychoanalytic Institute. We have a full schedule in what should be an informative and thought provoking day. I have several announcements to make concerning our schedule but first I want to tell you briefly about who we are.

Many of you have known us previously as the Mt. Zion Psychotherapy Research Group. As of October 1, we have incorporated into our own independent non-profit organization dedicated to studying how therapy works. We offer courses, workshops, and ongoing case conferences which are open to the public. We have two very active research groups, members of whom work on a variety of empirical research projects. Originally formed in 1972 by Drs. Weiss and Sampson, the research groups have over 100 active members. The research groups seek to empirically test Weiss's hypotheses on how patients make progress in psychotherapy. Weiss believes that patients suffer from certain unconscious beliefs he calls pathogenic. These beliefs hinder patients in their pursuit of certain normal, desirable goals. Patients are unconsciously motivated to disprove these beliefs. They work both consciously and unconsciously to disprove them. This, according to Weiss, is the essence of psychotherapy. Weiss's theory has been named Control Mastery theory to emphasize a patient's ability to exercise some control over his mental life and unconscious mind, and to acknowledge his wish to master traumatic experiences which have inhibited his development.

Weiss began his investigations in 1958 by studying the process notes of psychoanalyses. Weiss noticed certain phenomena which could not be explained by Freud's

original theories but were compatible with Freud's later writing, such as a patient's ability to change or acquire insight without an analytic intervention. Weiss published his first article, "Crying at the Happy Ending," which explored his observation that one could and did lift repression when one believed it was safe to do so, in 1952 in the Psychoanalytic Review.

In 1965 Weiss began a collaboration with Dr. Hal Sampson. Together they have successfully directed many research projects which test the validity and predictive powers of Weiss's theory of psychotherapy.

In 1986 Weiss, Sampson, and the Mt. Zion Psychotherapy Research Group published The Psychoanalytic Process: Theory, Clinical Observation & Empirical Research describing their work. It is available for sale at the registration desk during lunch breaks and after the conference. Lewis Engel's new book, Imaginary Crimes, which describes control mastery theory for the general public is also available along with three readers. The first is comprised of several of our articles; the second contains copies of the papers presented at last years conference, The Outpatient Treatment of the Alcoholic Patient; and the third contains papers presented at our conference held two years ago comparing traditional psychoanalytic theory, self psychology, and control mastery theory, a dialogue we look forward to continuing today.

We are pleased to have the opportunity to work with Dr. Ornstein to further our understanding of the differences and similarities of these two ground breaking theories. We have much to learn from each other about how to be most helpful to our patients.

As you are all well aware, a great deal of work is required in order to put on a conference. I would like to thank the conference committee of Jamie Edmund, Jane Jordan, Suzanne Gassner, Hal Sampson, and Joe Weiss for helping me with the arrangements. Special thanks are to be made to our administrative assistant Kelly McMullen whose hard work made for a smooth and pleasurable process.

I'd now like to introduce Dr. Kay Blacker, who will be our moderator today. Dr. Blacker is a professor and Chairman of the Department of Psychiatry at the University of California Davis Medical Center in Sacramento, California and training and supervising analyst at the San Francisco Psychoanalytic Institute. He is a graduate of the University of Utah, School of Medicine, the Langley Porter Neuropsychiatric Institute and of the San Francisco Psychoanalytic Institute. He is a member of the American Psychoanalytic Association, American Psychiatric Association, and the American Psychoanalytic Society. His professional activities include, among others, Examiner for the American Board of Neurology and Psychiatry and Consultant for Psychiatric Residency Training Programs of the American Psychiatric Association. He is Chairman of the annual Mid-winter Program in Continuing Education for Psychiatrists, Chairman of the Committee on Research and Special Training at the San Francisco Psychoanalytic Institute and Chairman of the Committee on Physician Health at the University of California Davis, School of Medicine. His research interests include patterns of cognition observed in psychotherapy and individuals with panic and anxiety disorders. We are pleased to have him.

CASE PRESENTATION

by William Dickman, M.D.

November 3, 1990*

I am happy to be here today to present a case which will, hopefully, serve as a springboard for all of us to learn from one another and sharpen our thinking about dynamic issues. But before proceeding with the case material, I'd like to thank the members of the organizing committee for asking me to present today; I feel privileged to be able to do so. I would also like to express my appreciation and gratefulness to Joe Weiss and Hal Sampson for the intellectual leadership and support they have provided in an on-going way to those of us in the Control-Mastery Group.

The case I'm presenting today involves the four-year treatment of a severely disturbed, primitive suicidal, violent young man. He embodies the type of patient not usually treated on an outpatient basis. His first three years of treatment were involuntary. Treatment was mandated as a condition of his probation. During this phase, the first 3 years, the patient made remarkable and surprisingly impressive and far reaching gains. However, for reasons entirely beyond my control as his therapist, which I fought vigorously against, the mandate for involuntary treatment was removed and over the last year the patient then saw me voluntarily. He relapsed markedly, then quit therapy entirely. So we'll be in no danger today of crying at the happy ending; I want to warn you about that in advance. However, the case did involve a number of telling and worthwhile features which I believe make it particularly suitable for our dialogue today -- including severe, narcissistic injury and a marked discrepancy between the patient's conscious desire to be free of treatment, not to do treatment at all, and his unconscious desire and plan to be in treatment. It illustrates how compulsory treatment can not only be effective, but how compulsory treatment sometimes is the only effective means for successfully treating certain issues. These issues concern paralysis on the part of parents in establishing protective limits and boundaries; and they concern issues when parents and other authorities misread issues of self-destructiveness as autonomy issues.

The patient, whom I will call David, began seeing me when he was 20 years old. He was a single Caucasian male with a high school proficiency certificate who was living at his 80 year grandmother's house.

* I would like to express my appreciation to Drs. Harry Coren, Suzanne Gassner, Hal Sampson, and Joe Weiss for sharing their ideas with me regarding the patient, his family, and the course of treatment. Discussions with them provided me with a most valuable enrichment of my understanding of the many issues involved in the case.

He had a younger brother and identical twin sisters who were younger. They were living with mother and father at the family home. The father was a radiologist working in a group practice in the Bay Area. The mother had been a full time housewife ever since the patient was born. David was referred to me nine days after his second arrest for drunk driving. He had not been arraigned yet. He said he wanted to see me because "it would look better in court to be in psychotherapy when he came before the judge". However, he also told me he had been feeling very despondent and about four days prior to his first session, he had actually fashioned a noose for himself from his bathrobe belt, looped it over the shower curtain in his bathroom, placed it around his neck and then reconsidered and took it off. In addition, he told me he was terrified of the prospect of being in jail, particularly out of fear of a possible homosexual violation.

His current difficulties had really begun in force when he was 18 years old. He had been driving his car wildly in the neighborhood of his parents' home. Police were called and shots were fired. He drove off and was never arrested. Also at age 18, he was working in his father's office but had significant difficulties with this. He would arrive late for work, shun people in the office, have screaming matches with his girlfriend over the phone in the office, and in other ways cause a great deal of disruptiveness. He was beating up his girlfriend at least once a month -- real physical assaults where he was slugging her very vigorously with closed fists. He was drinking each weekend to the point of getting drunk. He was smoking marijuana frequently. At home with his parents he was very violent, hitting his mother with closed fists, throwing chairs through windows, sweeping dishes off the table onto the floor when he was upset, slamming doors and shouting uncontrollably -- a terribly, terribly out of control young man.

When David was 18 he was asked to leave the family home by his parents at the suggestion of a child psychiatrist who was treating his then 11 year-old brother. That child psychiatrist told his parents that David was severely character disordered and that for the sake of the rest of the family he should have his own place. His parents agreed and rented an apartment for him. Shortly after David moved out, he was arrested for reckless driving.

At 18-3/4, David was arrested for the first time for drunken driving and a few days later he was evicted from his apartment. He'd absolutely trashed the place, screamed at the neighbors and disturbed occupants at the apartment building to the point that they complained vehemently with the landlord. So his parents moved him into his 80 year old grandmother's home. Then came the sentencing for the drunk

driving offense -- a $500 dollar fine (which father paid), drivers license suspension for six months, and six months probation.

At age 19, David stopped working in his father's office and began junior college. However, he was not able to make any progress as he was unable to get up in the morning consistently to get to class. When he was in class, he was too nervous to stay there and he couldn't deal with the anxiety engendered in him by taking exams.

After the six months of probation and license suspension ended, David began driving again. He was not working and not in school and he'd drive around with friends or by himself for half the night. At his grandmother's home he would smash TV trays and smash telephones, kick in doors and kick the furniture. He would drive his car up on the lawn. He would stay up all night and sleep all day. He would invite friends in to sleep off binges they'd been on. He grew marijuana in various flower pots throughout the home.

Four months following the end of probation -- and this is of note -- he stole food from a Safeway store. So probation ended and he began getting in further difficulty. Soon thereafter, he stole a case of beer from a beer truck. And then, at age 20, he was arrested for the second time for drunk driving. So a clear pattern was emerging. When he was unsupervised and not actively being regulated by some sort of structure, legal or otherwise, he would relatively quickly get himself in more trouble. So at age 20, following his second arrest for drunk driving, he was referred to me.

How does a young man become this way? His past developmental history obtained from his parents revealed that mother and father had married at 23 and 26 years old respectively. They were not able to conceive for five years. Mother and father both worked full time during this period. Finally mother became pregnant. The pregnancy was essentially unremarkable as were labor and delivery. Mother ceased working outside the home when David was born. During David's first year of life, he had high fevers up to 104-105 °F, and had to be rushed to the hospital a number of times for treatment. David's motor, social and speech developmental milestones for the first few years were all normal. Mother noted, though, that between the ages of two and four and a half, he could be characterized as bright, excitable, "hyper," intense, restless, anxious and totally doted upon by mother. She told me that her world revolved around David. Father was a

brilliant workaholic who was distant from David (and to a very great extent from mother as well), and she says she compensated for this by doing everything with and for David.

David began kindergarten six months early, at age 4 , in public school. However, his parents were not satisfied with the teacher. They had David tested by a psychologist, who noted that David was "very creative." So his parents removed him from this classroom because "David had a rigid teacher who was not appreciating his creativity." Because he was very bright, they decided at that point to skip him into the first grade. So let me note that in regard to David and the family attitude toward external structure, that this was the first (but certainly not the last) instance where, when there was a conflict between David and the prevailing external structure, his parents said that there was something wrong with the structure and that their boy needed to be protected from it.

So David was placed into the more demanding setting of a first grade classroom at age 4-1/2. (This was the first of a number of dislocations and abrupt changes of circumstance.) First grade proceeded relatively normally, as did second grade. But by the time David was in the third grade, he was, according to mother, "hyper, anxious, forgetful of assignments, always out of his seat, easily overstimulated, distractible, and very sensitive." His parents then took him to a pediatric allergist for a consultation. The allergist diagnosed multiple allergies, and a special diet was prescribed. The allergist also found David to be quite hostile, and recommended a neurological consultation.

The pediatric neurologist found David to be intact and normal neurologically, and no recommendations were made. Conspicuous by its absence, in my opinion, was the lack of a recommendation for a child therapy consultation at that point.

While David was in third grade, his younger brother was born. He'd been an only child for several years and then his brother came along. Further difficulties ensued in third grade for David, and his parents finally did have him tested psychologically. Testing revealed a verbal IQ of 134, a performance IQ of 106, and a full scale IQ of 123. Following the psychological testing, his parents removed him from his public school third grade class because "the teacher was trying to get this bright, creative youngster to conform too much." He was then placed in a private school setting, and repeated third grade. So now, after having been skipped ahead of his age appropriate placement from kindergarten into first grade and then repeating third grade in private school, he was back at his age appropriate level but in a completely different setting. Also, this was

the second dramatic instance where, when there was a difficulty between David and an authority figure, the authority figure (the teacher) was changed.

In the fourth and fifth grade in private school, David earned B's and C's. He displayed increasingly poor behavior. He could not organize himself and school became increasingly frustrating. During his fifth grade year, his sisters were born. Also during this time period, he had a homosexual encounter with a neighbor boy who was 14 or 15. David reports that David's participation was involuntary, but was never able to furnish significant details about this encounter during therapy. He did say that he felt terribly ashamed, humiliated, and awful, to the point that he could not bring himself to tell his mother or anyone else about it. He finally told his mother about it nine years later but kept this very emotionally difficult experience to himself for that whole nine years.

In the sixth grade, his grades fell to the C and D level. He would fall apart after making one slight error. His school behavior remained poor. His parents took him for educational testing. This revealed poor math skills, good verbal skills, a pronounced fear of failing, and a pronounced and striking tendency to deny and avoid aspects of situations which made him uncomfortable.

Mother recounts that the following year, 7th grade, was very pivotal. She notes that David would be out skateboarding in the neighborhood at 11:00 or 12:00 at night. It was in a well-to-do Bay Area neighborhood, so it probably was physically safe but David would be out there and he was on his own as to when he came in. Mother would be laying in bed next to father and would say to him, "Would you please go get David?" And father would say, "Look, if you want him in, go do it yourself." Mother would then turn over and go back to sleep. So David was completely out on his own. Neither parent would take initiative, and David would come in whenever he felt like it, no matter how late it was.

David became delinquent. He began removing hood ornaments from expensive cars. School pressures intensified, and a recommendation for child psychotherapy was at last made, in this case by the school. Father refused the recommendation outright, though mother says that she was open to it. Instead, father pulled David out of the private school quite abruptly, due to "too much pressure on David." So this was the third time in 8 years of school there was a sudden, abrupt, major shift for David.

During 8th, 9th, and 10th grade, David went to four different public and private schools. He did poorly in all of them and became increasingly violent, particularly at home. He would have temper

outbursts in which he would swear and scream and would knock dishes off the table when he felt like it. There were usually no consequences for his loss of control. The family further developed a "peace at any price" philosophy of trying to appease him. After an explosion, they would try to leave him alone, and not provoke him further, handling him with kid gloves, hoping things would remain quiet for a time.

David used alcohol and marijuana increasingly in his middle teen age years. When he was 16, father agreed at last to a trial of psychotherapy for David. It lasted 3 to 4 months, and everyone in the family reports that it was of little or no benefit. Finally, when David was a junior in high school, his family's tolerance was exhausted, and they abruptly sent him to mother's relatives in the South. The pattern of severe over-permissiveness, followed by abrupt, total rejection was one that David had to confront.

Following a year with mother's family in the south, he returned to the bay area for his senior year in high school. He did poorly, dropped out, and then took the SATs. He scored a 640 on the verbal, and a 490 on the math. When he was 18, he obtained his high school certificate of proficiency by taking the requisite test. Behaviorally, he displayed a pattern of increasing recklessness, and increasing verbal and physical violence at home and with girlfriends.

The above summarizes the reason for his referral to me, and the present and past history as I learned it. The treatment thus began with this huge crisis precipitated by David's second drunk driving arrest. He was very frightened, and his parents were very frightened about what this would mean. It was not his first arrest, but his second, and the laws had become somewhat tougher, though not to the point that they are today. Everyone was wondering if he would have to go to jail. It was a huge family crisis involving almost explosively intense affects of fear, shame, guilt, and anger.

David's parents were distraught and close to panic and asked me for advice on how to handle the situation. His father stated, "I'm sick and tired of bailing David out of things. I've done it for years, in terms of school, and delinquency, and reckless driving and his first drunk driving conviction. God damn it, let him rot in jail! He got himself into this mess, let him damn well get himself out!" Mother said, "This is the most shameful thing imaginable. No boy of mine is going to end up in jail. If you let that happen, husband, I'll leave you and take his younger brother and sisters and return to my family in the South. You and I, husband, know influential people in the community, and I want us to speak with them, and pull strings, and

to talk to the judge, and make sure that whatever happens, that David not go to jail, because if he does, I won't be able to stand it!"

I told David's parents that what I felt would be helpful would be to avoid either one of these polar opposite responses. If David were left totally to himself and defended by a public defender, I felt that he would feel abandoned, rejected, shamed, and discarded by his family at the hour of his greatest need. I told them that I thought they should get David a good lawyer but should not try to subvert the legal processes by pulling strings or utilizing their influence. I told them that their reactions were understandable and each of them individually was expressing feelings that were relevant to the crisis, but that for their son's sake, they needed to arrive at some sort of middle ground between these opposite poles of the continuum. I told them that I thought it would be helpful to David to have good legal counsel and support, but that if influence were used or special favors requested, he would be left with guilty feelings, and a conviction that he was above the law, or outside of it. That, in turn, would make him all the more anxious and prone to act out even more in the future. They ended up being persuaded, and agreed together to obtain a good lawyer for him. Mother also told me in my first session with them that she had heard from another psychiatrist, that people with severe character disorders could not be treated. Was that true? I told her that I did not share that view.

When David came to see me for the first time, he presented as a six foot, 150 pound, wiry, disheveled young man with long hair, punk clothes, and a hostile, suspicious, frightened air about him. An air of wariness was quite pronounced; he seemed very anxious, and labile, and was quick to take offense. He was an astoundingly acute observer of my office, and very quickly and keenly took in all the details of it. His speech was organized, and on the surface he was not depressed. Beneath the surface of his mood, there was a very faint, but nonetheless present, yearning quality to him. Despite his wariness, he seemed to want to have a connection made; he wasn't completely walled off from that. We talked for a few minutes and then he asked if I had a tape recorder. I said I did, and he demanded to know where it was. I showed it to him in one of my desk drawers, and told him I never taped people without their knowledge and permission and asked him if he had had some worries about that. He said, "maybe," and then pulled a tape out of his pocket and asked if we could listen to it.

I told him we certainly could, and put it in the machine. It turned out to be a tape of the Dead Kennedys. We listened for a few minutes, and then he asked me what I thought of it. I told him I was

hearing a lot of deep hurt and despair in the songs. He was very affected by my response and wanted me to listen more with him and to tell him what I thought. We did, and I kept commenting on the underlying affect of the music and words. I didn't tell David this at the time, but I felt that the Dead Kennedys were giving voice to feelings that he had. He then told me that he played the guitar and wrote songs, and I told him that if he was ever in the mood sometime, I would enjoy hearing them. I also told him that the amount of despair on certain songs of the Dead Kennedys must be hard to live with. He then told me about the noose he had fashioned, and how afraid he was that he might have to go to jail.

David and I had connected quite well, I felt, through the medium of the music and songs and all that they meant to him. Over the next few weeks, he did indeed bring in songs that he had written, and we went over them together. I listened to tapes that he had made with three other guys whom he was trying to shape into a band. The lyrics and music of the songs had a discordant, primitive, jarring, nihilistic quality. David had hopes of becoming a big rock and roll star, and music was the most meaningful thing in his life. He was going through the legal processes involved with the drunk driving arrest at the time, and his hopes for himself through his music were helping to keep his fear and despair at bay. His musicianship was only fair at best though, and his self discipline and that of his friends was certainly not strong. It made me wonder to myself about how he would cope with the disappointments I felt he would most probably face in the future regarding his hopes for himself with his music.

The legal process David was facing initially panicked him. Four days before his arraignment for the drunk driving offense, he got into an altercation with a meter maid. In a fury, he got into his car and backed away from the parking space with such recklessness that he hit the meter maid's vehicle while she was sitting in it. He was charged with a felony assault with a deadly weapon, his car. This was later reduced to misdemeanor assault with misdemeanor hit and run. Then, because the meter maid apparently had not gotten a real good look at David's face, all charges from this incident were dropped. In regard to the 2nd drunk driving offense, David was sentenced to three years probation, with no actual jail time, had his driver's license restricted for a year, had to pay a $547 fine (which his father paid), and had to attend the drunk driving school one night per week for a year. He was enormously relieved, as was his family. He was telling me at this point that he liked the therapy, and he agreed with my recommendation to him that he see me two times per week.

After a few weeks of twice weekly therapy, David told me that the drunk driving school was educational in purpose, utilized large group meetings, and was not as focused on his individual emotional needs as the therapy. He proposed that the twice weekly therapy ought to be a more than adequate substitution for the drunk driving school. He talked this over with his probation officer, who agreed to substitute therapy for a year for the drunk driving classes. I agreed to this also, and in fact favored the arrangement because it made David's treatment with me a condition of his probation. Prior to that point it had been strictly voluntary and I didn't think it would last. I discussed the issue with David, and he and I agreed that the content of his sessions with me would remain strictly confidential. I then wrote a letter to David's probation officer and told him that David was seeing me twice weekly and planned to continue with the therapy. I then left it at that, and in so doing made a significant, potentially crucial error because I assumed that David's probation officer would be checking with me regularly to see if David was attending his sessions consistently. The arrangement with the probation department was thus structured so that they were to check with me, rather than me reporting to them. This was the error, and if any of you ever have occasion to work with a probation officer where the therapy is mandated, you need to set it up so that you report to them if the patient is not coming because probation officers have caseloads of upwards of 200 people and they don't spend their time phoning therapists to find out if an individual probationer is coming to therapy regularly or on time or not.

David's life remained crisis filled, and the crises became the content of his therapy sessions. He soon asked me if he could use one of his sessions to have his mother see me with him. I agreed, and would see David individually once a week, and would see David and his mother together once a week.

David viewed his mother as loving but controlling in an intrusive and arbitrary fashion. He said she needed treatment more than anyone in the family. He experienced her as consistently more concerned with her needs than his. She was very focused on how things looked, particularly to the outside world, and this drove David crazy. She would talk with him repeatedly about his need to get his hair cut shorter, or his need to shave or wear better clothes. She thought that his friends were for the most part both beneath him and not good for him. He found it difficult to please or satisfy her and felt he was always wanting in her eyes and not up to par. When mother was provoked, she told David that he was ruining her life, and he believed her. What made David the most mad were interactions in which he thought that she was using her

authority as mother, with a capital "M", simply as a means of getting others to defer to her and humble themselves before her. David saw his mother as very self-centered. He felt that she should get a job and help relieve some of the financial burden for father. He viewed her as spoiled and pampered, and thought that her frequent socializing with her high society friends was frivolous and superficial. He frequently experienced her as distant and unengaged. I had this view of David's mother from David and agreed to see her with him one time a week because I thought that he was telling me he needed protection and needed help with this relationship. His father was unengaged and his father had never really protected him from these very difficult interactions with his mother. I thought he was looking to me to see if I could help him directly with that; not just talk with him about his feelings about it but actually go to the source of the trauma and to try to modify the traumatizing influence. So it was with that in mind that I agreed to see his mother in conjoint sessions. As a child psychiatrist, the idea of seeing family members with a child was something very familiar to me so I did that. Now, I did not insist at that point that David see me twice a week and come in for a third session a week with his mother. I thought that he actually would have experienced a demand for a total of three sessions per week not as a protection, but as an overbearing demand on him. Also, I felt that if I had refused to see his mother with him, David would have felt that I wasn't really understanding that an essential aspect of this treatment meant the interaction with the mother. That is why I proceeded the way I did.

David's mother was born in the south to a family which regarded itself -- according to a mother-in-law -- as superior to others. Mother's own mother was extremely passive and compliant; her father was a patriarch who expected to be waited on and obeyed. Mother was 3rd in a sibship of 4, and was the first born of non-identical twins. Shortly after mother's birth, mother's grandmother took mother from her own mother, and grandmother raised David's mother herself. Grandmother raised her like a princess until mother was 6, when grandmother died. Mother then returned to the nuclear family. Mother said she always felt "special" and as a result, guilty toward her twin, who had not been singled out this way by grandmother.

David's father had been absent from David's life to a marked degree from early on. Mother told me that in the evenings, father would have his radiology journals and his paperwork to do and he'd bring that

home and be busy with that. He didn't play games with David or play ball with him and seemed to engage with David only when David was in trouble. Mother complained that father never set limits with David, and failed to back mother up when she tried to do so. Mother said that father was similarly uninvolved and distant with David's younger brother, but was somewhat more interactive with David's sisters.

David experienced his father as easier to get along with than mother. He felt his father was relatively reliable and sympathetic, and more on David's side for the most part. At other times, however, when David was provoked at home, father would intrude himself physically in a way that David would find punitive and confrontational, and they would then get into physical fights as a result.

Mother reported that father was occasionally physically explosive himself, and that when he was, it was quite scary, as he was a large man. One time father had thrown one of mother's hairbrushes with enough force that it stuck in the wall. Another time, he threw a Christmas tree on a Christmas tree lot with great force, in full witness of mother and the kids. Once, he became enraged while in the car with the family and abruptly and dangerously executed a high speed "u"-turn. He had pushed or shaken mother on a few occasions in the past, sometimes in front of the children.

Father gave me absolutely no personal history, despite my attempts to talk with him in a supportive way about his background. Mother reported that he came from a liberal, down to earth west coast family. Father was sent to his grandmother's to be raised when he was 3 years old because of an inability of his mother to cope. He was brilliant in his field but had not done nearly as well financially as he might have, according to mother, due to difficulties in reading and coping with professional and office politics as well as he might have. Thus, we can see that both of David's parents had a history of significant rejection.

Given the data thus far, how can we formulate the issues in David's life in Control-Mastery terms? To begin with, I feel that David had three major sets of pathogenic beliefs that were crippling him. First, he had the set of beliefs that he deserved to be rejected and deeply and repeatedly hurt. He felt himself to be a doomed outcast, a deservedly worthless piece of trash who would do himself and the world a favor by killing himself. He held a pathogenic belief that he was inherently unlikable and unlovable. He felt helpless and hopeless and felt his life was supposed to be that way. He believed his fate to be that of an eternal loser and social pariah. He felt he was supposed to be alone and forlorn. He carried the expectation that he would inevitably be misunderstood and unappreciated and I believe he also felt himself to be profoundly defective,

including strong elements of feeling incompetent to deal with any real issues in the real world. He felt deeply unmanly and perverted as a consequence of his homosexual encounter. He believed he had no right to feel pride about himself and that he was destined always to be a shameful disgrace who was an eternal burden and drain on others. Worst of all, I believe that he thought all these terribly painful beliefs about himself were not only true but deserved.

How did he develop his first set of pathogenic beliefs? Control-Mastery theory posits that children feel responsible for the traumas inflicted on them: that what they receive in childhood is what they deserve. And what had David experienced? -- repeated and profound rejection. His father had never really gave engaged with David at all during David's growing up years. At the time of David's arrest, for example, his father was saying, "Look, let him rot in jail." David's mother had repeatedly told David that she wanted him out of her life and when David was 16 he was abruptly sent away from home. He was treated like a doomed soul by his family, and he had complied with this attitude, coming to believe himself that he was beyond help. David's parents held the pathogenic belief themselves that significant problems were intolerable. His parents felt that problems could not truly be worked on and solved. When David was having difficulty in school his parents were not able to help him face the problems he was encountering there and to solve them. Instead, they removed him from the school. This left David believing he was helpless and fragile and that he could not tolerate problems. David's conviction that he was incompetent arose from this attitude on his parents' part. His parents could not be empathic with him because they were overwhelmed with sorrow and guilt toward him, and because of their own self-absorption. For example, I believe that David could not tell his parents about his homosexual encounter at age ten for fear that it would devastate them and that he would end up having to soothe and reassure them rather than them reassuring and being understanding with him. Mother in particular felt she had to make David happy right away or have David out of her presence. Neither parent could tolerate normal sadness, worry, frustration, shame and especially guilt -- normal affects which are inherent in a problem solving process with a child with significant problems. David was in essence taught that these affects were not tolerable for him either and that his problems were therefore unsolvable. This is a major reason, I feel, why they did not take David to see a child psychiatrist prior to age 16. His parents could not stand facing the feelings that working on David's problems in therapy would have engendered in them. Neither parent could help David learn to work on issues step by step over

time. They either had to have quick solutions or to have David out of sight and out of mind. Control-Mastery theory posits that pathogenic beliefs are the result, broadly, of identification and compliance. David's parents, I had learned, had both been rejected and undoubtedly had significant feelings of their own unworthiness. David identified with the poor self-image of both of them. However, even more important in the pathogenesis of his belief in his own status as a reject, was David's compliance with his parents' rejection and neglect of him.

Now, to help someone disconfirm strongly held pathogenic beliefs regarding their own inherent, deserved rejection, what is the appropriate counter in human affairs, including therapy? Simply put, it is to accept them -- fully and unequivocally. That is why from session number one with David, I made a point of being accepting of him, of reaching out to him, of doing everything I could to connect with him and his underlying feelings regardless of the content. That is why, with the Dead Kennedys tape, I did my best to accept and understand his love of their music as valid and important. I wanted to impart the idea to David that just because he had been terribly out of control, that that did not mean to me that he was a worthless, awful monster who was unfit for human contact. I wanted him to know that he did not have to feel so alone with his feelings, and to feel that he had the right to be understood rather than to be dismissed or recoiled from. I took it that an essential aspect of my task with David would be letting him know that I was willing to meet him half way and far more if necessary, time and again, to counter this cluster of beliefs having to do with him feeling like a rejected loser.

David had a second cluster of pathogenic beliefs closely related to his first. The second set had to do with his mistrust of others. When people have been significantly rejected and neglected, they inevitably learn not to trust other people and to regard others with suspicion and wariness. To David, the world was a hostile place where he was repeatedly given enough rope to hang himself. He believed he could not rely on others to help him master issues. He had come to believe that it was dangerous to relax or drop his guard around others. He believed that hypervigilance was a necessary attribute to survival because the world could and would shift suddenly and without warning at any time. This had happened in kindergarten, third grade, seventh grade and then at age 16 when he was sent away completely. To David, the world did not cohere. Expressions of love or concern were masks for underlying brutal rejection and neglect which would soon be forthcoming.

David came by his mistrust all too honestly. His father was supposed to love him but had had almost nothing to do with him, except when David was in serious trouble. This left David with the idea that his father did not want David to do well because when David was doing well, his father was withdrawn and unavailable. Mother and especially father were both somewhat paranoid. Neither parent was capable of mutuality -- of giving and receiving love, of cooperating with one another, of being close in any sustained way. Mother and father fought with one another all the time, and each of them fought with David. In this family, no one could stand getting close to anyone else for fear of betrayal and outright attack. David identified with his parents' mistrust of one another and of him, and he learned adaptively within the family not to accept at face value what anyone is saying. His parents were always threatening him with consequences for misbehavior but never followed through. Their threats could not be taken seriously, nor could their expressions of concern. For all these reasons, David had developed a pathogenic belief of intense mistrust. So this was the second real set of severe pathogenic beliefs.

Again, what would be my therapeutic counter to David's pathogenic beliefs regarding mistrust? It would mean proving over time, in my capacity as therapist, that I was trustworthy. This would mean being reliable, steady and predictable. But most importantly it would mean being supportive and on David's side. David had learned to mistrust others because he had learned that they were not truly for him. He felt others wanted to hurt him. In order to disconfirm this set of beliefs, I had to demonstrate to David that I wanted to help him, to see him prosper. David's mistrust was a corollary of how rejected he felt, and because of that, my passing of his rejection tests would go a long way in helping him learn that I was trustworthy, and that it was not dangerous to trust me. I would need to be protective of him and help him protect himself from his self-destructive tendencies by being caring for him and to be careful never to be blaming or disparaging, and I would need to try my utmost to see things from his point of view.

However, in addition to that it would be important for me not to pull for David to trust me prematurely. Control-Mastery theory holds that defenses are to be respected rather than analyzed away. The theory holds that defenses will be dispensed with freely when the patient feels it is safe to do so. I knew it would be helpful for David for me to understand his mistrust in me, to help him see it as totally understandable and to help him not feel guilty about it. I would take the attitude with him -- why should you trust me, or anyone else, after what you have been through? When he would question my motives, as

he did when he expressed a fear that I was interested in seeing him only for the money involved, I told him it was good that he could raise that issue and helpful to him to be able to wonder freely about peoples' motivations, including mine. Trust had to be earned and I knew, given David's background, that with him it would be a very long, slow process.

David's third set of pathogenic beliefs had to do with his own omnipotence. He believed he had the power to hurt others grievously and that he was a terrible, victimizing monster. He felt he was so bad and awful that he could not be controlled. He thought his feelings were so strong that they were absolutely overpowering. He believed he was helpless to control himself and that he would end up hurting people endlessly. Because his parents had never effectively helped him control himself, he felt he was not supposed to be in control of himself. When his parents let David's protests in kindergarten and third grade dictate their response to the situation, David must have felt like a little kid suddenly put in charge of running a huge ocean liner, and I inferred that it must have scared him deeply, just as it must have to have been 12 years old and out on the street until midnight skateboarding, with no one telling him to come in. David's aggressive, assaultive outbursts had to have frightened him enormously also, particularly given the fact that there were no consequences imposed. David inferred from the lack of consequences that his parents felt he could not stand normal guilt. As a result, David came to believe that he was an impossible burden and too much for others to handle.

David's pathogenic beliefs regarding his own hurtful omnipotence were the result of an identification with his verbally violent mother and his physically violent father. They were also a compliance with his mother and father's inability to discipline him. David wanted a normal degree of strength from his parents; they did not have it. His mother was a very self-absorbed, guilt-ridden and totally compliant woman who left David feeling that he could make her do anything. His mother was deeply and irrationally tormented and in agony about David, and, out of the fear of hurting him and shaming herself, she could not set limits with David whatsoever. This left David convinced that he could not handle problems and that his parents could not exert authority. When David's father tried to set limits, the father would do so with extreme punitiveness and provoked actual physical battles between himself and his son. David came to believe that he was a defective mess and his ongoing episodes of violence were his way of demonstrating to his parents, out of compliance, that this was irrevocably true.

My role with David was to help him disconfirm his belief that he could not be in control. Setting limits for a child is an essential part of caring for them. It should always be viewed centrally as a way of protecting the child. Limits which are imposed as an end in themselves, divorced from true concern for the child, inevitably fail because they feel to the child as if he is being asked to submit to something which is not a manifestation of true concern. The task for me with David was to set limits in a non-rejecting, non-punitive, non-guilt-producing way which was in accord with helping him feel less rejected and less mistrustful. Limit setting with David would have to involve a holistic human approach rather than that of a narrow technique. I would always have to factor in my knowledge of how rejected and mistrustful David was. I felt he would make more progress on the issue of limits if he experienced them directly with me, within the context of a highly personal, caring relationship. That is why I agreed to have his initially voluntary therapy transformed into an involuntary condition of probation, substituting for his drunk driving course, which had been far less personal.

Thus, David came to me with this over-arching complex of three severely held clusters of pathogenic beliefs. His self-image on the one hand was that of a helpless, fragile, defective, incompetent loser -- this had to do with how rejected he felt and how neglected he had been. On the other hand, he felt like a terrible, monstrous victimizer. Both were intolerable. Neither was comfortable and they subsumed, in my opinion, his total view of himself. He felt there was no way out. He was either in the role of being terribly victimized or being a victimizer. As a result, he felt suicidal and despairing. He carried real beliefs about his own helplessness with simultaneous beliefs about omnipotence. This sounds paradoxical but if you think of a young infant it becomes clear. An infant is almost totally vulnerable, helpless, and dependent on others. What do concerned parents do? They respond to the infant's vulnerability because they recognize how helpless the infant is to meet its own needs. The parents get involved - they'll feed the child, they'll walk the child, they'll change it, they'll try to help calm and soothe it. And they will do this with an alacrity that has given rise to the expression "his majesty the baby". So a young infant is truly helpless, but its own helplessness gives it an awesome power within the family context to compel others to do its bidding. As children develop, they learn over time that they're not helpless because they develop abilities and skills as they mature; and they also learn over time that they are not omnipotent, that they can't rule the roost as they did when they were infants. All children need help in both gaining competence in the world and in

disconfirming their own omnipotence. David had help on neither side. He was left at age 20 with thought processes similar to those you might imagine would apply to a young infant or child, that he was both helpless and omnipotent, and that was his dilemma. I knew that in the treatment setting I had to address both of those concerns, because if either one was neglected, David would go on feeling suicidal. That was the therapeutic task in front of me and what I will talk about now will be how he tested me in therapy to disconfirm these three overarching sets of pathogenic beliefs.

There was a great deal of contact with David's parents during the first year of treatment, as David was continuing to run amok practically everywhere. He got into a street fight and was knifed in the abdomen, and was rushed to the hospital and successfully treated. He hit his mother full in the face on one occasion, and on another jumped up and down on the roof of her luxury car to the tune of $900 damage. He hit his new girlfriend repeatedly. Despite driving on a restricted license, he ran up a huge number of traffic tickets and moving violations, which he then did not pay. He stopped checking in with his probation officer every two weeks as he was supposed to. He got into another fight on the streets, received a head wound, was knocked unconscious, and again rushed to the hospital.

I was extremely concerned for David. He would get flagrantly paranoid when he was stressed, and his street fights and reckless driving were clearly life threatening. Because of the danger his paranoia and violent temper exposed him to, I spoke with him about taking low dose mellaril when he was feeling particularly stressed. He considered the idea briefly on two or three occasions, but then refused to avail himself of this potential source of help.

In our individual sessions, there was hardly ever any time for reflection or introspection. Crises kept coming fast and furiously. I found myself trying to help David slow things down and concentrating on ego skills. I found myself assuming the role of auxiliary ego a great deal of the time. For example, in between other crises, I would talk with him about my concern about his mounting unpaid traffic and parking tickets. I told him that if we could deal with those, we could prevent a crisis from occurring. He had lost the tickets and did not know how much money he owed, or where he was to send it. Together, we would get out the phone book, look up the number and make the call. If he were put on hold by a telephone operator at City Hall, he would slam the phone down in frustration. I would then try actively to understand with him how

frustrating it was to be put on hold for long periods, or routed to the wrong office. In these ways I would try to help him modulate those feelings and cope with them and try to see if together we could expand his frustration tolerance. Sometimes he was able to re-make the phone call; sometimes I had to do it, talking with him while I was on the phone, modeling to him how you cope with the frustration of being put on hold. His parents had never done any of this kind of thing with him and it left him feeling incompetent. They had never gone step by step through a problem solving process. So what I was doing had to do with that first set of pathogenic beliefs regarding his own incompetence and rejectability. I was working with them to show him problems in the world could be solved step by step and that he could attain the skills to be competent in the world. My work with him in this regard was to function as an auxiliary ego -- helping him to disconfirm his first set of pathogenic beliefs.

I ended up getting a list of his tickets with him and the amounts due and consolidated the amount he owed on all of them. We composed a letter detailing all the ticket information, and then went across the street to a bank and obtained a money order. I walked with him across the street to the bank and in essence I held his hand as we went through each step of the process. He had never had this sort of experience. He needed help each step of the way with these tasks, particularly in managing the feelings of annoyance, anxiety, frustration and shame -- all of which made him want to say to hell with the whole process and avoid the task. It took us about 7 weeks worth of sessions to complete this issue of getting the tickets paid for, because we could do so only a little bit at a time and I'd have to titrate it, do a little bit one week (between one and 15 minutes worth) and a little bit more (5, 10, 15 minutes worth) the next week. After working on this task for as long as he could during a session I would listen to David play his guitar and sing his songs and talk about his girlfriend or the difficulties he was having in getting the band together to practice.

I would also try to talk with David about his feeling states just prior to the explosions that resulted in him getting into fights and becoming violent. I told him that if he could sense when he was beginning to get upset, that he and I could think of strategies that would help him avoid reaching a flashpoint where he exploded. I was trying to help him to disconfirm his destructive omnipotence by telling him, "Look, I think you can solve this. I'm not writing you off. This is a solvable problem. Yes, it's a painful one. Yes, it's a shameful one. But that doesn't mean that we have to turn away from it. We can get through it together." I would try to bring the matter up in a gentle, understanding fashion but even that was usually too much for

him to bear. I would then at other times comment on the fact that these explosions left him feeling so ashamed and guilty that that's why they were so hard to talk about. But this approach too was usually unrewarding in terms of helping David talk with any true openness about the issue. He felt like such a despicable monster he couldn't bring himself really to talk about this issue significantly at all.

The sessions with David and his mother were often very difficult. He was appreciative of her coming -- appreciative of her commitment to him manifested by this action, and appreciative of her implicit acknowledgment that issues between the two of them were contributing to his difficulties. But his appreciation soon was washed away each week as the two of them got into their arguments with one another. His mother would often concern herself about his appearance, and would talk with him about how she felt about the way he looked in her home when she would have friends over. She would also express concern over more substantive issues -- his health, the amount he might be drinking or not, whether his friends were good for him or not, how he was doing with his grandmother, how he was interacting with his father, and his brother and sisters. As David's mother would address these concerns, she would not be able to judge the moment to moment extent to which these issues were upsetting to David to talk about, in the way she was talking about them. I knew from first hand experience how difficult it was for David to talk about any "loaded issue." Sometimes he could talk about things a little bit; sometimes he could not talk about them at all. But his mother seemed to lack the capacity to make any sort of sustained, fine-tuned judgments in regard to this, and she would invariably end up goading him to the point of verbal explosion. Then, when he exploded, she would then dissolve into tears or rage and tell him that she never wanted to see him again; that she wanted him "out of her life." This, of course, made matters worse, and provoked David even further. I would intervene to try to interrupt this dynamic. I told each of them that each of them needed to be able to take a time out from the other whenever they wanted; that if things were heating up, each needed to be able to back off and break things off for a time. I modeled this for them by having one or the other step outside the office, into the hallway, for a 5 or 10 minute break when things began getting too intense. David complained that his mother would use this as an excuse not to talk to him at all. I told mother that when she told David she wanted him "out of her life" that he felt completely cut off and rejected. I told her that it would work better if she could tell David that she couldn't or wouldn't talk about something at that moment, but would reconnect with him at a specific time later that day, or early the next day. I told

her that she needed to give David that point of reconnection; that otherwise he felt he was in limbo and that that was intolerable. Thus, I was trying to help each of them take time outs but to do so within a context of fairly immediate future reconnectedness.

The model was clear to both of them; their ability to utilize it was minimal to non-existent. During one session, mother had goaded David to the point of him screaming at her verbally. He would not take a time out and give her any space. The session time ended, and she told him she did not want him to drive home with her. She told me that when he was in this kind of mood, with him in the car, he would backseat drive from the front seat and he would grab the steering wheel; he'd hit her on the shoulders, he'd hit her on the head and it was very dangerous. So for very good reason she didn't want to drive home with him. I told her that she had the right to drive home by herself and that she should give David money for a taxi or bus ride home. He was standing right there and heard me say this. He kept hounding her, and I finally took her to a room near the lobby at Langley Porter. I was on the UCSF Medical Center faculty at this point and had an upstairs office and went down to the lobby where the crisis rooms were constructed. We went down there and I had mother go into one of the crisis rooms and David would still not stop and leave her alone and was constantly in her face screaming at her. I said, "David, you need to leave and give her a break," but he wouldn't do that. So at that point I called security and within about two minutes six campus security officers arrived. This was a major test, I thought, of David's beliefs concerning his own omnipotence. He had the ability to frighten and dominate others. He had always frightened and dominated his parents, both with the fear that he'd get more violent or that he would detach himself from them forever and never come back (via suicide or running away). His parents were always helpless in the face of this dilemma so I felt he was testing me to see if I would be helpless and paralyzed like his parents. So the campus security police arrived, and they told David that if he did not leave the building, they would arrest him for disorderly conduct. He screamed in fury at his mother and at me, and he told me he was never going to see me again, that I was a total "fuckhead." He then left. His mother was shaking and sobbing uncontrollably and told me that this was what it was like at home. I told her that I understood that, including how very awful it was for her, and that we would go on working to make it better, and that I thought that we could.

Control-Mastery theory posits that if you pass an important test, the patient then has a decreasing amount of anxiety, either immediately or in the fairly near future. It also posits that if an important test is

passed, a patient will have access to new memories and the affects involved with them, and that the patient will be able to do things in their life that they couldn't do before. So the question was, was David going to abandon me, make good on his threat to see another therapist rather than me, or what?

He returned to me two days later for his individual session. He was pleasant, cooperative, and considerably less anxious. This confirmed for me that the limit setting in the face of his livid fury in fact deeply reassured and calmed him. He had looked furious, he had acted furious, but unconsciously he was terrifically reassured by my call to the campus police. David's parents were both morbidly afraid that if they set limits with him, they would end up provoking and alienating him forever. I told mother about the fact that David was feeling far more secure following the episode with the campus security force. I told her that when he lost control at home, and she could not handle him, that she should call the police. She was appalled at this idea, and was able to tell me that the shame of her neighbors seeing the police come to her home to handle her son was too much for her. She was also fearful that the police would just laugh at her over the phone, or come once, and then never come again. She thought that if she called the police, and they did not respond, or did not respond helpfully by taking her side, David would scorn her and treat her all the more badly for her having tried to invoke the police in the first place. I then began talking with mother as actively and as in great a depth as I could about where these fears came from. She was very, very fearful. She was paralyzed and I thought if I could explore issues in her background that had a bearing on her paralysis, I could help her with them. But despite my efforts to do so, she couldn't get very far with this at all.

I also discussed with mother another pattern that I had observed. When David did something upsetting to mother, she was inclined at times to dismiss him entirely by telling him to get out of her life. At other times, if his transgression was not that profoundly upsetting to her, she was inclined to forgive him too readily. David would do something hurtful, feel badly about it, and would want his mother immediately to forgive him and carry on as if everything were perfectly okay. I told mother that in therapy we worked to help people not be burdened by irrational guilt. But when people were feeling normal, rational, appropriate guilt, they should not be relieved of that burden too quickly. Mother had a problem with that because she couldn't stand to see David in pain. She had to make David happy immediately or reject him. When he was suffering even a normal amount of guilt, frustration or sadness, it was intolerable to her. So how did she

cope with it? She either excused him from the situation or she banished him. In either case, she didn't have to face his pain. Because she reacted by feeling overwhelmed with sorrow, guilt, and shame toward David, he felt that a normal amount of pain was intolerable. He inferred he could not handle normal guilt, and that he was fragile and incompetent. So this was profoundly disabling to him in terms of that first set of pathogenic beliefs, that he was this incompetent, rejected, helpless loser. I counseled mother to try to find a middle ground between telling David she wanted to disconnect from him forever, and forgiving him inappropriately quickly. She tended to go from one extreme to the other, and then back again. Father did this with David as well, and mother and father did it as a couple with David -- one parent advocating one extreme, and the other parent the opposite extreme, as they had in their initial discussion with me concerning the issue of whether or not David should be provided with a good lawyer. David constantly felt whipsawed between polar opposite positions.

David's father would not come in to see me with any regularity at all. I met with him once every three months or so, and it was like pulling teeth to obtain that degree of frequency. His tone was one of pessimism towards the process, scorn and not totally disguised contempt for my efforts, and an expressed fear that I was taking risks with his son (for example, in calling the police at the university) and that these risks would make things worse. Father was a manifestly extremely bright man, and would use his intellect to differ with me on virtually everything. Relating with him felt like being in an unending intellectual jousting contest with someone. It was as if father felt that agreeing with me on any issue would expose him to a lance in the ribs. So I had a very direct sense of father's inability to be mutual at all and of his "paranoia." He would not tell me a thing about himself and was very, very mistrustful of me.

In my sessions in the office or during phone conversations, David's father would reflexively disagree with me. But on some issues, without conceding a thing, he would somewhat follow my advice. For example, David was supposed to meet for dinner with father once a week. David would obtain money from his father at these dinner meetings, and father told me that he was sick of being exploited by his son. He told me that he thought David wanted to have dinner with him just to obtain the money. Actually, what I thought was going on was that father wanted contact with David, and that David wanted contact with father, but each was very fearful of expressing that for fear they'd be rejected by the other. Neither could admit it. Closeness felt scary and dangerous to both of them. David would go to his father and say he

needed money, which he did, but that was just a surface excuse for him to say, "Look, I want the contact." And his dad would have the dinner meeting ostensibly just to give David the money, when in fact he liked the contact too. I explained all of that to the father but I told him I could appreciate the fear that he had that he was being exploited. I told father that I felt that it was not actually the case that he was being exploited. I did tell father that David used the dinner meetings as an excuse to have contact with father, that I knew that father and David had not had nearly as much contact with one another in the past as either of them had hoped for, but that despite David's vulnerability in expressing this openly, that David was comforted by his dinners with his father. Father didn't express any emotion when I said this, but told me gruffly later that maybe he would go on having weekly dinners with David, though he thought that what I was saying was totally fanciful.

After the first six months of treatment, David initiated a new phase. He stopped coming in with any regularity. He would fail his appointment, and I would then phone him at his grandmother's and later, his apartment. He would tell me to go fuck myself, and hang up. I would then phone him back. He would take the phone and put the receiver next to a blaring stereo speaker, or he would hand the phone to a friend, who was drunk, and they'd get on and talk with me. He'd say yes, that's my idiot psychiatrist and then the friend would hang up. Then I would phone back. Now, how was I understanding this? Well, Control-Mastery theory was actually very helpful here. The theory posits that patients will test in one of two main ways. They'll test in a transference mode where they will invite you to traumatize them as their parents have but hope deep down you won't. That's one mode. The other way they will test is by turning passive into active. This involves the patient doing to you what has been done to them. They then identify with your capacity to deal with the traumas they are imposing on you. So I was understanding this in terms of both these modes of testing. In terms of a transference test, David was acting in a totally obnoxious, disgusting way, showing me how truly awful he felt he was, and inviting me to give up on him. His not coming in, I thought, was a test. We had connected quite well and then he stopped coming in with any regularity. That could be read as a worsening; that I'd failed a test. However, I did not think that was the case. I thought it was due to a number of other factors. First, his probation department was not phoning me and I felt handicapped because I couldn't talk to them without violating the agreement I had with David, so that there was no structure there, so he wasn't coming in. But second, I thought that David was wanting

to see how deep my commitment to him really went. I think he thought to himself, look, this fellow Dickman can connect with me around the Dead Kennedys and the vengeful, nihilistic expressiveness of their songs, but those are just songs. What if I become vengeful and nihilistic and bitter and condemning toward Dickman himself? What will he then do? I think he needed to test that out very accurately because I think he thought, boy, if he showed me what he was really made of, how truly awful he was, that then I'd give up. So I think he was testing that in the transference mode.

But at the same time I think he was letting me know in a passive into active mode what it felt like to be totally rejected, scorned and held in contempt. He had been rejected as a monster repeatedly by his family and he was letting me know in this very contemptuous, almost sadistic way, what that felt like. Here my task was to not accept the rejection, not take it to heart. In this passive into active mode, David was inviting me to think of myself as an incompetent therapist. What I think he unconsciously really wanted of me, was for me not to buy into that and to proceed. He could then identify with my handling of scorn and contempt. I would be demonstrating that even when you are rejected, even when you're scorned, you don't have to buy into it. You don't have to believe it; I thought David wanted me to role model for him an ability not to take rejection to heart. So when I kept calling him back I think he took it as reassuring in both these major testing modes. Interestingly, to confirm this for me was the fact that when I phoned back he would not unplug the phone and we almost always had 50 full minutes of contact time over the phone. He could have unplugged the phone but he didn't do it. At the end of the 50 minutes I'd say we're going to have to stop and he'd get mad and damn me for that. So we had lots and lots of phone sessions.

David's mother and I were not meeting conjointly with David with any frequency, due to the fact that those sessions remained unmanageably intense over time, despite my best efforts to defuse them. So we stopped them. When David would come in to see me for his individual session, he would sometimes not say anything. Instead, he would demand a piece of paper and a pen from me. I would give them to him, and he would sketch for a time as he talked. I would express an interest in what he was doing, because I thought that was helpful in disconfirming his idea that he was worthless and rejectable. So then he would show me and hold up a piece of paper and it would be a skull and crossbones that would say "Fuck you! Go die!" Another diagram was "Dr. Dickface! Go screw yourself!" So with this very rejecting, sadistic quality, in this passive into active mode, he invited me to think I was an incompetent idiot. At other times, he would draw

pictures of automobiles, which were a passion of his, and leave the drawings in my office. I would keep them and put them in a special file. Sometimes, weeks later, he would ask if I had a particular drawing that he had done. I would tell him that, yes, I did have it, and would get it out. He would express gratification and surprise, and I would try to explore with him why he was so surprised that I had kept his productions. If he was worthless, I wouldn't have done that. I was appreciating what he was producing and treasuring it; that was helping disconfirm the idea that he was valueless. It was also a test of my trustworthiness -- would I maintain a reliable, consistent regard for him?

During this time period, comprising the 6th to 12th months of therapy, I talked with David when I could about the fact that he was not keeping in contact with his probation officer. I told him that I knew that he was in this way setting himself up to get into serious trouble. So here I began trying to protect him from his own self-destructive tendencies. It was one thing to hang up on me or not come in, but quite another to do that with his probation officer. David would respond, "Screw my probation officer. He's an asshole, and I am not going to call him."

Sure enough, during the 12th month of therapy, David was arrested on a bench warrant for violating probation because he hadn't kept in contact with his probation officer. Father paid David's fine and new conditions for David's probation were set. This time, I structured my arrangement with the probation department in a much more helpful way. I set it up that David was to have regular psychotherapy with me. If he failed in that, I would be the one to report this to his probation officer as a violation of probation.

Also, toward the end of the first year of therapy, David had behaved so outrageously at his grandmother's house that even she could not take it any more. His family found and rented an apartment for him, but he was soon evicted from it. He would stand on the balcony of the apartment and yell "faggot" at gay men going into the apartment building, and behave in other thoroughly obnoxious ways. Also, David really trashed the place physically. Father, typically, came close to threatening the landlord with a law suit if the landlord persisted in his efforts to have David evicted. This of course left David feeling that he had been unfairly treated by the landlord; and David said that his father was on his side. My own perspective on this, which I told father, was that being for David in this way was really being against David's best interests. I told the family that they should not give in to David's request of them to let him return to the family home

to live. I felt actually if he were still out in the community he would find that people would and could find ways to protect themselves from him; that he couldn't go on indefinitely victimizing others. But if he were taken back into the family home, the entire family would endlessly absorb David's misbehavior. I feared that David's pattern would continue forever because his parents were helpless in terms of confronting him except in a brutal and rejecting way. But despite my recommendations to the contrary, his parents took him back into their home to live.

By the end of the first year of therapy, despite all the ongoing tumult and crises, David had demonstrated some real and hard-won gains. He obtained a manual labor job and kept one it for three weeks before being fired. After a few weeks, he obtained another job and kept it for five weeks. Then, after another month of unemployment, he found a part time job and kept it for five months. That was by far the longest period of employment he had ever enjoyed. As we progressed toward a year and one half of treatment, it was clear that the number of street fights and altercations had decreased markedly, and in general, he was doing better. The amount of violence with strangers and casual acquaintances had decreased quite dramatically. And the fact that he could hold a job for five months was a strong indication of increased self control. So I thought we were making progress and it was substantial.

However, David still remained violent with people who were close to him. Living at home, he would become physically assaultive with his mother and brother, and would also get into physical fights with his father. He continued to destroy property in the family home, one time throwing a chair through a stained glass window, and destroying innumerable telephones. He continued beating up on his new girlfriend at least once a month.

The initial twice a week individual therapy had evolved into a once a week individual session with David, and an occasional individual session with his mother. I heard from mother on the phone frequently, filling me in on what was happening with David, particularly in regard to the episodes of violence at home. David was coming to his once weekly individual sessions with fair regularity, as he knew that if he didn't come, I would report him to his probation officer. Also, he did not seem to mind the once weekly sessions particularly.

But after a year and one half of treatment, despite his gains, and they were real, my gravest concern for him had to do with his violence. It was an absolutely crippling liability. Though he had improved his

impulse control in many other areas, with people who were close to him, he remained just as violent -- or more so -- than ever. I consulted at that point with a neurologist at Stanford, Dr. Barry Tharp, who is a leading expert on the West Coast concerning neurological origins of violent behavior. He did not feel that David's violence was neurologically based, due to the fact that it seemed so purposeful. But he was willing to see David for an evaluation, and I felt it would be potentially helpful. I felt that David's violence was almost certainly of psychological roots rather than neurological, but I wanted to make sure we weren't missing anything. His mother agreed to this idea, but David's father and David refused to go along with it at all. As I mentioned earlier, David repeatedly refused low dose mellaril as an adjunct to our work together to quell his violent explosions.

I knew by this point in the treatment, after having worked with mother and occasionally with father, that I'd have to do virtually all the work on the violence issue alone because David's parents could do so little. I had had a number of joint sessions with the two of them in which I tried to help them to come to some agreement, as a parental team, as to a course of action for David. It was inevitably non-productive. They would end up screaming at one another furiously despite all my attempts to referee and defuse issues. They always took opposite positions from one another, and there was deep marital distrust and bitterness. Mother told me privately that their sex life was non-existent, and father's mother (David's grandmother) told me that father had given up on his wife. Father eventually refused to come in with mother at all, saying that they would never agree, so why try; it just made things worse between them. And I felt that father in many ways had almost totally given up on David.

In addition, my individual once-a-week psychotherapeutic work with David was not reaching him in this most crucial area. It was not effective. Control Mastery theory posits that if you're on the right course, over time, the patient will get better. David had gotten better in certain ways, but on this issue he made no progress. The theory then says at that point you have to change your therapeutic stance. You have to come up with some different kind of intervention if things aren't working. At that point in David's treatment, I knew that the once a week sessions were not working in terms of his violence. The frequency was not sufficient to give David the message that I could handle him -- violence and all -- and that he could handle himself. I truly did think that David could overcome his propensity to violence, so I recommended to him that he needed to come in twice a week. In doing so, I knew that David wasn't addressing the issue of his

violent outbursts because he was not bringing it up spontaneously in the therapy. I knew that his parents were not addressing it with him, that they'd given up on him. So in telling him he had to come in twice a week, that represented a positive expectation on my part, that I did not want him to be violent. It was a reaching out to him. I expected him to do well and wanted him to do well. I expected him to be able to overcome the problem of his violence. It conveyed the idea that it was possible for him to master the problem of his violence. His family had always railed at him about it and told him he was a terrible person but had never helped do anything about his violence. In telling him "You need to come twice a week," I would be saying "You're not a terrible person and I can help you overcome the problem of your violence. I have faith in your ability to do this." I was conveying the message that I thought he did not have to comply with the idea that he was a big, huge violent failure. I wanted to convey realistic optimism about this. I felt that David would take this as an expression of faith in him and in his ability to overcome his gravest problem. So I told David that he should come in twice a week and I told his parents that. Everyone became livid and outraged with me.

His parents said "Look, he's doing better. You're making progress with him. Leave him alone! Why are you doing this?" His parents accused me of being financially exploitative, of wanting more money, and they got very vitriolic with me. In one phone call, his mother told me, "Dr. Dickman, I thought you wanted to help us and I thought you were my friend. Now I see that you are not. Goodbye. I never want to see you again!" She was doing with me what she did with David. At the same time I thought she was turning passive into active with me because whenever she had come into a session with David, he in essence said to her, "Look, Mother, don't expect anything of me or I will run away or commit suicide, I'll leave your life." So she was criticizing me, wanting to see if I would wither because when David was furious with her, she would always wither. So she was doing to me what he was doing to her. Father did the same thing. This is a very well known phenomenon in child psychiatry where the parents will test you themselves (even though they're not your patients) by doing to you what the child does to them in order to gain mastery over the issues the child is dishing out to them. At that point the father phoned me up one morning -- I'll never forget this phone call -- and told me, "Dr. Dickman, we in the family want you to know one thing." I said, "Yes, what was that?" "We hate you! Goodbye!"

Father's outrage was based on a fear that I was being a "high risk gambler." Father felt that his son was making progress, was holding a job, and doing things at long last in a more mature way. Why disturb something that was working partially, they reasoned. They were both very scared that David would rebel and they did not want to face that possibility. They had the option of taking him to another therapist. I knew that; they knew that. They threatened to do that, but eventually decided to go along with his two times a week sessions with me. I then phoned David's probation officer and told him that there were some absolutely crucial, crippling issues that David's once weekly treatment was not able to address, and that I needed the probation officer's support in making twice weekly treatment a requirement of probation. At that point, he backed me up.

Because I knew David would most likely be testing me around the area of the twice weekly sessions -- as he needed to test all important limits -- I began to keep careful time records of his attendance. I had two 50-minute sessions per week, and over the course of 4 weeks, that was a potential of 400 minutes of time with me in my office. The first month of the twice a week, he came for 83% of that time -- that is, he missed 68 minutes total. So he missed an average of about 7 minutes of the 50 minute sessions. Sometimes he was on time and sometimes he was 30 minutes late but 7 minutes of missed time was the average. The second month, he came 78% of the time. I then told him that for the third month of meeting twice a week, he needed to come, as a minimum, to 80% of his session time. I stressed to him, that it would be even better if he were to make 100% of his time, that would get him further in the work, but that as an absolute minimum I was going to require 80%. And I told him, "If you don't make that, I'm going to inform your probation officer.

So the next month, the third of twice a week, after I had set down the 80% rule, he came 79.5% of the time; he had missed two more minutes than I had said was allowable. And the issue was -- what was I going to do? I told him that 79.5% was not satisfactory. He screamed at me -- "You are going to come down on me for missing two minutes? Two minutes? What a fuckhead you are! I don't believe it!" He was outraged and furious. I said, "Look, it is not for two minutes; it is for missing 82 minutes. You had 80 minutes worth of margin over the month and used it all up. You used up your margin; this last time you had to get here on time and in fact you were two minutes late and I am going to come down on you if you do

this again next month. Because if you don't make 80% of your session time, I will report you to your probation officer for having violated the conditions of your probation."

The following month, he came 76% of his time. In retrospect, it was clearly inevitable that he would need to test me in this way. His parents always made threats to him at home, and never carried them out, so he felt they didn't mean what they said. So he needed to find out how I'd respond.

So I phoned the probation officer and told him that David had not made 80% of his session time; and David phoned the probation officer and told him that I was screwy and arbitrary and totally unreasonable. David told his probation officer that he had been two minutes late the previous month, and I had threatened him, and now this month, he had a total lateness of 16 minutes, and this was preposterous and unfair. The probation officer told me he was sorry, but that he could not back me up on this; that 2 minutes of lateness one month, and 16 minutes the next month seemed pretty trivial; that David was not getting into trouble with the law and that he, the probation officer, could not justify disciplining David for his lateness. I explained to the probation officer that it was not 2 minutes and 16 minutes; instead it was 82 minutes and 96 minutes of absence. I told him that this seemingly minor limit violation within the therapy had enormous symbolic, psychological meaning to David and that if we did not respond appropriately to this acting out within the treatment setting, that David would soon be very vulnerable to start acting out again in society, and would come to the probation officer's attention that way before long. However hard I tried, though, I could not convince the probation officer. I talked and I talked and I talked and I argued in a reasonable way. But there were no consequences to David having fallen below the 80% level.

The next month, the fifth month of the twice a week, David's sessions with me were even more rancorous and difficult. We had developed the procedure in his individual sessions, as well as in the conjoint ones with his mom, that when he got too upset he was to take a time out for 5 or 10 minutes. So one day, he was getting overheated, and I suggested that it seemed like a good time for a brief time out. He stepped out and then stayed out for a longer and longer time. I began to wonder where he was and got concerned. At this point, I had left my faculty position at the University for full time private practice in a suite of three psychotherapy offices in San Francisco. The other two offices in the suite were vacant at that time. I kept my files and a lot of my play therapy toys in one of the vacant offices. I stepped out of my office, and looked in the hall way and did not see David; then I looked in the vacant office. He was in there, reading one of my

files. I advanced toward him and asked him to please give me the file. I said ,"Those are confidential, you can't read those." He then moved toward the window, and taunting me, held the file out the window so if he let it go, it would fall and passersby on the street would have access to it. At that point I got very alarmed about confidentiality, and out of that alarm, I made a mistake. I lunged toward David to grab the file, at which point he cocked his fist and hit me as hard as he could, full in the chest.

At that point, I took a time out. I composed myself after a few minutes, and called him back and said, "Look, we can't work this way. If you ever hit me again, I will press charges for assault and do my best to see that you go to jail. And after you get out of jail I will treat you and take you back." I wanted him to know that I could protect myself and I was not going to tolerate him hurting me. But I had to do it in a nonrejecting, nonpunitive way. I wanted to affirm for him, look, this will not end our connectedness. So I was operating within the framework of his major over-arching sets of pathogenic beliefs -- his fear of rejection and his need for limits. I was trying to speak to both of them simultaneously. I felt that David needed a clear statement of reasonable limits, and a clear statement of my connectedness with him and commitment to him, that one would not work without the other. If I just said, "Go to jail, get out of my life," that wouldn't work, and if I was too understanding and didn't protect myself, that wouldn't work either. So I thought I had to speak to both. And it was interesting -- he was testing me here in the very area where his parents had failed him.

It turned out that the file was his. I told him that I was sorry that I had lunged for it, but that I had not known it was his, and was worried about confidentiality. He said he wanted to find out what sort of terrible things I was writing about him. I told him that I was not writing anything terrible about him at all, and that if he wanted to see his record at any point, including now, that all he had to do was ask me, and I would show him anything and everything in it. He seemed satisfied with this whole exchange and we went on.

Later on during that same fifth month of the twice a week, there was another incidence of violence. Often, David would come to his early morning sessions with me with shaving cream and a razor in a paper bag. He would then use the bathroom down the hall, and shave there after his session. This particular session, he came in late with the bag in his hand and asked how late he was. I told him 12 minutes. He exploded, saying "God damn it!", and he threw the bag with the shaving cream can in it as hard as he could

and it flew across my office. I have a wood panelled wall in my office, and it took a big divot out of the wall. At that point I took another time out myself and thought about how I'd handle this. After about 5 minutes I called him back in and told him I'd have a repairman come in and repair the wall and I would then bill David for the cost. He accepted that; it ended up costing $25.00 and he paid it promptly.

After these two incidents, it seemed clear to me that, in fact, the twice a week treatment was working well. He was testing me directly in regard to his most important issues. He was disconfirming the idea that I was helpless to protect myself in the face of his upset and he was thus disconfirming his hurtful omnipotence. He had a chance to work very directly and with immediacy with me on these issues, to disconfirm his hurtful omnipotence and rejectability. I was responding differently from his parents, being neither overly permissive nor abruptly rejecting, and he was learning from that.

These two episodes of violence occurred in the 5th month of the twice a week. I think he was somewhat scared by these flareups, because after that month he ended up making 79% of his session time. But the following month, the 6th month of twice a week, again, when the probation officer was not backing me up, he dropped down to 67%. I phoned the probation officer again and told him that things were getting worse; couldn't he please back me up. He told me that he could not. The 7th month was even worse -- David made only 52% of his session time. I knew that if this kept up, I soon wouldn't have any therapy time at all with David. The mandate was crucial for him; he couldn't survive without the therapy being mandated.

I found myself getting more and more upset that the probation department was letting this salvageable kid go down the drain. So at that point I elected to go over the probation officer's head and phoned his boss -- the municipal court judge in the Bay Area. I explained the issues to the judge, and told him that this kid was indeed salvageable, but that we were only going to be able to salvage him if I got some backup; that I couldn't do it without that. I had no leverage. The judge agreed with me, fortunately, and scheduled a hearing for David for the nearest available time, which was four months away. That was dishearteningly distant in time, but I knew it was helpful to David to feel that he was being monitored and watched. Being watched, to him, meant being watched over and protected. He knew that his attendance record at our sessions over the next four months would be an issue of importance at the upcoming hearing.

Prior to the hearing for David, I wrote a long letter to the judge, outlining my recommendations, and I communicated those very directly to David. I gave David a copy of the letter and I communicated those recommendations both orally and by letter to his parents. I said that if David did not make 80% of his session time for any month, that it would be helpful for him to spend the first weekend of the next month in jail for two days. I also said that it was helpful to David to know that people were reviewing how things were going with him, and that I felt a judicial review every three months during his probation would be best. Thirdly, I said that his probation should not be terminated prematurely, that it should run for the full three years which were originally outlined because this degree of structure was crucial to David.

David was consciously incredulous and furious with me about this. He couldn't believe I had gone over the head of his probation officer. He was mad as could be over the fact that a hearing had been scheduled. I felt that unconsciously he was deeply reassured by my stance. And during the following month, the 8th month, he came 85% of the time. In the 9th and 10th months of twice a week, leading up to the hearing in the 11th month, he came through with 84% and 87% attendance.

Even more significantly, during the nine months, then, of the mandated twice a week therapy, his violence had stopped almost completely. There was only one episode of violence outside of the therapy in that whole nine month period of mandated therapy. In contrast, before we started the twice a week mandated therapy, David was violent with his girlfriend or his parents at least once a month and often more. So the violence outside the therapy session had decreased to one time in that whole nine months. And then he had had two episodes with me. But outside the therapy it had gone down really to zero. And that was very impressive. I was surprised that he responded that quickly and that well to this intervention but he had. That let me know that unconsciously he liked the mandated twice weekly treatment.

In addition, he had stopped getting drunk, and had been working at the same job now for over a year. He had left his parents' home to move into an apartment with his girlfriend and lo and behold he had not been evicted. He had maintained that relationship with the girlfriend for 11 straight months. He was acting responsibly at their apartment and there was no great danger for him there. He had begun bringing his girlfriend to one of the twice weekly sessions, wanting me to do couples therapy with them so that they could work on issues without huge verbal blowups. His girlfriend had her own issues and David asked me to find an individual therapist for her. So clearly this intervention had been enormously powerful and very

helpful. He was salvageable and was being salvaged and he made his remarkable gains in a relatively short time. The content of his sessions reflected this also. He was talking for the first time about the sexual violation at age 9 and the fear and shame that that created in him. He also talked for the first time with me about his sense of being a total loser compared to his sibs who were doing far better. His brother had a measured IQ of 160+ and despite having been kicked out of two schools for insubordination and rule violations, was on track to go to an elite college. David's brother, in addition, was far more gifted musically than David, and had surpassed David in the music sphere, with far less overall time and experience. So he had this superstar sib; he felt shown up by this and was able to talk very meaningfully about that. His sisters were gifted academically, musically, and athletically. David spoke of how hard it was not to feel like a total failure compared to his sibs. He had been taking a design course at a community college and had passed the course, but barely, and it had been a real struggle. He spoke at length with me about his music, and went into great detail about the kinds of speakers and amplifiers that he was assembling for concerts that he hoped to give. He also spoke at length about his car, which he was fixing up. He would show me with pride from the office window the improvements that he had made with his car. He was repairing another old car at home, out in front of the apartment and spoke in detail about that work -- how to get parts, how to learn how to put them in efficiently, that sort of thing. As he spoke about the music, and the speakers and amplifiers, I took it as a metaphor for his hitherto unmet needs to be heard and attended to carefully. His prolonged discourses about the work he was doing on the cars were another metaphor, I felt, this one concerning himself. He was wanting me to participate with him in affirming that things in disrepair, even an advanced state of disrepair, could be salvaged and made to run smoothly again. I thought that's what he was experiencing in therapy and he was wanting to confirm that with his work with the cars. At times, I would try to interpret these metaphoric aspects of our communication, but I didn't get too far with it with him. Usually, I simply had to content myself with staying within the metaphor with him, and affirm things with him that way.

He also told me that when a person gets arrested for drunk driving, that that arrest is only the tip of the iceberg; that for every arrest for drunk driving, there have probably been at least ten times when someone was driving drunk and was not arrested. He told me that getting arrested for drunk driving the second time was the best thing that had ever happened to him; that he was feeling a lot better these days,

and that I had helped him. So I thought in terms of the drunk driving and the like he was coming up with remarkable insights, again, that he was making remarkable progress. He also told me that it was an awful feeling to feel that people were afraid of you. He said that sometimes when his family or girl friend would cooperate with him, he didn't know if they were doing it because they wanted to, or were doing it out of fear, and that that was a horrible feeling for him to have.

He was coming in for each of his two sessions before work. He had to get up early to do this, and again I was maintaining this active reaching out to him. I would call him in the morning, would give him a wake-up call at home on each of those mornings. I was doing a great deal of this, calling up and letting him know that today was our therapy session. "You need to get going and on your way." Sometimes he would be sleepy and roll over and go back to sleep and I would call him again. I was doing a lot of reaching out to him in other ways as well; I was bringing in tapes for him to listen to. I was making phone calls for him at non-session times; I was phoning him to see how things were going, and he utilized me as something of an organizing safety deposit vault. He would leave money with me if we were working on a project involving him paying someone back. He would leave designs in progress for his music system with me, designs for his car, and materials for his community college class. He would ask me information about myself at times, and made it clear that I needed to tell him the truth, as an expression of trust, which I did. He would very frequently ask my advice about how to get along with people, and began to face, to a degree, how worthless he felt, and how much of a drain he felt he was on his family.

Therapy was going beautifully at that point. He was making gains; he was getting more and more intimate and open with me and really working actively on a number of issues. At the hearing, during the 11th month of twice a week, the probation officer told the judge of David's relatively exemplary record over the previous year. The probation officer was saying, "He's doing beautifully. We don't need to maintain the structure", and was taking David's progress as evidence that this could be dropped. I said, "We need to take this as evidence that it needs to be continued because it'll all fall apart if we don't continue this." The probation officer also spoke to the judge about David's conversations with the probation officer in which David indicated a strong desire to be free of probation and free of court mandated twice weekly therapy sessions. So even though David was telling me that the therapy was good for him, David was telling the probation officer and the judge he did not like mandated twice weekly treatment. I felt that David's

conscious desire to leave treatment was a test of others and a by-product of severe guilt, and that truly empathizing with him meant seeing through to his unconscious wish to remain in the reassuring structure of the mandated treatment. Unfortunately, the judge agreed with the probation officer and said that with murderers, rapists, and professional thieves on their caseloads, that he could not justify the further expenditure of public funds on monitoring a kid like this so closely; particularly when David was doing so beautifully and the end of probation was just 4 months away. I argued against this with the utmost vigor and told the judge and told David that the reason David was doing so beautifully was because the structure had been imposed, and that lifting it prematurely would be inviting trouble. I also argued to the judge that not monitoring this young man closely when he was doing well was repeating the very trauma David had experienced in his relationship with father. Father engaged with David when David was in trouble; when David was not in trouble, father was distant and remote. I told the judge that mandated treatment was essential for David, that it disconfirmed David's sense of being undeserving and it disconfirmed omnipotence -- it spoke to both and that both had to be spoken to in this way.

The judge elected not to make a decision at the hearing, but decided to give himself a few days to think about the issues. At the end of that week, I phoned the probation officer and got the bad news from him. The judge had ruled that David's psychotherapy from here on in was to be strictly voluntary, and that probation would in effect be in name only for the next four months. The judge really dissolved the probation and said that therapy was voluntary. Revealingly, David did not ask me what the judge had decided; nor did he phone his probation officer to find out. So on one hand he was saying, "Look, I want to be out of this treatment." But when David had an opportunity to find out, he didn't inquire. I took my cues from David, and decided not to volunteer the information to him unbidden because it was clear to me he did not want to know. He continued to come twice a week, as if the status quo had never been in question. That was further proof of his unconscious wish to remain in a mandated twice weekly treatment. However, after about two weeks, he obtained the news from his probation officer during one of his routine calls to the probation department. David then spoke to me of the guilt he felt about his parents paying so much money for his psychotherapy. He also said that he felt like a dependent little kid because his parents were also helping subsidize his apartment rent to the tune of $400 per month. I said that yes, these certainly were expenses that they were having to bear, but that they had not had to spend money on sending him to college,

as they would be on his brother and sisters, and so I did not see it as an extraordinary burden on them that he should feel so guilty about. I vigorously and strenuously urged him to keep coming twice a week, emphasizing to him the fact that he had done so much better with this. I told him that we could further improve on the gains he had made and that I was concerned that if we didn't continue twice a week, he would lose ground. He gave it some thought, but then after a few days told me that he wanted to cut down to once a week. At that point I took up the case very, very actively with his parents. I said, "The court system isn't backing me up. I'm concerned this is going to be disastrous for your son. You can do this. He needs $400 a month from you for living expenses. Utilize that as leverage to compel him to do what he really wants you to have him do -- which is come to me twice a week involuntarily." I told them that David, in fact, wanted to be forced to come, that he needed to be forced in order to overcome the feelings of being so undeserving and to disconfirm the idea that he could overpower people. However, I could not persuade them. So what happened?

Three weeks later, he was arrested in a neighboring county for the third time for drunk driving. So in the three years of the mandated therapy, he had not been arrested for drunk driving at all. Shortly after the mandate was removed, he was arrested a third time. After nine months of not being violent, he became violent, smashing his brother's expensive guitar and amplifier, and got into a physical fight with his father when father tried to intervene. I read this as a clear signal from him, a clear attempt, to get back into a mandated treatment with me. He had gotten into mandated treatment by drunk driving in the first place and then when the mandate was taken away, he repeated the drunk driving to get back into mandated treatment.

David's parents obtained a new lawyer for him in the neighboring county, and that lawyer then had the third drunk driving hearing postponed. A week after the postponement of the hearing, David became violent again at his parent's home, smashing more of his brother's musical equipment. So he had shown that, again unconsciously but very clearly, he needed to be in mandated treatment; the contrast with the previous three years was striking.

David's probation officer in San Francisco had of course heard about the third offense for drunk driving in the neighboring county. I asked him to please reinstitute the mandate for twice weekly therapy. It clearly was working and we needed to have it working some more. The probation officer, I think, probably

out of guilt about how he handled things, blamed me and said that the treatment had not been effective, that I had not focused exclusively enough to David on the issue of alcohol abuse and look what had happened -- a repeat offense of the drunk driving. So he said the therapy had failed; and he said what he really needed was compulsory attendance at AA. I said that I certainly had no quarrel with making David go to AA; that I thought it would be helpful to him. But I also told the probation officer that David's violence was a very crippling liability, and that almost all of the times when David was violent, he had not been drinking.

If David's violence had been a result of alcohol abuse, it would have been far easier for him to solve. He could have maintained sobriety and not have been violent. But the issue of his violence was a deeper and more difficult problem for him. I said that David needed mandated help with his predilection toward violence as much as anything else. I said that treatment had not failed David, that the failure had been a failure to support ongoing twice weekly mandated treatment; that in fact what had happened had unfortunately confirmed the very predictions and fears I had voiced at the hearing just two short months ago. I said then that David needed more time to internalize the external structure that had been in place. As a matter of fact, even without attendance at AA, David's abuse of alcohol had decreased remarkably during the 11 months of the twice a week. And during the almost 3 years he had been on probation and in a mandated therapy, as I pointed out, he had not had a repetition of the drunk driving offense. I pressed my case again and again with the probation officer. I could not convince him. I pressed my case with David's new lawyer, but could not convince him either. I pressed my case again and again with David's parents and with David. I could convince none of them.

During the following weeks, David's new lawyer in the neighboring county -- being a good lawyer -- had David's first drunk driving conviction removed on a technicality. So the third offense was reduced into being only a second offense. At the arraignment, David was sentenced to three years probation, and had to attend the drunk driving course. Psychotherapy was not included as a condition of probation. I fought and fought against treatment being reduced to a voluntary once weekly event. I did this demonstrably with David. I told David that he unconsciously wanted twice weekly therapy but had to comply with his parents' inability to stand firm with him.

So the story became very sad. David did not have the time with me in that first 3 years to disconfirm the beliefs about himself enough that he could then make appropriate and self-affirming

decisions about himself. He had responded remarkably well to the therapeutic process of the mandated therapy. The rug had been pulled out from under him approximately three years too soon. With another three years of treatment, he would have had time to disconfirm enough of his severe pathogenic beliefs about himself that he could have made appropriate self affirming decisions. If the structure had been kept in place by the courts or his parents, he could have kept getting better. He was salvageable but was allowed to go down the drain. The treatment had been working for good and understandable reasons. His violence was a huge compliance. He had been on an upward course and could have had a very favorable outcome if his parents and/or the courts had been able to stay the course. His parents should have known that therapy was vital and was helpful and they should have told him that it was no burden for them for him to be in treatment. They should have told him they were proud of him for having been in treatment, that they were proud of him for having done so well, that they were proud of him for changing his life around so dramatically and that they would back him financially and in other ways. In backing him, they were not undermining his autonomy. They were backing him so that in the future he could be truly and totally financially and emotionally independent. They should have told him that the financial burden of paying for David's treatment, and partially underwriting the expenses of his apartment were not a huge strain to them. I urged them to tell him that it was the least they could do; to tell him that he would be in a position in a couple of years to pay for more of his expenses himself. Until he was in that position, they should have indicated that they were willing and able and desirous of helping him, and that they did not want him to be financially independent before he was ready truly to handle it; that they wanted to help him until he could be truly independent.

If David's parents had been able to respond as above, that would have truly strengthened his autonomy, rather than leaving the decision about treatment, and David's guilt about burdening them, up to David. In the past, David's parents had repeatedly given him the message that he could not stand normal structure. They treated him as if he were fragile; David complied and viewed himself as fragile and helpless. But when this "fragile, helpless" son threw a tantrum, his parents then complied with that totally and gave way to David. This left David feeling omnipotent. His helpless-fragility yielded him enormous power with his parents. His pathogenic beliefs about himself being helpless and omnipotent were really opposite sides

of the same coin. Only a mandated therapy could speak to both sides. I explained this in detail repeatedly to David's parents but could not convince them to make him come to twice weekly treatment.

David reduced to once a week voluntary treatment and his life worsened at that point. He got fired from his job and then was unemployed and he would sit around the house and live off the girlfriend's income and wouldn't look for other employment. The girlfriend became enraged with him and told him that he was being parasitic with her. She urged him to get going and he wouldn't. Eventually he broke up with his girlfriend; David's mother was relieved by this as she had a real fear that David and girlfriend might get married. She felt the girlfriend was beneath him. Now, the girlfriend was one of the best things that had happened to him in a long time, but again his mother was consistently on the wrong side of issues, and said that she was glad that they had broken up. David kept having increasing difficulty in keeping appointments with me. The sessions began to feel less and less meaningful. The energy of the whole therapeutic process seemed to be slowly but surely draining away.

After a number of months of unemployment, he obtained a job with a landscaping company. He talked with me a bit about having to get along with co-workers and his boss. David and his girlfriend re-united, and then he started having violent outbursts with her again. I told his parents this continued to prove David needed the twice a week treatment. I said please compel him to come. I couldn't get them to do that. I couldn't make headway with David on this issue. They left the decision entirely up to him and he decided after a time it was too much of a hassle to come in at all, and he broke off treatment entirely.

One year following his arrest for what should have been his third drunk driving offense, and a little more than four years after he had first come to see me, the therapy ended. His younger brother was due to go off shortly to an elite college. His sisters had elected, interestingly, to go off to boarding school. I was left wondering what would become of David, and how his parents would cope with their impaired marital relationship, now that all the children were out of the home. And that, sad to say, was the last I heard from David or his parents.

This concludes my presentation. Thank you.

DISCUSSION OF CASE PRESENTATION

by

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CONTROL-MASTERY WORKSHOP, SAN FRANCISCO, NOVEMBER 3. 1991

INTRODUCTION

The first order of business is for us to take our hats off to a therapist who has this kind of perseverance. As I read the clinical material, I wondered whether this kind of perseverance ought to be attributed to the therapist's personality---and, whether or not and to what degree, he may have been aided by the theory that guided him in this difficult treatment process.

This is my first and probably most important question regarding this case presentation. After all, what are theories for if not that they can guide and aid us in the conduct of the treatment?

Theories, I believe, aid therapists in their clinical work in two ways: one, in a global way with epigrammatic statements such as "where id was ego shall be" or "to make the unconscious conscious" the latter emphasizing the uncovering "the truth" and achieving insight. Such statements reflect the close relationship between a particular psychoanalytic theory and the corresponding theory of cure. The first statement expresses the ego-psychological, the second, the topographic theory of the mind. In this respect, control-mastery theory appears to be closer to the topographic theory (making the unconscious conscious so that patients can confront hitherto repressed or otherwise defended psychic content), then to ego psychology which

places the emphasis on resistance analysis. Briefly stated, I understand control-mastery to consider the curative factors to reside in the achievement of insight into the nature of repressed affects and in correcting unconscious "pathological beliefs".

The difficulty in discussing clinical material from a theoretical perspective different from the one in which the treatment was conducted, is related to the fact that theories constitute systems; systems in which the parts are related to each other logically. The theory of pathogenesis determines the theory of cure, which, in turn, determines how interventions are formulated and how their impact on the patient is being evaluated. For example, if my theory maintains that patients become ill because they had failed to develop reliable and abiding psychological functions, that is, they are suffering from the consequences of deficits in their psychic structures (which clinically translates into problems related to affect-and self-esteem regulation), then, my interventions will have to enable my patients to have therapeutic **experiences** that facilitate the development of compensatory psychic structures.[1] In self psychology, strengthening the self through interpretations that convey acceptance and understanding represent such therapeutic experiences; these are the experiences that firm up the self and make the resolution of intrapsychic and interpersonal conflicts possible. However, if my theory of pathogenesis maintains that

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[1] Compensatory psychic structures have to be differentiated from primary and defensive psychic structures. See Kohut 1977.

people become ill because they are suffering from the consequences of "pathological beliefs", then my theory of cure would dictate that my interventions correct such beliefs.

I had become acquainted with Joe Weiss' ideas some years ago because of my interest in the process of working through in psychoanalysis. Specifically, I was interested in understanding how we can best conceptualize changes as these occur in the course of psychoanalysis. I read as much as I could about the way psychoanalysts conceptualized changes in unconscious mental mechanisms, specifically, in unconscious defense organizations. My graduation paper from the Chicago Institute for Psychoanalysis dealt with the question of working through (A. Ornstein, 1974). This was very much in keeping with the dictates of the leading psychoanalytic paradigm of that period-- which was ego psychology--and the technical concerns related to this, namely, the refinement of the technique of resistance analysis. It was at that time that I read about the preliminary findings of the research that your group is currently conducting in a report, The Modification of Defenses in Psychoanalysis (JAPA, 1972). Recently I re-read this report. I found my copy heavily underlined indicating my agreement with the major points of the report. This was of interest to me because I found myself much less in agreement with two other, more recently published papers, the Bush-Gassner article in the Clinical Social Work Journal (1988); and the article by Joe Weiss in the Scientific American (1990) on Unconscious Mental Functioning. I am tempted to ask

some questions and have you enlighten me on the differences in the theoretical orientations of these various publications. This, however, was not your reason for inviting me here today, so I hope to raise my questions about control-mastery theory as I review the case that Dr. Dickman was good enough to share with us. Before I do that however, I shall briefly state the most important aspects of the clinical theory that has been articulated in psychoanalytic self psychology so that you see more clearly the theoretical position that I am coming from.

In psychoanalytic self psychology, the relationship between the empathic listening perspective and the therapist's selfobject functions, is of the greatest clinical significance. Selfobject is an intrapsychic concept, it designates the way in which the therapist is being **experienced** by the patient. In order to assess the impact that their verbal and non-verbal communications have on the patient's psychological state, therapists have to make an ongoing effort to remain in empathic contact with the patient's subjective experiences. In other words, there is a tight and inextricable relationship between the concept "selfobject" and the therapist's empathic listening perspective. The two together, the concept of the selfobject and the therapist's empathic listening perspective, constitute the experience-near clinical theory in psychoanalytic self psychology.

If I understand correctly, one important aspect of control-mastery theory is related to therapists' ability to "pass tests"

that patients subject them to, either consciously or unconsciously. If this means that therapists are expected to understand the deeper meaning of their patients' behavior so that they will not respond to provocations, then "passing the test", could, in some sense, be compared to the empathic vantage point.

DISCUSSION OF "CASE PRESENTATION"

If you find that in discussing the case I am being "picky", and that I am focusing on only certain aspects of the clinical material, I hope you will remember that I do so only because my job is to discuss the case from a self psychological perspective. Thus I shall focus my discussion on those areas that I found most suitable to indicate the differences between our respective theoretical orientations. I had also approached the discussion of the case selfishly, in the hope that it will offer me an opportunity to understand control-mastery theory better.

I shall divide my discussion into two parts. The first part shall deal with the process of treatment; the second with the way I would conceptualize the nature of this young man's psychopathology as I understood this from the protocol.

THE TREATMENT.

Dr. Dickman introduces David to us by first describing his

background. I had to clear my mind of certain assumptions that we all tend to make on the basis of the patient's history before I could meet this young man the way his therapist first met him. Most fortunate for us, Dr. Dickman shares the first impressions of his patient with us vividly. He tells us that David appeared to him to be very anxious, labile, quick to take offense; that he looked around the office eagerly; there was an air of hostility and suspicion about him. However, most importantly, Dr. Dickman also tells us that "beneath the surface of his mood, there was a very faint, but nonetheless present, yearning quality to him." In other words, Dr. Dickman perceived the young man's expectation that here, in this special situation, he may receive something that his home environment had not been able to offer him.

In the first hour Dr. Dickman appeared to follow his patient's lead by listening to the record that he had chosen to bring to the first session. I believe that this was David's way of introducing himself to the therapist and asking him to recognize that his drinking and chronically angry, provocative and very destructive behavior was an attempt to deal with his profound depression and deep despair. Having gotten the kind of reception that made him feel accepted, made it possible for David to tell Dr. Dickman about his suicide attempt.

But the good connection Dr. Dickman was able to establish with his patient in this first hour could not be deepened and could not be effectively maintained. Certainly not because Dr. Dickman lacked empathic capacities. With due recognition of the

fact that he received no help from David's parents and the authorities with whom David was involved, we would still have to look at the clinical theory that guided his listening perspective as having some responsibility for this. His theory may not have helped him appreciate sufficiently the significance of this initial engagement so that he could have remained focused on the patient's inner experiences, on David's turbulent inner life.

Dr. Dickman knew that he would have to make contact with his patient's inner world in order to have impact on his major problems, which, in my opinion, were related to his inability to moderate and regulate his affects and to maintain a reasonable sense of self-esteem. Dr. Dickman knew that "to cure his readiness to explode at people..." he had to get close to David and that together (he and David) needed to expand David's frustration tolerance. Such statements indicate to me that Dr. Dickman recognized that he would have to become the "regulator" or stabilizer of David's chaotic emotional life.

It is at junctures such as these that we recognize the significance of the selfobject concept. Not having the concept of the selfobject at his disposal and not watching for the manifestations of selfobject transferences that could have helped him recognize the ways in which his patient needed to use him for self-regulatory purposes, Dr. Dickman opted to approach this difficult therapeutic challenge by trying to enlist the cooperation of his patient's environment to enforce limits to his behavior. Limit setting requires that the therapist focuse

attention on how firmly and how consistently the limits are enforced. This can lead to the abandonment of the empathic position as the therapist joins other members of the patient's environment who concern themselves with **his behavior** and not with his emotional state.

This does not mean that there are no important aspects of limit setting on which I would agree with Dr. Dickman. For example, when he tried to get the point across to the probation officer, that the main function of limit setting is to convey respect and care for the child, I agree with him. This indeed is the task of a police officer who is performing a very different function from that of the therapist.

A further point in which the two theories seem to diverge: Dr. Dickman recommended that when David lost control at home mother ought to call the police. Mother was afraid that these may make things worse and may not help her establish her authority, that David may become more abusive toward her then he already was. In response, Dr. Dickman wondered whether her fears "had significant reality to them". Here the therapist became the arbiter of factual reality, rather then one who is exploring the **meaning** of the patient's psychic reality. As I shall discuss later, once the mother was included in the treatment process, the exploration of her psychic reality (the source of fear to call the police), becomes an aspect of the treatment process. He also asked that mother distinguish between "rational, appropriate guilt" and "irrational guilt". Who determines which is which?

Judging as to what is "normal" or "pathological", what is "real" or "unreal", and what is "appropriate" or "inappropriate" means that patients are assessed in relation to a hypothetical norm. This is the opposite of recognizing and responding to the patient's highly idiosyncratic experiences and the unique manner in which they protect themselves from possible further traumatization.

When I am pointing to these clinical-therapeutic differences in our conceptualizations, I am mindful of the extraordinary measures Dr. Dickman took to make himself available to his patient: he phoned David to wake him up, helped him pay his fines, and taught him how to make out a check. However, here too our understanding as to what functions these activities on the part of the therapist may have served for David, differs. In these situations Dr. Dickman thought of himself as an educator who was teaching his patient "ego skills". Viewed from my theoretical perspective, the therapist's interest and caring would represent selfobject functions that could have--theoretically at least--effect the patient self-esteem: experiencing himself as someone worth caring for.

An other example of the difference in our respective theoretical orientation is the one in which Dr. Dickman was trying to ascertain the precipitants for David's severe temper outbursts. He told David that if they knew the precipitants, then they could "think of **strategies** that would help him avoid reaching a flashpoint where he exploded."

Coming from a perspective in which this patient's difficulties are understood as **deficits** in the capacity to regulate affects and anxiety, I would question whether his thinking was well enough organized and focused to learn and to utilize "strategies". To learn and to utilize strategies requires the capacity to take distance from one's affects. David, however, was usually overwhelmed by them. This indicated his inability to moderate his affects because of a defect in self-regulatory capacity; he could not take distance from his affects and consciously employ learned strategies to deal with situations in which he would become enraged.

I, too, would want to learn about the precipitants to his temper outbursts and destructive behavior but for very different reasons. In engaging the patient in a therapeutic dialogue (Ornstein and Ornstein, 1986) in which I could inquire about the nature of his self-experiences that had precipitated his outbursts, I would hope to help him identify the areas of his narcissistic vulnerabilities. Should these precipitants turn out to be experiences in which he felt demeaned, in any way humiliated, not only I but he too could begin to understand the source of his severe narcissistic rage reactions. I would tell him that we--he and I--could now understand better why he has been having so much trouble containing his rages. Such comments have a therapeutic affect because they convey acceptance and understanding of affects the patient has not been aware of as his rage has been a relatively well functioning defense against their

perception. Feeling understood in terms of the **motives** of one's behavior can have a powerful impact on the organization of the self. These are experiences that increase self-cohesion and enable a fragile self to reduce overwhelming affects to signal levels so that they can be made conscious and can then be articulated. I would also give expression--as did Dr.Dickman--to the expectable shame David had about these outbursts that made it so difficult for him to talk about them.

Being a child psychiatrist myself, I appreciate Dr. Dickman's position in this case particularly well. The important question that frequently emerges is this: should one include the parents--or at least the willing one--into the treatment process or ought one limit one's efforts on establishing a therapeutic process with a patient who is so prone to acting out, so unable to contain intense affects? Once the decision is made to include the parent(s), the nature of the therapeutic process has to change because the aim of the treatment had changed. The goal of the treatment had become more ambitious: the therapist now will try to untie the complex and convoluted knots that had been created by the hurts, anger and various forms of symptomatic behavior; these are the defenses that constitute a powerful obstacle to communication between parent and child. This is a treatment process in which one has to do several things almost at once: to be attentive to the inner world of all participants; to be mindful of the ways in which the members of the family use each other for their own unmet selfobject needs and be prepared

for the violent eruptions that expectedly follow when such needs are regularly frustrated. Including the parents into the treatment process means that the therapist will make every effort to undo the complex and complicated cycle of interactions that are keeping the child's symptomatology alive.

In this respect, a case like David's represents the most challenging clinical situation: though deeply enmeshed with both parents but particularly sensitive to his mother's alternatingly hot and cold behavior towards him, his symptoms, (alcohol abuse and violent temper outburst) exclude the possibility of empathic parental responsiveness even if the parents would otherwise be capable of these. But then we would have to ask: should one, under these circumstances, undertake outpatient treatment at all?

It is not clear how Dr. Dickman used David's perception of his mother and his own observations of her in his interpretive comments when the two were seen jointly. Obviously the tension between them did not permit too much reflection--it was a constant effort to put out fires. But for our discussion today it maybe less important what was actually said then to spell out how our differing theoretical views would effect this kind of a therapeutic situation.

My view is that once a parent(s) enter(s) treatment, the understanding and acceptance of their feelings has to become as much the therapist's task as are the feelings of the child. If I hope to engage the mother in the treatment process, then, rather then questioning the validity of her fear about calling

the police, I would have to appreciate the legitimacy of her concern that, from her perspective, by doing so she may destroy whatever thin thread of connection she may have to this very disturbed child. Most likely, it was her fear that she would loose David altogether that had made it difficult for her to be firm with him not only on this, but on many previous occasions too. Hearing the therapist articulating her own bewildering emotions and feeling understood in her own psychic pain, is an experience that is most likely to put the mother in touch with whatever empathic understanding she may have toward the child.

If the parents of our disturbed children only needed an education in parental skills, maybe it would be sufficient to advise them not to respond to their children by dismissing them when they are difficult and irritating. However, if we recognize, as was true in this case, that the parents were emotionally not prepared to live with a seriously disturbed child, then, they need to know that we understand and appreciate the psychological pain that they too are suffering. Only then can we expect them to be able to understand that their child's destructive behavior is motivated by similar emotional anguish. When I speak of untying the knot that had formed between parent and child because of their pathological interactions, what I am referring to is a therapeutic effort aimed at helping the parents make contact with the inner world of their children. An extraordinarily difficult therapeutic task made possible only by the parents' feeling heard and understood first by the therapist.

(A. Ornstein, 1977; A. Ornstein, 1981).

THE NATURE OF THE PSYCHOPATHOLOGY

Viewing David's psychopathology as an expression of structural deficits that found symptomatic expression in the area of affect and tension regulation, I believe that his drinking was related--though most likely there were other factors involved as well--to his effort to calm himself. But, like with so many efforts at self-medication, this produced a paradoxical reaction as the intoxication further reduced his already impaired ability to tolerate painful affects. In this respect, I think it is important to note that on several occasions when he went on a rampage his brother's instruments became the victims of his rages. Jealousy and rivalry were among the affects that proved to be overwhelming to his fragile self.

What was the genesis of David's illness? At the time we meet David at age of twenty, his emotional life was already severely compromised. Dr. Dickman informs us that his patient's condition had greatly deteriorated around age 18. What happened at that age? I suspect that finishing high school and experiencing himself ill-prepared for entering college as would be expected from a boy with his intelligence and socio-economic status, played an important pathogenic factor. It was then that his alcohol consumption and his violent behavior had increased. I suspect that this may have constituted "the last straw", the

precipitant to his current illness but that his difficulties started much earlier in his life.

The developmental history alerts us to some important predisposing factors. David had frequent illnesses accompanied by high fever during the first year of life. We are learning to respect more and more these early assaults on the immature nervous system, especially the manner in which they may increase its irritability. When mother describes David during his toddler years as "bright, excitable, hyper, intense, restless, anxious", we are beginning to form a picture of a child whose interactions with his environment are characterized by frequent and high-intensity encounters. Mother's "devotion" to him alternating with angry withdrawal may well have begun at that early age. This not only gives us some idea how such interactions may have effected David in the formation of his personality, but this also alerts us to the possibility that mother too had suffered from considerable degree of narcissistic vulnerability. Self disorders in parents are the most frequent sources of failures in parental empathy (A. Ornstein & P. Ornstein, 1985). Whenever David may have failed to respond to mother's efforts to calm and sooth him because of his preexisting difficulties, she may well have experienced these as rebuffs and responded to this with rejecting the child in turn. In my experience there is hardly anything more destructive to the development of self-soothing and self-calming capacities as is this rapid and unexpected alteration between "total devotion" and sudden withdrawal of

caring and attentiveness.

Parents ordinarily need to be affirmed by their children in their parenting abilities. However when parents themselves suffer from a self disorder and had not developed adult forms of empathy, then they are particularly vulnerable to their children's difficulties whether these are due to earlier caretaking failures or not. Under these circumstances, any difficulty the child is experiencing, is felt by the parents as an indictment of themselves. This is why, I believe, it was so difficult for these parents to tolerate anyone bringing complaints against their child. Protecting themselves from narcissistic hurt, the parents could not assess the child's educational needs and capacities: he was exposed to early and repeated feelings of inadequacy. David was bright enough to do well in the first two grades in spite of being placed into first grade at age four and a half. However, by the time the third grade came along, he was definitely out of step with his peers. This was also the time that his younger brother was born. Ordinarily, I don't believe that the birth of a sibling in itself has to be a traumatic experience. But by then David was a symptomatic child, one that "could not organize himself and school became increasingly frustrating to him."

The significance of the homosexual experience at age nine is hard to assess. His shame over this is indicated by the fact that he kept this a secret for nine years and still felt the need to share it with someone, hoping to be forgiven for it. This,

and his feeling of being "a total looser" in relation to his siblings were the "secrets" he wanted to and needed to share with his therapist.

In the sixth grade his narcissistic vulnerability and selfesteem problems were in full bloom: in school, he would fall apart after making one slight error, his psychological testing revealed "a pronounced fear of failing and a pronounced and striking tendency to deny and avoid aspects of the situation which made him uncomfortable." This is the description of a child who will start himself on mood altering drugs as soon as he can put his hands on them. His passion for skateboarding is of interest in this respect: David may have tried to calm himself with such endless and exhausting physical activities.

None of us is surprised that this child had become delinquent during adolescence. Nor should we be surprised that his parents became afraid of his temper outbursts which could probably easily be provoked--neither he nor his environment knowing at times what may have set them off. I believe at age 16, when the father agreed to a trial of psychotherapy, it may have been too late for outpatient treatment.

In closing, I like to thank the Arrangement Committee for having invited me and giving me the opportunity to discuss a case that was conducted with a great deal of skill and commitment.

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TREATING A VIOLENT ADOLESCENT: A DISCUSSION OF DR. WILLIAM DICKMAN'S CASE

A Dialogue between Control-Mastery and Self Psychology

November 3, 1990

Suzanne M. Gassner, Ph.D.

Goodness knows, it is a far easier task to discuss the case of David than to treat him! I want to thank Dr. Dickman for his candid and riveting description of David's psychotherapy, and for this real-life portrayal of a therapist's work "in the trenches".

It is rare for a clinician to be willing to describe such a difficult treatment where despite tantalizing signs of significant progress, the hoped-for outcome has not occurred. Even before discussing the content of Dr. Bill Dickman's work I want to say at the outset how much I admire his dedication, persistence, patience and resilience. I also admire the progress that David did make in his treatment. It seems quite possible that without this therapy, David might well have been found dead some years ago, either as the result of his street fights, his drunk driving or suicide.

One's theoretical orientation inevitably determines what patients one does or does not treat. Many practitioners, like the psychiatrist who advised David's family to give up on him, would conceptualize David's character disorder as untreatable.

Although control-mastery practitioners view their theory as potentially applicable to most patients I should say at the outset that I have had very little experience working with a patient like David. I have found this case instructive not only from a theoretical point of view, but also in terms of some general issues of case management. I will return to these issues

later in my discussion.

Control-mastery theory was developed by Dr. Joseph Weiss, and empirically tested by Drs. Harold Sampson, Joseph Weiss and the Mount Zion Psychotherapy Research Group. Dr. Weiss' theory and the systematic, quantitative, empirical research that has been carried out by Sampson, Weiss, and the Mount Zion Psychotherapy Research Group can be found in a volume entitled The Psychoanalytic Process: Theory, Clinical Observations and Empirical Research, published in 1986 by Guilford Press.

I will describe some of the tenets of this psychoanalytic theory and their implications for understanding David's psychopathology and treatment. This will give you some sense of why a control-mastery practitioner like Bill Dickman might tackle work with a patient such as David. I will also try to make clear why this theoretical viewpoint would strengthen a therapist's resolve to tolerate working with a family that so freely dishes out rejection, hostility, contempt and blame. The theory leads to conceptualizing the constructive therapeutic purposes that can be served by such seemingly destructive interpersonal interchanges.

Control-mastery theory views psychopathology as caused by unconscious, grim and maladaptive beliefs (beliefs we call "pathogenic beliefs") that impede a person's ability to pursue normal developmental goals. People develop such beliefs as a result of trauma. Although we assume that one can be traumatized as an adult, most psychopathology arises in the context of a

child's traumatic interpersonal experiences. In Inhibitions, Symptoms and Anxiety Freud (1926) included among the traumatizing dangers of childhood the loss of the parent, the loss of the parent's love, castration anxiety and superego guilt. We consider these dangers to be crucial, but we extend Freud's list of dangers to include parental failures that give rise to pathogenic beliefs, and the associated anxiety and defense which these beliefs cause.

Because a child is utterly dependent on his parents, he is highly motivated to have good relations with them. In order to maintain a sense of security, he is also very motivated to view his parents as supreme authorities. As a result, based on his experiences with his parents, the child develops unconscious beliefs about reality, the way the world is, and about morality, the way the world should be (Weiss, 1990). Except under highly unusual circumstances, any child is going to believe that he deserves to be treated in the manner that he has experienced his parents to have treated him. Therefore a child will generalize and expect others to treat him in ways similar to what he experienced as traumatic in his interactions with his parents.

Since the patient unconsciously maintains his repressions, inhibitions, compulsions and indeed his psychopathology in obedience to the irrational beliefs developed as the result of trauma, Weiss (1990) refers to them as pathogenic. Compulsions and inhibitions then can be understood as efforts to avoid the dangers which are foretold by pathogenic beliefs.

People are continually using their pathogenic beliefs to monitor unconsciously whether or not any particular experience might expose them to retraumatization. Pathogenic beliefs warn a person that if he pursues some normal or desirable goal he risks "either an external danger, such as a disruption in his relations with someone important to him, or an internal danger, such as the experience of a painful affect, e.g. fear, anxiety, guilt, shame, humiliation or remorse (Weiss, 1990)."

Typically, pathogenic beliefs are irrational explanations about how one caused a trauma to occur. These irrational ideas may stem from a number of sources including the patient's identification with his parents' pathogenic beliefs, or the child's compliance with the parent's interpretation of reality. Sometimes beliefs that involve realistic assessments of the child's family situation become pathogenic because they are incorrectly generalized to the world at large. Other times pathogenic beliefs are based on inferences which the child makes due to misunderstanding his parents' intentions or motives. Yet other times pathogenic beliefs involve inferences which the child makes to explain his own bad fate, or the bad fate which has come to a beloved family member.

We understand the therapeutic value of any treatment to be the provision of experiences which disconfirm pathogenic beliefs. Such therapeutic experiences free the patient to resume the pursuit of normal developmental goals. Therefore, when we are presented with case material, the first questions we try to

answer the likely nature of the patient's traumas are, what the pathogenic beliefs are that the patient may have inferred from these traumas, that interfere with his pursuing normal developmental goals. Based on these formulations, we begin to develop a case-specific understanding of the interpretations, attitudes and other therapist interventions that would likely help the patient disconfirm his pathogenic beliefs. From these formulations we also begin to infer how the patient is likely to work in therapy to master his problems.

I want to focus now on what I have inferred to be the three most major pathogenic beliefs that were expressed and at times disconfirmed in the course of David's therapy. After I list these beliefs, I will discuss my understanding of the traumas from which, in my judgment, David developed these pathogenic beliefs.

David developed the pathogenic belief that authority figures are untrustworthy and, more broadly, that nobody should be trusted. It is dangerous to trust authorities because they inevitably disappoint, frustrate and humiliate you. They behave capriciously and never seem to mean what they say. Authority figures are incapable of offering help, guidance or direction. Put another way, David believed that to trust someone was to make himself vulnerable to traumatic experiences of betrayal.

David also suffered from the pathogenic belief that he deserved to be neglected and rejected, patronized by overprotectiveness, and deprived of attuned parental attention,

protection and guidance. Remember that we view it as a nearly universal reaction to childhood trauma to feel responsible for the bad things that have happened. In David's case he believed that he was too worthless, perverse, defective, incompetent and draining a presence to deserve parental protection, love, or understanding and perhaps at a deeper level, to deserve to have life at all.

Finally, David suffered from an intense omnipotent belief in his destructive power to harm others. He believed he was too impulsive, explosive and unmanageable for anyone to handle. Unconsciously he saw himself as a frightening and horrible monster, a monster who nobody could control, a monster whose destiny was to victimize others irresponsibly and endlessly. Any human interchange that in any way confirmed his sense of his own unmanageable, destructive powers horrified him. Such interchanges heightened a related belief, namely that he was undeserving of human contact, and unfit to be part of the human family.

Before describing my understanding of the traumas that led David to develop the aforementioned pathogenic beliefs, I want to present as a backdrop a brief description of some of the most obvious traumas that David's parents had suffered. This case serves to illustrate the transmission of trauma across generations.

From the little data we have I would infer that both of David's parents were severely traumatized by their own parents

whom they experienced as rejecting, and whom they believe they had overwhelmed. They both had been required as small children to live with their grandparents. We know that father was sent away at age three because of his own mother's inability to cope. Mother was sent away as a baby. There is a hint in Dr. Dickman's presentation that mother's mother may have felt overwhelmed by having given birth to twins. Both mother and father, then, were dislodged from their grandparents' homes and in a sense sent away from home yet a second time, this time to live with their parents. This kind of shared trauma may have been a major reason that David's parents were so emotionally drawn to one another to have married, and may also be relevant to their inability to end such an unhappy marriage. It is striking that this history is in a sense repeated with David; that is, he is sent to live with other relatives including his grandmother because his parents are overwhelmed by the task of taking care of him. I would further speculate that the impact of these traumas was being reenacted when mother said to Dr. Dickman (as well as many times to David) "I never want to see you again", and when father said to Dr. Dickman, "We hate you, goodbye".

Given these inferences about the parents' traumas I think I myself would be reluctant to treat a patient like David on an out-patient basis unless the parents had committed themselves to some form of on-going treatment. Ideally the parents' therapist(s) would be someone other than Dr. Dickman, preserving the privacy of this adolescent's treatment. If I believed that

the parents would not be amenable to individual, couples, or family treatment, and if they would not even be receptive to regular consultations about managing the emotionally daunting tasks of parenting David, I would be most reluctant to treat David on an out-patient basis. Even if the parents were eager to get therapy I would consider residential treatment for a patient like David as potentially advantageous. It would provide David with greater protection, especially during the early phase of treatment when he was getting into potentially life-threatening street fights. It would also offer the parents some relief from the anguish that I expect they experienced on a daily basis, thereby possibly helping them develop a more positive basis for relating to their troubled son. Finally, and in retrospect, it would protect the therapist from being solely responsible for managing a treatment where he does not have the authority that he needs to keep the treatment going.

There are a number of traumas that David appears to have suffered. I have inferred these traumas primarily on the basis of the history which Dr. Dickman reports. Some of Dr. Dickman's interchanges with the family seem further to corroborate these inferences.

In control-mastery theory we try to infer the nature of the patient's traumas, and the related pathogenic beliefs, because this orients us as to how we can best help the patient. Our formulations are then revised if we find that our therapy strategy is not leading to patient progress. So our initial

formulations are tentative.

One major trauma for David appears to be his exposure to a parental disciplinary stance that combined permissiveness and hostility. Even during the course of David's treatment we see this pattern at work. At one moment the parents angrily threaten to wash their hands of their son, one of the most severe, hostile and destructive punishments a parent can inflict. At another moment they permissively assume total responsibility for the consequences of David's impulsive and destructive behavior, teaching him (as Dr. Dickman has already pointed out) that he is either above the law or outside of it. They provide him a car and pay for his ticketed-violations while he fails to find employment, and worse yet, while he is presumably driving and drinking and abusing drugs. When his provocative behavior leads to his being evicted by his landlord, father indulgently threatens to sue the landlord. Dr. Dickman's case report is filled with examples that reflect this pattern of being both hostilely rejecting and overindulgently permissive.

Numerous researchers have found that in homes where parental permissiveness is combined with hostility, children are found to be aggressive, poorly controlled, and lacking in a capacity for persistence (Becker, 1964; Harvey, and Schroder, 1961.) It is noteworthy that researchers have found none of these characteristics in children who come from homes where permissiveness is combined with warmth.

In David's family, parental discipline was

characteristically inconsistent from yet a second point of view. David's parents were routinely polarized in their responses to crises. Whereas one would take the indulgent position, the other would take the hostile-rejecting stance. Neither parent consistently took either stance. It seems that David grew up in a family where he witnessed his parents as unable to cooperate.

Because David's parents could not maintain any steady, consistent set of expectations which they required him to meet, he was inadvertently discouraged from becoming either a more self-disciplined or a more socially competent person. Thus there developed a realistic basis for him to judge himself as inadequate. He could not discipline himself to develop his musical skills and he failed to benefit scholastically from his native intelligence. The 30 point difference in his verbal and performance scores provided strong evidence that his emotional difficulties were seriously impeding his intellectual functioning. His profound distrust of relationships guaranteed it would be difficult for him to develop a sense of pride or self-esteem based on any kind of success with interpersonal relations. Because David's parents would not tolerate those efforts his teachers made to require him to conform to social norms, it seems likely that he never had the opportunity outside the family to develop his social intelligence, yet another powerful factor which foretold how doomed his social interactions would become.

David also suffered from the trauma of parental neglect. It

is not only permissive to let a child drive a car when there is reason to believe that the child will drive and drink, or drive under the influence of other drugs, it is also profoundly neglectful. For the most part father was too busy and too disengaged from David and from David's mother to provide much of a constructive parental influence. Mother was highly vulnerable to feeling shamed and humiliated. As a result she was more invested in making things look good than in protecting David by setting limits. David urgently needed to be controlled, but we are told that mother could not tolerate risking the public commotion that might ensue. Father apparently lacked the energy to keep his son from skating at all hours of the night; mother presumably avoided making the public scene that possibly would have followed from taking action to get him to come inside.*(1) Neither parent offered David the protection that comes from setting reasonable limits for their son.*(2)

Yet another of David's traumas was the seeming inability of both of these parents to express their own aggression in a regulated way. Father himself is described as periodically out-of-control, and nobody appears able to stop him from his occasional violent attacks. Mother and the sons are subjected to his physical assaults, and to his explosive tantrums in which he throws objects around. Mother not only goads David by saying things to him that are highly critical and rejecting, but she is unable to give herself time to think about what steps she needs

*See Footnotes

to take to protect herself from engaging in interchanges that leave her so enraged. She is so out of control that she is unable to sustain the benefits of Dr.Dickman's behavioral interventions of giving her time-outs. I would expect that this mother, like her son, needed a great deal of help to learn how to express and reflect upon her enormous frustrations, and all the associated negative affects. As it is, when these parents were not expressing their anger in an out-of-control fashion, they were feeling an unrealistic need to mollify David. Here too the parents express an inability to tolerate on-going conflict and tension. So David is traumatized by two parents who are unable to demonstrate a capacity for using angry feelings as a guide for recognizing, addressing and solving problems. They both seem out of control when they are on the receiving end of David's rejections and hostility.

Another important trauma of David's arises from his parents inability to attune themselves to David's emotional needs. It seems likely that mother, from the beginning, had an intense need for David to be highly dependent upon her. How could it be otherwise, given that she had such an unsatisfying marriage, and had elected to sacrifice her career altogether? It appears likely that she looked primarily to David to satisfy her own needs. Therefore I would expect that even during David's first seven years, when mother's life only revolved around him, that she would have had difficulty separating her own wishes and fears for David from the realities of his actual developmental needs

or emotional states. What a calamity for them both. I would also assume that because of the parents' failure of empathy David did not learn to recognize or control emotional expression of any kind.

Ordinarily when I hear case material I find it easier to separate out and delineate the specific pathogenic beliefs that a child would be likely to develop based on specific traumas. In contrast, in this case each of the traumas I have listed seem to compound and further intensify the three pathogenic beliefs which the other traumas would likely have caused David to develop. I think this may be one factor that contributes to the enormous difficulty of treating a patient like as David. A pathogenic belief that he might well have developed based on any one of these traumas is endlessly reconfirmed by many of the other related traumas.

This description of David's traumas is by no means complete. Given the limitations of time, I am going to proceed with the hope that I have said enough about David's traumas and the associated pathogenic beliefs for us to think together about the treatment process.

I will begin by stating one of our theory's essential ideas about the therapeutic process. We view patients as strongly motivated both unconsciously and consciously to master their trauma by disconfirming their pathogenic beliefs. We think that patients are capable of working constructively to master their problems and that they develop unconscious plans for enlisting

their therapists to help them with their efforts to achieve such mastery. Unconscious plans are not fixed or rigid but rather are conditional and tentative. They are revised as the patient attempts to make therapeutic progress.

A key component of these unconscious strategies is what we call "testing". Testing is the most effective means by which a patient can reevaluate the reality basis for their pathogenic beliefs. Patients test to ascertain if it will be safe to make conscious their pathogenic beliefs, and to master the traumas from which they were acquired.

We have demonstrated through empirical studies that when patient tests are passed patients progress and, conversely, that when tests are failed, patients will get worse (Weiss et al., 1986). In our clinical work we seek to identify and understand such patterns that characterize the therapeutic process. In this sense we make the patient the ultimate supervisor of our therapeutic work. Our research has provided some evidence that when therapists pass patients' tests patients feel unconsciously safer. The patient may seem more relaxed, bold or insightful. Sometimes the patient brings out new information; sometimes, warded-off memories and feelings. While a test is in progress, patients may express negative feelings about the very therapist behaviors which they find unconsciously reassuring. The fact that passed tests lead to the patient doing progressive work is empirical evidence that the patient is motivated to use therapy to master his problems.

There are two major ways in which patients test the therapist. One is that patients unconsciously turn passive into active. In this process, patients treat the therapist in the very ways in which they felt themselves to have been treated and which they found traumatic as children. For example, David rejects the therapist by missing his hours and then ridiculing and humiliating the therapist who attempts to maintain good contact with him. One aspect of these interchanges is that David is treating Dr. Dickman the way he experienced his parents to have treated him. Like father, the patient disappears from the relationship by missing hours and not cancelling. Like both of his parents the patient invites Dr. Dickman to feel humiliated by treating him with overt hostility and contempt. When a patient turns passive into active, he hopes that the therapist will not be traumatized as he was, but will instead be able to maintain a therapeutic stance. I believe that when David humiliated Dr. Dickman, Dr. Dickman passed these tests by not becoming defensive, by not "counter-rejecting" and by not complying with David's contempt. Dr. Dickman's persistent and steady stance demonstrated that he did not believe he deserved such ridicule. He thereby invited David to identify with the stance that one does not have accept as deserved the ridicule that others dish out.

The other way that patients test is through transference repetitions. They repeat those behaviors which they believe provoked their parents into traumatizing them. The patient

attempts to disconfirm a pathogenic belief by testing to see whether the therapist, like the parents, will respond in a manner that the patient found traumatic. In my judgment, a second meaning of David's rejection of the therapist by missing hours and provocatively insulting him was to test in the transference whether Dr. Dickman would remain available and engaged or would prove instead to be untrustworthy by accepting David's invitation to become exasperated and disengaged.

Control-mastery theory posits that "in addition to passing the patient's tests, the therapist helps the patient by making 'pro-plan' interventions whose import is to make conscious and implicitly disconfirm some aspect of the patient's pathogenic beliefs, or to otherwise assist the patient in moving towards his therapeutic goals. When the therapist disconfirms the patient's pathogenic beliefs, it increases the patient's conscious control over the effects of those beliefs as well as the patient's capacity to reality test the dangers predicted by those beliefs. When the therapist makes interventions which confirm the patient's pathogenic beliefs, we expect that the patient will experience an increased sense of danger and become more beleaguered, resistant and uninsightful (Gassner and Bush, 1988)." A number of research studies have demonstrated these postulated effects of pro and anti-plan interventions (Fretter, 1984; Silberschatz, Fretter and Curtis, 1986; Gassner and Bush, 1988).

Notice that periodically David is out of control. It is

possible to make pro-plan interventions at such times, interventions that help David gain control and that disconfirm the related, operative pathogenic beliefs. But such interactions should be contrasted with testing, a process where the patient is unconsciously in control of what it is he is doing.

In David's very first hour with Dr.Dickman, we see a dramatic example of the therapist both passing David's transference test and making pro-plan responses. David immediately responds progressively. The patient plays ten minutes of music by the Dead Kennedys. I think that playing this music constituted a major transference test. The patient is evaluating how inclined the therapist will be to reject the patient. Mother presumably would dislike and condemn such music; father presumably would not have time to listen to it much less to discuss its import to his son. Dr. Dickman passes this test by being interested in the subjective meaning of the music and by making highly pro-plan responses. He empathically tells the patient that he is hearing a lot of deep hurt and despair in the songs and that it must be difficult to live with that amount of despair. The patient responds by talking candidly about feeling tempted to commit suicide and about being terrified by the prospect of being sent to prison. I would infer that David must have momentarily experienced a reduction in the unconscious danger he feared, namely the danger that he would be rejected if he tried to express his feelings to the therapist.

From a control-mastery point of view, true empathy means

making those interventions which help the patient pursue his unconscious plan. It means passing patient's tests and making pro-plan responses. Empathy, in the experience-near sense that self-psychologists have described, oftentimes does pass tests and is often pro-plan. I think that Dr. Dickman did a beautiful job being empathic in the experience-near sense in the first hour, and that his responses were highly pro-plan. Whether or not experience-near empathy will pass a patient's tests or be pro-plan depends on 1) whether the response has an unconscious import of confirming or disconfirming a patient's pathogenic beliefs, and/or 2)whether the response increases or decreases the patient's unconscious sense that he is in danger of being retraumatized. In this instance these highly empathic responses were strongly pro-plan because they were on the side of disconfirming several of David's pathogenic beliefs. Dr. Dickman's response opposed David's pathogenic beliefs that authority figures are untrustworthy, that they are incapable of being helpful, and that David deserved to be rejected, neglected and treated with disrespect.

I have some questions and reservations about a few of Dr. Dickman's interventions. I want to share them as a way to explicate further the process of thinking about clinical material within a control-mastery context. Since David was not my patient, and since I did not have access to detailed process notes, I certainly have no conviction that the following ideas are necessarily correct. I trust that Dr. Dickman will feel free

not only to disagree with what I say here, but to offer clinical data to illustrate how my ideas may be off the mark.

Dr. Dickman pointed out a clear pattern: David would get into trouble when not supervised and not actively regulated by some sort of structure. I would like to make a related observation about the treatment. The most consistent pattern reported in this treatment involves David becoming calmer and regaining some measure of self-control following the harrowing interchanges where the therapist protects David by setting a limit. In some instances, despite David's initially protesting these limits, he demonstrates that his therapist's taking control leaves him feeling significantly less anxious. I would assume these interchanges imply that it was crucially important that the therapist consistently oppose David's pathogenic belief in his destructive omnipotence.

The patient periodically tested the therapist by asking him to agree to a change in the treatment structure. My overall reading of this case leaves me concluding that David is more inclined to experience flexibility and reasonableness as a form of destructive permissiveness than he is to experience structure, rules and requirements as hostile or rejecting.

So, in hindsight, what would an optimal response be to the patient's request that Dr. Dickman substitute a weekly meeting with both mother and son for one of his two weekly therapy sessions? Certainly I would be attentive to the meaning of the patient's request, and to demonstrate my understanding of what

the patient hopes thereby to accomplish. Nonetheless, without strong evidence to the contrary coming from my patient I would treat as sacred the structure of twice weekly individual therapy sessions. If I had come to believe for some reason that I had to be the therapist who would also meet with David and his mother, I think I would invite them to schedule additional sessions where all three could meet together. My intention would be to disconfirm both David's pathogenic belief in his omnipotent power and his belief that he deserves rejection.

When it was no longer possible to continue the mother-son meetings, I wonder again whether it would not have been helpful to maintain the twice weekly meetings with David. It was shortly after the mother-son meetings were discontinued that David began to fail to attend any of his sessions. In my mind there is some ambiguity about what this meant. One possible interpretation is that the therapist's willingness to be responsive to David's terms for the treatment left David more trusting in his therapist, and therefore better able to test further the therapist's readiness to reject him. I am more inclined to think that the patient may have been feeling too powerful and unconsciously rejected by the evolution of fewer weekly sessions. The testing may then have been an invitation to the therapist to demonstrate over a protracted period of time his strong commitment to engaging with the patient. Some time later in the treatment Dr. Dickman insists on reinstating the twice weekly treatment. The family treats Dr. Dickman in an

emotionally abusive way, but Dr. Dickman wisely remains uncompromising. The parents come around, and the treatment progresses. This is very tough work for any therapist.

There are of course many other issues that come up concerning the treatment structure. Is it optimal in a case like this to require from the beginning the patient's participation in Alcoholics Anonymous? Should David be allowed to back out of the drunk driving educational program in exchange for his increasing the frequency of his therapy sessions?

We hear a fascinating description of how David responds to being required to attend a minimum of 80% of his treatment sessions. Once again I find myself wondering if it might have been advisable to have imposed an even more firm structure, but once again a structure that demonstrates the therapist's commitment to spending more time engaged with David. One that occurs to me would be to expect David to make up any treatment time that he misses, and to discuss all the associated feelings he experiences in response to this treatment structure. Towards the end of the treatment David once again insists on reducing the frequency of the sessions to once per week. Had I been in Dr. Dickman's shoes, I probably would have done just what he did. But I would also wonder whether the more therapeutic stance might be to continue taking the position that the twice a week treatment structure needed to be maintained, recognizing that this might increase the chance that David would quit then and there. David's pathogenic belief in his omnipotence is

disconfirmed each time he deals with an engaged, protecting, committed and confident authority figure who cannot be intimidated, who will not accede to invitations to reject him, and who won't respond to any form of emotional blackmail. With some patients, disconfirming their omnipotence may be more important than keeping them coming to a seriously compromised treatment. In this circumstance I think it would be important to be very acknowledging of all the progress which the patient had made. I would also discuss with him my observations that the treatment was seemingly grinding to a halt, and encourage him to dwell on all of his feelings, most important perhaps, his negative feelings about being in treatment. Dr. Dickman may well have made many such efforts. Because so much of this case report involves actions more than dialogue, it is difficult to assess the range of possible interventions that one might make at a critical time.

Another issue of interest to me involves the question of what it is in David's psychology that leads him to first cutting back to once-a-week therapy and later refusing to continue the treatment at all, once it was no longer mandated.

David's consciously stated reasons for not continuing involved his guilt about the cost to his parents, and his distaste for feeling like a dependent kid. I believe that both of these reasons were pertinent. His parents in various ways, overt and covert, told David he was ruining their lives, and David had pathogenic beliefs that he was undeserving of help and

that he was too burdensome to handle. David adopted early a "pseudo-independent" stance, a stance perhaps to defend against maternal intrusion and criticism. Moreover, twice-weekly therapy always posed the transference dangers of reexperiencing the painful affects (anxiety, shame, guilt, anger, confusion and humiliation) that seemingly were such a prominent part of his experience of relating to his parents. So David once again reinstated his "pseudo independent" stance.

But I think there was yet a more compelling reason that might explain why David could not continue with the treatment. It is my impression that what was most warded off for David was any awareness of how profoundly neglectful and rejecting father had been. Father was only momentarily available to David at moments of crisis. As Dr. Dickman has pointed out, the courts and the probation department, both extremely overburdened institutions, have no time, funding or mandate to work with anyone who is not on the brink of disaster. David, who needed to maintain his idealization of his father as the reasonable one, warded off any awareness of his continued need for help first from father, and now from Dr. Dickman, his father surrogate.

I want to make one atheoretical comment about something that it is important for all of us to learn from studying a case such as this one. Typically mental health professionals, myself included, lack a very sophisticated understanding of how the criminal justice system works. Dr. Dickman's case reminds us that the probation system is not designed nor equipped to

supervise the preservation of a long term therapy, regardless of how useful that therapy might be. The probation department's primary purpose is to respond to immediate crises. Even for these purposes departmental personnel are seriously overworked. We might wish it were otherwise, but when we take on the treatment of such an impulsive and potentially dangerous patient, it behooves us to be realistic about where we can and cannot expect to find enforcement for our efforts. In retrospect, this becomes another reason to consider whether patients like David can better be treated therapeutically within the context of residential treatment.

My last comments are addressed directly to Dr. Dickman. I think your efforts on David's behalf were heroic. There was much evidence that he made good use of your work, and that he was vastly better able to pursue some of the normal goals of late adolescence. Against the backdrop of the significant gains you observed in David, I can only imagine the frustration you must feel in not being able to continue the important work that David needs.

FOOTNOTES

1. Research studies are demonstrating the long-term impact on the child of the present but unavailable father. This year Koestner (1990) published a study that looked at a range of factors that characterized the family life and school behavior of 75 five-year-olds to see what factors were most associated with these same children 25 years later demonstrating a capacity for empathy. Koesler concluded: "Of all the factors studies, including parental affection and a child's unruliness at school, the single most powerful predictor of empathy in adulthood was how much time the children's fathers spent with them". Koestner stated, "spending more time with their children may give fathers more opportunities to be responsive to their children's emotional needs, and so model empathy for them. And it may be that those fathers who are more willing to spend that much time with their children are more empathic themselves"...Other child development researchers have suggested that it was not the time spent with father in itself that influenced the child's empathy as an adult, but what the contact with the father showed about the family life. High father involvement probably means that mother wants him there and that there is a more harmonious family climate.

2. I think that one reason that empirical research demonstrates that juvenile delinquents characteristically come from homes where the parents are a combination of lax, erratic, hostile, rejecting and neglectful is that such children try to protect themselves from the internal danger of experiencing very painful affects by compulsively rebelling against the attitudes and values of their untrustworthy parents. The antisocial behavior reflects both the child's motivation to gain some independence and thereby to protect himself from traumatic experiences of parental betrayal, as well as to get the world at lodge to disconfirm his frightening convictions of omnipotence.

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