THE MAKE-UP ARTIST

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Case Presentation[1]

Mary first came to see the psychotherapist, accompanied by her parents, at age twenty-two. She had taken an overdose of pills and had cut her wrists. For five years, she had been going on destructive and self-destructive rampages, tearing up her room, thrusting her hands through windows, and banging her head against walls severely enough to leave visible contusions. When asked why she acted as she did, Mary blamed what she perceived to be her bad skin and general repulsiveness. The failure of her efforts to improve her skin had left her angry and wanting to die. The therapist describes her as an attractive young woman with no apparent skin problems. Her tone challenging and angry, she suggested he not waste his time; nevertheless, she agreed to return.

Mary was the eldest of four children. Except for her sister at college, they all lived in the parents' home. Her father had

been physically abusive as far back as Mary could remember; his attacks were unprovoked and unpredictable. As she approached adolescence, he began tearing off her bathrobe, calling her a slut, and so forth, but he never attacked her sexually. The attacks ended when Mary began injuring herself; her mother was unpredictably supportive or depriving. Mary's parents kept her indoors for her entire eleventh summer as punishment for fighting.

Mary was concerned about her looks as far back as she could recall. In kindergarten, she destroyed her lunch box because she thought it was pretty and she was not; she felt she did not deserve it. In elementary school, she thought that her hands were large and repulsive and, as puberty approached, that her hair was frizzy and unattractive.

She had been popular and active in high school, coleader of a singing group and co-captain of the cheerleaders. When asked to lead these activities on her own, she deferred to a friend whom she idolized. She perceived the friend as beautiful, popular, and poised—all of the things she wished to be but felt she was not. The friend broke with her toward the end of high school in a sadistic manner. Characteristically, Mary felt she deserved it. When the therapist began seeing Mary, she had another best friend whom she idolized

and deferred to in a like manner.

Until her seventeenth year, Mary avoided her male admirers. She deflected them in any way she could and disbelieved their compliments and advances. When she finally allowed herself a sexual encounter, her fears seemed confirmed. He was a man in his thirties who appeared to be upset that she was a virgin. He ignored her afterward and allied himself with the idealized friend. Mary felt that the two of them joined in mocking her. She remained fearful of men and shunned involvement.

Mary attempted college and achieved good grades, but anticipating failure, she dropped out. A series of employers liked her and wished to advance her, but in each job she became uncontrollably anxious that she was doing badly, and she quit. When the therapist began seeing her, she had held a job for six months. She was about to receive a third, substantial raise and an increase in responsibilities, but she felt she was doing poorly and experienced each day as an overwhelming, anxiety-filled struggle. Three weeks after therapy began, following a typically destructive episode in her room, her parents hospitalized her. Her behavior was no different than it had been on previous occasions, but the parents claimed to be "fed up." She was observed for three days and discharged. During this time, the mother called her employer and told him what had happened, adding that Mary would probably not return to work. The mother gave the employer the therapist's telephone

number, and the employer called the therapist to say that he liked Mary, thought her an excellent worker, and would keep her position open for her.

Mary's employers liked her, most of her friends remained loyal, and she was often called for advice from her large circle of friends and acquaintances. She was able to disguise her feelings to a point where she was perceived as a bright, attractive, and enjoyable person. This was a strain on her, however, and she continually fought anxiety during her social and work interactions. She acted out only at home.

Mary was hospitalized several times, mostly after threats by the parents to do so—threats that Mary challenged them to carry out. The last hospitalization was a voluntary three- month stay in an inpatient program. The staff admitted to being perplexed by her. She was medicated and she received psychotherapy, but there was no improvement in her functioning. She was discharged on the understanding that she would continue therapy.

After some largely supportive and nonconfrontational treatment, Mary's destructive behavior and suicidal attempts ceased. But the therapist could not make progress against her delusion concerning her skin. Her parents would periodically refuse to continue paying for treatment, usually when she seemed improved, and at one point, they evicted her from their home. During this time, she stayed with a female friend, and she refused to see the therapist.

But Mary did call him after two months to say that she had concocted a plan for suicide and that she felt much better. Then she hung up. The therapist did not have her current phone number or address, so he contacted her family, who refused to believe that she would "embarrass" them this way, despite her history. He finally located her, her parents took her back, and she began seeing the therapist again. This episode convinced her, she said, that he truly cared.

Early in therapy Mary reported the following dream: "I am on a train with a group of women. You are outside on the station platform. I try to attract your attention by tapping on the window, but you walk away. The train pulls into another station. Men get on and begin beating or having sex with the women; I am not sure which."

Mary showed considerable ability to take charge in crises. On one occasion, her sister was trapped on an island during a dangerous military operation. Mary kept in touch with the State Department, organized the relatives of others in the same situation, and arranged a way of exchanging information on a regular basis. Nonetheless, she felt constantly out of control and could barely conduct her daily activities. A journal I asked her to keep of her typical daily activity included the following:

1. Up at 8:00 a.m. feeling anxious.

2. In bed trying to fall back asleep for one hour while fantasizing about looks and sex.
3. Rush to mirror worrying about looks and staring for one- half hour.
4. Hair and skin care activities for one hour.
5. Overwhelmed by panic and screaming curses at self.
6. Outdoors in attempt to calm down but stopping before mirrors in shop windows.
7. Out with friends, acting "normal."
8. Home, staring in mirror obsessing over ugliness.
9. Panic and cursing again.

In a much more detailed account, from waking to sleeping over a period of a few weeks, Mary described her unsuccessful struggle against her fears and urges. Her failure to control her impulses increased her anxiety.

Mary developed very powerful feelings toward the therapist. She was reluctant to express them directly but alluded to them often. She harbored fantasies of "getting better" and running into him years later whereupon they would begin a serious relationship culminating in marriage. There were also sadomasochistic sexual fantasies in which he would abuse her.

Perhaps the most perplexing aspect of Mary's case is the high degree of insight she displays concerning the motives and actions of others, and even concerning some of her own behavior. Yet, she has not given any sign of abandoning her delusions concerning her skin.

The hospital diagnosis (with which Mary's therapist disagrees) is as follows:

Axis I: Obsessive-Compulsive Disorder

Axis II: Histrionic Personality Disorder

Formulations and Treatments

Stanley B. Messer (Psychoanalytic)

Let me start by putting my cards on the table. I do not view Mary primarily as a histrionic personality. I would not recommend psychoanalysis, brief dynamic therapy, behavior therapy, family therapy, or medication as the treatment of choice for her difficulties. I believe that Mary suffers from a narcissistic personality disorder, as understood psychoanalytically, and that she would respond best to a Kohutian self psychological approach with its stress on therapist empathy and support (Kohut, 1977, 1984; White & Weiner, 1986).

How are we to view Mary's major symptoms or maladaptive behaviors, namely, her self-destructive rampages and suicidal threats? Following Kohut, I would understand these as rage brought on by what she alternately perceives as an unresponsive or hostile environment. There is an urge to

destroy those who thwart Mary's expectation of controlling them.

When her rage was met by a parent's counteraggression ("Father had been physically abusive as far back as Mary could remember") or by inconsistent nurturing or neglect ("Mother was unpredictably supportive or depriving"), her aggression was turned back on herself, leading to self-hate, depression, and masochism. The masochism, including giving up jobs at which she performed well, is itself a way of defending against her fear of unleashing still greater self-destructive rage in the form of suicide.

Mary's anxiety that she was doing badly at her job and that she was repulsive physically (in spite of realistic assurances to the contrary) suggests unconscious expectations of self-perfection. To self-psychologists, the view of oneself as perfect is considered natural in early childhood; it is referred to as the *infantile grandiose self.* Grandiose beliefs of being able to exercise complete control over the environment are modulated through daily confrontation with reality, optimally in a gradual way, leading to healthy ambition and achievement.

As children's grandiosity is tamed, it yields to a second way in which they try to control the world and make it safe, namely, idealizing the parent. They assume that parents are all-powerful and that they can and will protect their children from feelings of helplessness and pain. Mary's parents,

however, were poor figures for idealization; the father was more abusive than protective, and the mother (so far as we are told) did nothing to protect Mary from her father's violence. It is quite apparent that they were unable to help her transmute her natural grandiosity into healthy narcissism or self-love. Both Mary's grandiosity and tendency to idealize have taken a pathological turn due to failures in her environment. In this connection, note that she continues to feel the need to cope with the world either through her own perfectionism—being physically flawless or performing flawlessly at work—or by idealizing others ("She deferred to a friend whom she idolized" and "When the therapist began seeing her, she had another best friend whom she idolized"). Neither her self-perfectionism nor her tendency to idealize others currently contributes to a satisfactory life for Mary.

The therapist's initial and primary job is to provide the supportive environment lacking in Mary's development, thereby allowing her to identify with and internalize a very different kind of parent imago. Early in therapy, I would not confront, or try to direct, or even interpret Mary's self-destructive behavior. I would try to be, in Kohut's terms, a "self-object" for Mary—someone who, she feels, is part of her in some way, who can help maintain, by virtue of the merger, the coherence, continuity, and positive affective coloring of herself. That is, she should be allowed to display her arrested grandiosity and idealization rather than be confronted with them. I would try to

appreciate what it must be like to be Mary and to empathize with her dilemmas. There is no place here for Freud's (1921/1959, p. 527) model of the analyst as a surgeon "who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible." I would take an introspective-empathic stance, always trying to remain sensitively attuned to the nuances of Mary's experience. I would admire her accomplishments—and she clearly is capable of considerable achievement as the case report indicates. She was coleader of a singing group and co-captain of the cheerleaders; her employer thought her an excellent worker; she could take charge in a crisis. The model of a good parent to the patient is not a bad idea for the therapist to keep in mind in this kind of therapy.

Mary must feel that she has an ally in the therapist (which she did not have in either parent), someone whom she can idealize, at least for a time, and with whom she can bask in the glow of her accomplishments. Alongside his attunement and support, the therapist must show respect for Mary's autonomy and decision-making capacities. We would, I am sure, explore her view of men—graphically portrayed in the dream—as ignoring women or beating them. I would ask for her associations to the dream in order to explore more deeply the personal meanings and memories conveyed by its rich imagery. Because of the explicit reference to the psychotherapist,

discussion of the dream would be an opportunity also to focus on Mary's developing transferential reactions to him. Eventually, if all goes well, Mary will be able to make use of interpretations of her self-destructiveness, anxieties, and idealizations.

Is there evidence that sustained empathic inquiry and support would work for Mary? I believe there is. Two kinds of interventions were salutary: (1) "After some largely supportive and nonconfrontational treatment, Mary's destructive behavior and suicidal attempts ceased." (2) When Mary called the therapist to say that she had a plan for suicide, the therapist's concerned, extensive efforts to intervene, consistent with the self-psychological approach described above, convinced Mary that he truly cared, thus allowing therapy to resume.

In brief, the therapy I would recommend and conduct would try to provide Mary with a responsive and attuned environment emphasizing sustained empathic inquiry and, eventually, interpretation. I would expect her narcissistically based rage to surface whenever she felt that I was off the mark, inattentive, or in any way critical of her. And I would expect that these episodes would present opportunities to explore her reactions, eventually enabling her to modify them. Over time, she would come to put trust in, and internalize, a very different kind of "self-object" in the figure of the therapist, an internalization that would result in a more cohesive, lovable, and enhanced

sense of herself.

J. Kevin Thompson (Cognitive)

Mary has characteristics of several different diagnostic categories. In addition to the disorders cited in the hospital diagnosis, she has symptoms consistent with obsessive-compulsive personality disorder, borderline personality disorder, intermittent explosive disorder, and body dysmorphic disorder— extreme disparagement of physical appearance (Thompson, 1990). More information is needed before a specific diagnosis is made.

There is information lacking that might help explain Mary. It does not appear that other schizophrenic symptoms accompany her specific physical appearance delusion; however, I would like to be certain that there are no signs of other delusions and to be informed whether there are occurrences of schizophrenia in her family. I would also like to know the precipitating circumstances for the onset of her dissatisfaction with her looks (if available). Was she teased or insulted by family or peers? Also, what specifically are the "skin problems" of which she complains?

Other background information might be relevant. Was she often compared to her elder sister? Is she less attractive, and was this pointed out to her at an early age? Other aspects of their relationship would also be

helpful, especially because her need to idolize a female friend may be a substitute for a failed relationship with her sister. Were either of her younger siblings female, and if so, what was their relationship? What about her parents' treatment of them—as Mary saw it? Finally, I would also like to know the specific medications and types of psychotherapy she has previously received.

The relationship that must be developed between the therapist and Mary is one of the utmost trust, based on unconditional acceptance, genuineness, and caring. Mary has never been accepted for herself—by parents, by peers, or by men (Thompson & Williams, 1987). I would suspect that the abuse she received as a child led to self-blame and increased efforts to please her parents. The need to please others was also present in her peer relationships.

Unfortunately, her desperate drive to be loved and accepted resulted in extreme acting out and attempts at suicide. The therapist's efforts to find her brought her (first?) realization that he "truly cared." The evolution of Mary's fantasies of involvement was foreseeable. The therapist must be completely up-front regarding these transference issues, which might allow him to suggest that if someone can "truly care," so can others—and that, therefore, she needs to give other men a chance. Acceptance of this model by the client could lead to interventions such as role playing and training in dating skills

and relationship skills.

The therapist must deal aggressively with Mary's specific problems of anger control and physical appearance delusion. Given Mary's past sexual problems with transference, a female therapist might be preferable. Once core aspects of the relationship—trust, acceptance, caring—have developed, the therapist would be more free to be openly directive and challenging (Thompson & Williams, 1987).

Let me review my conceptualization of Mary's case, based on the available evidence. Mary's problems are a consequence of pathological early socialization in the home. Her protective self-abuse and self-disparagement, leading to low self-esteem and inappropriate acting out, communicate her feelings of isolation and despair. Her acting out was initially both a way to escape from her father's abuse and an attempt to get attention from her mother. The attention from her mother was inconsistent (schizophrenogenic), and therefore Mary sought nurturance from peer-group women. However, her female friends tired of her idolization and rejected her. Her one attempt at trusting a male also met with rejection. Consequently, Mary developed as an individual who did not trust others and felt others were trying to control her. She rejected any evidence that she was a worthwhile person, or even the possibility that she might be bright, and tended to back away from imminent success at college or on the job. Her efforts to hide her

low self-esteem and to act socially appropriate worked in some settings; however, on returning to her pathological home environment, she was unable to override her loneliness and lack of direction, and she gave way to further outbursts.

The delusion regarding her ugliness seems symbolic of her inability to accept herself. Comparisons with her sister and possible teasing or insults from her family may have contributed to this focus of self-disparagement. I do not see her delusion as schizophrenic, but rather as a learned obsession, which makes sense given her background. It protects her from experiencing the anxiety that might manifest itself if she had no reason for hiding from success, men, and independence. The fact that she still lives at home suggests that she may have difficulty breaking away from this crazy environment.

Treatment should be multifaceted and, if possible, should include family and individual therapy. The family intervention should focus on her need for true acceptance from her parents and on the necessity of a separate residence for Mary. In individual therapy, the therapist needs to work on her self-esteem, anger control, social and sexual relationships, and ugliness delusion. I would use desensitization procedures, thought stopping, and cognitive restructuring for the delusion (Thompson, 1990). Skills training, role playing, and cognitive therapy might be useful for issues of self-esteem and for social and heterosexual relationship issues. I would also work with her fear of

success regarding college and employment, and I would use stress management strategies for anger control. It is essential that any directive intervention be in the context of a caring client-therapist relationship.

Mary's therapy is likely to include numerous ups and downs, especially when she feels misunderstood or unaccepted. I predict that she will slowly give up her delusion and begin to accept herself, but only if active interventions are begun with a therapist whom she trusts implicitly.

Elisabeth A. Lederman (Humanistic)

In the account of Mary's case, there are many signs of the likelihood of a hidden history, and these clues might be ignored by clinicians who follow a tradition of denying the reality of incestuous violation. The first line of defense, traceable to Freud, is to say that incest did not happen; it was all a fantasy that represents a desire of the victim. Since it did not happen, there is no need to ask the violator embarrassing questions or to disturb elements of society whose emotional security depends on keeping their heads in the sand. The second line of defense is to say that, yes, it happened, but it was the

victim's fault because she was seductive. Both these defenses conveniently scuttle the facts of child development. All children need love (as expressed by warm hugs); they do not want or seek genital fondling or intercourse. In those rare instances when sexual fantasies or truly seductive behaviors (in contrast to healthy sensuality) occur in early years, it is because the children have already been denied loving warmth and then are taught by their violators that they can get contact only through sexual behavior.

Seven signs, taken together, signal a high probability of a hidden history in Mary's case. First, as Mary neared adolescence, the father "began tearing off Mary's bathrobe" (that is, he did it many times or regularly); but he is said not to have attacked her sexually. This repeated sexual harassment, it is implied by the form of the sentence, is not to be regarded as sexual. Yet, the act is sexual in itself and is unlikely to have been the only manifestation of the father's proprietary interest in Mary's body.

Second, as Mary's father tore off the bathrobe, he called the preadolescent girl a "slut." This word implies some prior sexual activity for which he is abusively blaming her.

Third, there is a history of physical abuse as far back as Mary can remember. We are not given the details; are we therefore to imagine that the father scrupulously avoided baring sexual parts of his daughter's body and

that he avoided beating her on any part that might have had erotic connotations to either of them? The form of the physical abuse chosen by this father—who stripped his preadolescent daughter and accused her of being sexual—was therefore almost certainly implicitly sexual. It may also have been explicitly sexual.

Fourth, Mary has a dream in which she tries to get the therapist's attention, but he walks away. The glass window between them also indicates she has difficulties being heard (by her father or mother or therapist?); she is reduced to futile tapping. Let us hear what she is saying: "Men got on the train and began beating or having sex with the women; I am not sure which." When, and under what circumstances, would one not be able to tell whether she was having sex or being beaten? This dream, in the context of what we are told about Mary's history and symptoms, is an early memory of punitive sex or sexualized beating.

Fifth, Mary had masochistic sexual fantasies about her therapist. Thus, she recapitulates in the transference the "path to love" that her father taught her.

Sixth, Mary's self-destructiveness is typical of sexually abused clients, who maintain the feelings of abuse by head- banging, cutting their own limbs, tearing at their own faces, or ripping their clothing. The feelings are "I am bad,

dirty, unworthy."

And seventh, Mary's distortions of reality strongly indicate that she is hiding something from herself. Her denial of early incestuous violation by her father is no more trustworthy than her blaming her problems on her supposed ugliness. The revulsion at her own hands (in elementary school) and face is typical of patients who have been required to perform manual and oral sex at an early age. Children repress the experience of sexual contact and transfer the feelings to their hands and faces, thus sparing the incestuous violators their feelings of revulsion (and maintaining the hope of being loved). Mary's choice of her lunch box as an object to destroy may be significant beyond the explanation Mary gave. The lunch box is a place to put food, like her mouth; it may also represent her vagina, and often appears as a symbol with that meaning in dreams. Vaginal intercourse may have occurred or may have been threatened.

How could vaginal intercourse have occurred if Mary's first sex partner scorned her virginity? We know about this peculiar reaction only from Mary's account. Is it not just as likely that Mary rejected herself because she was not what she was supposed to be and withdrew from the relationship?

Note that the loss of virginity may be regarded as occurring normally through gradual stages in adolescence. Whether or not Mary's father

technically deflowered her, he appears to have taken her virginity in the more general sense of having initiated her sexually.

Mary's version is understandable as a triple denial of the loss of her virginity to her father. As Freud pointed out in other circumstances, the denying mind negates every element of the distressing scene. Mary says, (1) "My boyfriend rejects me" rather than "I reject our sexually intimate relationship" and "I reject myself," (2) "I was a virgin" rather than "My father deflowered me," and (3) "He rejects me because I am a virgin" rather than "I reject myself because I am not a virgin—because my father made me unfit for normal relations."

Mary may have been violated very early, beginning at an age before the capability for memory developed. All that would be left from these experiences would be vague feelings, defensive reactions, and a disordered mind.

The hypothesis of incestuous abuse, whether through fondling, any form of intercourse, or other means, would be corroborated or disconfirmed by the gathering of information, essential in any event. The following questions—and others—would be asked of the father in an individual session: Did he at any time sexually abuse Mary? If so, over what period of time did he sexually abuse Mary? Why did he rip Mary's bathrobe off, and

what did he mean in calling his daughter a slut? What was his rationale for the physical abuse of his daughter? Why did he stop the physical abuse five years ago? What did he think of his daughter, and how did he feel toward her when she was a little girl (questions reiterated through the age range)? Does he love his daughter now? What does he mean by the word *love?* Why is Mary still living at home? What is his present relationship with his wife and with the children? And is he close to anyone in the family or outside?

The father would probably begin by denying sexual abuse; but the questions probably would elicit contradictions in his responses, opening up avenues for further confrontation. He might deny that pulling off his daughter's bathrobe was sexual, but I would say that I did not believe him, for there is no plausible alternative meaning to that act.

Perhaps a psychotherapist sensitive to civil rights analogies might ask, What right do we have to confront the father with the presumption of incestuous abuse? The answer is, first, that since we are not in court, the father is not entitled to a presumption of innocence; second, the risk to the patient of not uncovering the hidden history (by not grilling a guilty father) is far greater and more harmful than that of hurting the feelings of an "innocent" father who in this instance "merely" stripped his daughter and abused her physically and verbally; and third, the fact that Mary's parents brought her to a therapist itself presents an aspect of the family pathology. If they had not

done so, let us say, if they had given Mary the therapist's telephone number and left it to her to call, they would not be part of the treatment process. (If Mary wished her parents to be involved later—and I might suggest this, depending on the evolution of the case—and if the parents agreed, then it would be up to Mary, with my support, to confront them.)

The following questions, among others, would be asked of the mother in an individual session: What made this attempted suicide, in contrast to Mary's preceding five years of self-destructive behavior, mobilize the parents to bring her to therapy? Was she aware of her husband's physical abuse of Mary? How did she feel about the bathrobe tugging? Did she ever intervene on her daughter's behalf? Did her husband ever abuse her—physically or emotionally? Why was she on and off with her daughter emotionally? Does she love her daughter now? What is their relationship? What is her relationship with her other children? Does she encourage her children to become individuals guiding their own destinies? How does she view herself within the family? Why did she phone her daughter's office and give them information of the attempted suicide? Why did she not just inform them that Mary was ill and would be in touch? What were her motives for giving information that could have jeopardized her daughter's job? What does she get out of controlling her daughter?

I would not be surprised to learn that the mother is cold to Mary and

possibly to the other children. This would fit the picture of the incestuous family in which the mother is unavailable physically or emotionally to the abused daughter. On some level, mothers know about abuse but are incapable or feel incapable of doing anything about it. The first daughter is usually the target. Information is needed here to ascertain whether the other children, especially other daughters, were abused in the same years that Mary was—or if, after father's abuse of Mary ceased, he attempted to move down the line.

My sequence of treatment goals for Mary would be first, to help her become strong enough to face her feelings about herself and her family, and second, to enable her to separate from the family.

Digging out the truth by confronting the parents serves these two goals. First, Mary needs some basis in reality to which she can respond emotionally. If she does not know the truth, she will continue to substitute imaginary problems— such as her face. Second, the true history is needed to interrupt the family pathology that keeps her dependent.

In the first phase, I would see Mary in individual sessions. Time would be required to allow trust to develop between us; I would say to her that no matter what she told me about what had happened to her, I would believe her, and it would take still more time for her to find out that I meant that. As I show her that I care about her, that I find her face likable, that I find her

(apart from her defenses) likable, her defiance and resentment of her face might temporarily become more intense; the more I accept Mary, the harder she would have to work to maintain the idea that her so-called ugliness precludes a relationship between us.

Since Mary presents her history as a consequence of defects in her appearance, we would start with them. I would not ask her to tell me what is wrong with her face, but rather how she feels about the supposed defects. My assumption is that feelings of any kind (except anxiety) are foreign to her and need to be brought into awareness. I would use the Gestalt two-chair method. As she allows more of her feelings to come to the surface, I would relate them to the physical abuse and her feelings about it.

I would use Gestalt and bioenergetics methods in working with Mary on her feelings within the train dream. That dream, describing both physical and sexual abuse, is her way of saying, "This is what happened to me. Now, how do I deal with it? Who is going to listen? I have tried, but there was a glass window between me and the one I wanted to hear me, and he just walked away."

I would ask Mary to lie on the mat, eyes closed, breathing deeply, relating the dream in the first person as if she were living it in the present, owning the feelings of the dream as hers. I would suggest that Mary allow

whatever emotions she felt to come to the surface. This method would allow me to see where she stops her breathing, cutting off her emotions and (according to the teachings of bioenergetics) storing her repressed feelings. I would use similar methods for the bathrobe memories. Having Mary lying down allows body defenses to relax and stifled feelings and thoughts to emerge.

If Mary arrived for a session angry or suicidal, I would place a pillow in front of her, give her a plastic bat, and ask her to smash out the angry feelings. As she was doing this, I would ask her to scream, "I'm angry!" or "I hate myself!" or "I hate my face!" If the self-hating expressions were expressed loudly enough and long enough, the underlying issues would surface, since the feelings about her face are defenses against her emotional responses to what has happened to her. As she cries how she hates her face, she might recall, or I might prompt her to recall, her father's violations of her.

Mary would in time give up her self-abusive actions, expressing directly the feelings that behaviors such as head banging communicate dysfunctionally.

In the second phase, concurrent with individual sessions, I might attempt to see Mary together with her parents—not necessarily to resolve the issues, but to allow Mary to confront her parents in a positive and supportive

environment. It concerns me that Mary, at age twenty-two, with adequate financial resources to maintain her own living space, is still living at home. In family therapy, we could explore how the parents are maintaining the dependency, and we could work to break it. Mary shows in her outside activities that she is a capable individual who can socialize and maintain a normal existence. She needs to extend these capabilities by leaving home and establishing her own life. I conjecture that the attempted suicides and the self-abusive actions would diminish once she was out of the family home, since these actions have not occurred anywhere else.

Bernard D. Beitman (Integrative)

My first concern is whether a *DSM-III-R* diagnosis would indicate an approach likely to be successful or to aid in my understanding of Mary's problem. It appears from the text and from her diary that Mary has panic attacks. She is self-destructive, has attempted suicide several times, and utterly depreciates herself in the face of work successes. These findings suggest a strong depressive element. I would therefore ask questions to confirm or disconfirm the diagnoses of panic disorder and depression. Also, it appears Mary may fit diagnostic criteria for narcissistic personality disorder or borderline personality disorder. The tendency to idealize others and devalue herself reflects interpersonal and intrapsychic dynamics that are

critical for a therapist to address.

What else would I need to know? Mary's family is strongly implicated in the development of her difficulties. Her need to live with her parents, taken with their reactions to her hospitalization and her suicide threats, calls for an assessment of her difficulties in individuating and separating from them.

Since Mary does live at home, I would want to see her mother and father at least once to get some idea of their behavior with her. I would also instruct her to keep a triple-column diary, in the form suggested by Beck and his colleagues, to help recognize and discriminate episodes of panic, depression, suicidal thinking, and self-destructive behaviors. In this way, I might be able to isolate the situations giving rise to these episodes and then to track the associated cognitions. I suspect that many of these experiences are related to fears of abandonment, isolation, and her own rage. Another way I would begin to learn about Mary is through the manner in which her transference develops. I am assuming that she is not being transferred to me but that I am the presenting therapist, continuing to see her. It appears that she has developed a powerful transference in which the twin elements of idealization and self-depreciation are beginning to unfold.

As for the progress of therapy, I see that engagement was very difficult. Mary came to trust the therapist's ability to care for her through his response

to her suicide plan; he sought her out despite her parents' lack of concern. I am sure his nonconfrontational and supportive approach to her was at variance with her previous experiences with men, whom she sees as exploiting her in violent and possibly sexual ways. I anticipate that she would make many attempts to run from therapy, fearing the therapist's violence against her. At this point, however, she appears to have given up some of those concerns.

Since Mary is fairly disorganized in her personal life, cognitive therapy for panic and depression might require more time and energy than she would be able to devote to this energy-intensive approach. Instead, I would consider using medication. Although Mary was receiving medication as an inpatient, what she received is not clear from the report. I would consider a tricyclic antidepressant and possibly a benzodiazepine for panic attacks (if that diagnosis is warranted). It is possible that during her episodes of aggression, she is simply attempting to release intense pressure within herself by banging her head, putting hands through windows, and destroying her environment. It is possible that a short-acting benzodiazepine might disrupt the spiral of intense emotion by relaxing her and distracting her from impulsive behavior. The prescribed medications, if successful, should help her engage more fully in therapy. Even if not successful, discussion of medications might provide a relatively objective way of describing symptoms and related cognitions and

behavior.

I would engage Mary in a pattern search to define her interpersonal difficulties as seen both in her transference and in her relationships with others. I would anticipate a good deal of countertransference in the first part of the pattern search, and I anticipate that she would respond intensely to me with both fear and strong desire. She might have difficulty forming a self-observer alliance, at times falling into fantasy and wanting that fantasy to be reality. The vignette states that Mary fantasized about marrying the therapist and also about a masochistic involvement with him. I believe these wishes would not always be deferred to after the therapy, but would appear at some point in therapy (demanding to be acted upon at once!), creating anxiety and disorganization in the therapist.

The purpose of the pattern search is to define patterns in such a way that the possibility of change is implied. These patterns would be derived from Mary's transference reactions, from her narcissistic, grandiose, and depreciated self, and from the meaning of her perception of herself as having bad skin and being generally repulsive. I would expect that she would have difficulty receiving compliments from me: she would either exaggerate their significance to infer that I wanted a sexual relationship with her, or she would deprecate them, saying that they were silly or that I was lying or being insincere. I would be most concerned about the discrepancy between Mary's

self-evaluations and the success of her actions, particularly in regard to work. I would repeatedly point out discrepancies between what Mary says about herself and what her actions show, and I would attempt to engage her in considering the possibility that the supposed bad skin was a reflection of her tendency to depreciate herself. I would remain aware that the notion of herself as having bad skin may be fixed in Mary's mind and difficult to remove, so I would not attack it as a single focus, but would consider it as an element of a major dysfunctional pattern of self-depreciation.

I see change as being extremely difficult for Mary and taking place over a long period of time. Will she be able to separate from home and live on her own? That would be one major objective. Will she be able to catch herself at depreciating herself? In the transference, will she be able to talk freely and easily about her fantasies toward me, maintaining a strong self-observer alliance with me?

Termination may be fraught with difficulty and danger. Mary may find me to be the first man who is kind and caring and who does not exploit her. Termination means she will have to go out into the world and attempt to establish such a relationship again. She may prefer simply to stay in the warm and secure therapy setting and not ever say good-bye. That inclination would have to be confronted and discussed, and its associated cognitions would have to be examined for change. One set of strongly associated thoughts and

feelings would concern her difficulty in giving up her parents and leaving their home. Ideally, at termination, she will have made it out of their house. I would hope that she would not have rushed into another dependent relationship quite yet but that she would have had some experience of being out on her own.

Points of Contention and Convergence

Stanley B. Messer

There are both shared emphases and specific points of difference between my approach to Mary, based on psychoanalytic self-psychology, and those of my counterparts, who are proponents of either cognitive-behavioral, experiential, or eclectic therapy. The clearest arena of convergence is the kind of relationship that we regard as necessary to engage Mary in a therapeutic process. Thompson aptly describes it as "one of utmost trust, based on unconditional acceptance, genuineness, and caring." Lederman also emphasizes the development of trust, adding the importance of believing Mary and conveying that the therapist cares about and likes her. Beitman refers, at least indirectly, to the value of a nonconfrontational and supportive approach, one in which the therapist might compliment Mary. In psychoanalytic therapy, too, caring, empathy, and support are advocated, especially when working with more severely disturbed clients like Mary

(Messer, 1986, 1988).

All of my fellow psychotherapists, however, introduce practices stemming from their different theoretical positions that I would be hesitant to endorse. Once the relationship is established on a firm footing, Thompson advocates a more directive and challenging therapy. Because of Mary's fragility, I would be concerned about whether she could withstand confrontations without decompensating. That is, as a narcissistic personality, she may interpret confrontation as criticism and may view her difficulty complying with the therapist's suggestions as evidence of her badness. I would worry, too, about how the therapist's authoritative-directive role may affect Mary's efforts to establish herself as an autonomous person, one who is fully capable of making her own decisions. On a manifest level, she may comply with the psychotherapist to maintain his caring and attention, but she may then find it more difficult to become a person who possesses her own locus of initiative.

Although I am intrigued by Lederman's formulation and speculations about Mary having been sexually abused, I would not be as willing as she to probe the repressed emotions so directly. There is the possibility of Mary's unleashing more feeling than someone so unstable could handle. In addition, the bioenergetics approach, by attempting to bypass her defenses to produce a catharsis, does not allow her to learn how she uses various symptoms,

behaviors, and defenses to protect herself from her own worst fears in her relationships to others. I believe that such awareness could help Mary integrate her feelings, cognitions, and behavior in a more adaptive fashion. Furthermore, I would not bring in her parents or encourage her to leave home, as Lederman suggests, because I would see this effort to increase her independence as, paradoxically, fostering her dependence on the therapist (cf. Lazarus & Messer, 1988). I would prefer to let her arrive at such decisions on her own when she feels ready to do so.

Beitman and I share a similar understanding of Mary's problems. I like the way he uses that understanding to anticipate the course of therapy, especially the obstacles that are likely to arise. Unlike Beitman, however, I would not refer Mary for medication until I had sufficient opportunity to observe how she responded to psychotherapy. My hope would be that a soothing relationship would calm her sufficiently to obviate the need for medication, which often brings unwanted side effects. In addition, medication shifts the perceived locus of change from the person's volitional capacities to an outside chemical agent. And Mary could interpret the use of medication to mean that she is not able to learn to deal with her feelings through her own psychological efforts. I should add, however, that if matters deteriorated in spite of my best efforts, I would consider medication.

All three instances of my divergence from the other commentators

relate to their advocating measures outside a purely supportive or interpretative therapeutic framework. These measures include therapist suggestion and confrontation, involvement of the client's family, and medication. Although I agree that each has its place in a therapist's repertoire, my contention is they all have pitfalls that probably can be avoided in the case of Mary, who so much needs to come to believe in herself, in her abilities, and in her considerable adaptive capacities.

J. Kevin Thompson

Upon rereading the case, my own initial conceptualization, and the formulations of Messer, Lederman, and Beitman, I am struck by the complexity of the case and by the richness of our attempts to understand Mary. I found myself agreeing with the great majority of the other writers' recommendations, especially with regard to the need for Mary to separate from the family (Lederman, Beitman), the importance of a warm, empathic client-therapist relationship (Messer, Lederman), and the role of transference (Beitman). I was particularly affected by the case Lederman made for a sexual abuse component. I now see that this issue must be fully addressed. In addition, Messer's Kohutian model deserves attention as a possible explanation and treatment for Mary's problems. And Beitman makes a cogent

argument for the further assessment of panic disorder and depression, the use of confrontation procedures (for her facial delusion), and the role of medication. My own analysis of this case has been broadened by the exposure to the opinions of colleagues who have backgrounds quite different from my own.

On the other hand, I am somewhat dismayed that the use of cognitive-behavioral techniques was not advocated by Messer and Lederman. While these procedures are not without limitations, they have certainly received more empirical validation than Kohutian analysis, Gestalt procedures, or bio-energetic methods. In addition, some of Mary's primary complaints are amenable to cognitive-behavioral procedures, including delusions, impulsivity, anxiety, and possibly depression. At the very least, cognitive-behavioral procedures, including cognitive restructuring, assertiveness training, relaxation methods, and desensitization, should be used as ancillary procedures for symptomatic relief, problem solving, stress management, and coping. I also concur with Beitman that self-monitoring procedures would add a wealth of assessment information.

I am also dismayed at the lack of parsimony apparent in our collective formulations of Mary. After rereading the case, I note that her initial explanation of her acting-out behaviors was her failure to improve her bad skin. She had always been concerned about her looks, including large hands,

frizzy hair, and general unattractiveness. Accordingly, she idolized others she saw as more attractive, and she avoided men. With this background, a crazy family environment, and the possibility of sexual abuse, it is fairly clear how she became an angry, hostile young woman with low self-esteem, depression, and a high level of self-punitiveness. Thus, it seems logical to me that, regardless of the accompanying problems and etiology of her delusions regarding her appearance, we are faced with someone who meets the *DSM-III-R* requirements for body dysmorphic disorder. Even if other issues are involved and more in-depth psychotherapeutic approaches are considered, an immediate intervention of directive techniques is indicated for the modification of her physical appearance disparagement (see Hay, 1970; Thompson, 1990).

Elisabeth A. Lederman

Let me consider convergence first. We all agree that Mary needs time to develop trust and a sense of security. For this, the psychotherapist must provide an environment where Mary feels she can bring the feelings that are represented by her perception of herself as ugly and by the head banging and other self-destructive behavior. We all recognize this will be a long-term process, at least initially involving the parents because she is living at home.

Thompson notes that Mary needs someone who really cares. I agree

with him and with Messer in his recommendation of support and empathy; but I also agree with Beitman when he says that Mary probably would attempt to run away from treatment numerous times if she became frightened that the therapist was getting too close or cared too much. Survivors of abuse find it extremely hard to accept that anyone cares about them. In some cases, to get a caring person "back to his or her senses," that is, "to respond to me as my parents do," survivors may go to great lengths to sabotage relationships. Love often means hurt to survivors, because even as it feeds into their strong desire to be loved, it rouses the feeling of being unlovable.

Messer's "introspective-empathic stance," sensitive to Mary's experience, is commendable. Most survivors of physical and sexual abuse have not had a healthy person to depend on or to reflect a sense of self. Instead, exploitation leaves them feeling nonexistent; they are expected to play roles in which they deny themselves. Mary needs a psychotherapist with whom she can begin to develop a sense of self, "a good parent," in Messer's words.

Themes of contention arise in looking at the same material from different perspectives. While I concur that Mary exhibits perfectionism (Messer), delusions (Thompson), and narcissism (Messer, Thompson, Beitman), I consider these symptoms not to be the primary issues, but

defenses against underlying feelings. These feelings are responses to a reality that has been too painful and frightening for Mary to cope with.

I agree with Messer that Mary is not a case of histrionic personality and that her rage, elicited by a nonresponsive, hostile environment, has been turned against herself. However, I do not agree with diagnosing or characterizing Mary on the whole as narcissistic. As a brief example, let me examine perfectionism and show how it can be a symptom with different shadings.

A frequently observed manifestation of grandiosity is the child seeing herself as perfect. Such perfection implies the capability to do anything she wants if she puts her mind to it, and therein lies a wishful way for her to improve her milieu. However, to the abused child, perfectionism is also a magical means of self-protection. The abused child acts as though she follows an unconscious belief system that, in words, would sound like this: "If I'm good and do not do anything wrong and anticipate my father's or mother's wishes, then I can stop them from hurting me, because I won't have done anything to get him or her angry." Here is perfectionism deriving from feelings of guilt and self-blame. Since it is too dangerous for the abused child to say daddy or mommy is wrong, since she still needs whatever her parents can give her, she regards herself as faulty, and she then fantasizes and endeavors to improve herself to meet standards of perfection. Hence,

perfectionism can be either narcissism or an archaic defense mechanism.

I see diagnoses such as depersonalization disorder or PTSD with borderline features as coming nearer to the underlying issue: What do the presenting symptoms that occur only at home—disorganization, head banging, window smashing, and suicide attempts—tell us about how Mary coped with abuse when it was actually taking place? Now, long after the first abuse, Mary has found a way of stopping her father from abusing her: she acts crazily self-destructive.

Thompson would look to family therapy to focus on Mary's need for acceptance by parents and the necessity of a separate residence. While I agree regarding the latter, Mary's need for parental acceptance seems to me to call for individual therapy, wherein Mary would be helped to recognize (1) how her parents treated her and (2) that her parents are unable to give her what she needs. If Thompson intends the conciliatory sort of family therapy wherein old abuses are covered over or "forgiven," then I disagree. Mary needs to realize the truth about her parents' behavior in order to individualize and separate. As Beitman stated, in effect, Mary's problems in individualizing and separating will continue as long as the therapist ignores the primary teaching of this family unit. Mary looks for others to reinforce her parents' teaching that she is bad and ugly, and when this is not corroborated, she goes back home. Mary's inner prerequisite for individualization is not to

be accepted, though we all need that, but to recognize the truth about her past, to place the responsibility where it lies, and to decide to move on from there.

Beitman's idea of using a triple-column diary is a technique I have never used, nor would I begin in Mary's case. Mary has episodes of panic, depression, and suicidal ideation expressed in her head banging and other self-destructive actions, such as quitting her job because it gave her positive feelings that she could not handle. She needs to focus not on her symptomatic feelings and behavior, but on what they represent.

I take this position because the determination of cause and effect here is already evident. Mary's history tells what Mary and her therapist need to know; addressing the issue of Mary's self-abuse as a continuation of her parents' teachings would be more helpful. Mary needs to be confronted not on the surface (for example, not on the precipitating details of her episodes of harming herself), but on the underlying pattern— who taught her, by what means, and how she can at last express her feelings about it.

Bernard D. Beitman

Lederman offers powerful arguments for the possibility of incestuous contacts between Mary and her father, a conclusion with which I agree.

Careful attention to the indirectly stated references to these likely events adds to the therapist's approach by encouraging the uncovering of sources of the crucial patterns governing Mary's self-destructive behavior and thinking. Lederman's questions for Mary's parents appear to be incisive and important, but in order to help Mary in her struggle to free herself from their external and internal domination, I would want to prepare the groundwork with Mary for the confrontation. Without such preparation, Mary could be confronted with the often terrible problems with which rape victims are faced when they are asked to testify against the accused in court. In order for the confrontation to be useful, Mary should help direct the inquiry. In reading her section, I sensed Lederman's fury with men and abuse. While I share some of her fury, I would want to balance the confrontation with the best interests of the patient, as I am certain she would in practice.

Mary's fragile self-concept makes me quite hesitant to consider the active approaches with bioenergetics and Gestalt techniques that Lederman advocates. Perhaps I am more cautious because I am a man and these techniques (which include having Mary lie down and fantasize) may too closely resemble the sexually abusive commands of her father.

One cannot argue with Messer's insistence upon a highly empathic approach to this patient. Mary is likely to be highly sensitive to therapeutic errors and deviations, so her negative reactions must be carefully anticipated

and noted. Unfortunately, depth of empathic sensitivity is likely to be necessary but not sufficient for change. What is to get her through the next days and hours, tormented perhaps by panic attacks and major depression? How can Messer categorically deny the value of medications for this person when several studies and much clinical evidence suggest that borderline patients are often burdened with major depression that is responsive to antidepressants?

Thompson seems to share my belief that strong engagement through the establishment of trust may lead to more active work on the part of the psychotherapist. I do not see this emphasis on engagement in Lederman's description. While keeping in tune with Mary's strong need for empathic connections, I too would work on specific cognitive and behavioral problems in her life, but I would not be quite so active.

Clearly, one cause of my disagreements has to do with differences in training relative to the other respondents. The three other writers are psychologists having had much less experience with medication than I. More than 50 percent of the patients I see for psychotherapy are on medication. I have not been trained in bioenergetics or extensively in either cognitive-behavioral approaches or psychoanalysis. I am also not a woman. No point in this discussion deserves greater emphasis than the fact that in this exercise involving three men and one woman as commentators, only the woman

clearly and forcefully made the case for the almost obvious sexual abuse of the patient. As a result, all of us, particularly male psychotherapists, should increase our sensitivity to this all too common and all too commonly neglected problem.

Notes

1 Note: This case was contributed by Joel Weinberger of the Henry Murray Research Center, Harvard University, and the Center for Applied Social Sciences, Boston University.

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