Psychotherapy Guidebook

SULLIVANISM

Leston L. Havens

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DEFINITION

Participant Observation, or Sullivanism, refers both to a general proposition that can characterize all psychotherapy and to certain technical suggestions for working in the social field; both spring largely from the work of Harry Stack Sullivan. The general proposition is that clinical psychiatric work precludes observations of the patient alone; the relation between observer and observed is so interactive that statements about the one must include statements about the other. In short, every clinical observation involves a system of at least two persons.

The specific technical suggestions that also comprise Participant Observation arise from this interactive nature of psychotherapy. Patient (and therapist) are in part responding to the ideas each develops about the other; many of these ideas are projections (parataxes or transferences); the projections may in turn cause anxiety and other symptoms. Therefore management of the projections is, first, a critical goal of the interview and, second, a means of diminishing the patient’s symptoms over the longer run.

HISTORY

Sullivan’s was a social psychiatry; that is, he located the causes of mental disturbances in social experience. As a result, it was of central importance to discover what had actually happened in the patient’s life. Sulivan believed that the principal obstacle to this discovery was not an intrapsychic process of repression but the inhibitions to frank disclosure that came from projecting on the interviewer various parataxes or transferences. Social patterns learned early in life repeat themselves in the interview; it is often as difficult to remember and tell the truth to therapists as it was to parents. Furthermore, the behavior of many therapists serves to reinforce the pathological patterns. In contrast, the purpose of Participant Observation is to counteract and extinguish the patterns.

TECHNIQUE

The method has two chief technical innovations: means for getting at what Sullivan called the patient’s “social geography” and statements “kicking at the underpinnings” of his pathological ideas.

1. By “social geography” Sullivan meant how things would have looked if the therapist had been sitting there with the patient. He believed that the study of facts should precede the study of fantasies. To this end he sometimes literally sat beside the patient, both to avoid staring at shy people and to

direct attention “out there,” to the world of social experience he believed had been pathogenic. Directing attention “out there” also had the effect of directing the patient’s attention away from the therapist, and so reducing projections on the therapist.

Sullivan would also help his patients reconstruct their historical scenes; he would not, for example, await free associative reconstructions. His implication was that many patients cannot remember alone; they need someone actually on their side to face the forbidding historical figures. He emphasized that assisting patients accurately to reconstruct scenes from their lives requires considerable knowledge and clinical imagination.

2. The purpose of “kicking at the underpinnings” of pathological ideas is to keep transference phenomena under control; they are not to be allowed so free a development as in classical analysis. Sullivan’s anecdotes suggest a number of ways of controlling transference development. The principal one to be discussed here is what I (Leston Havens) have termed counter-projective statements.

Counter-transference statements aim to reduce or eliminate projections placed on the speaker; more exactly, these statements aim to deflect the projections away from the speaker to “out there,” where their origin can be examined in the patient’s experience. Essentially they imply: “I’m not father or mother; father or mother is there.” (Note that interpretation of the patient’s misunderstanding is avoided; instead the misunderstanding is directly reduced.)

There are three characteristics of counter-projective statements. They refer directly to the past person being projected on the therapist; they talk about father or mother, for example. Second, they point, again deflecting the projections away from the therapist. Third, the feeling with which they are expressed must match the patient's feeling, if the therapist is to be with the patient and looking at the difficult figures, rather than being one of the latter himself.

APPLICATIONS

These techniques are most useful in clinical situations dominated by transference distortions (transference psychoses); for example, in dealing with paranoid patients and with the great expectations of many borderline patients. In both these instances the clinical atmosphere can be rapidly improved by strong counter-projective statements.

Therapists would be wise to have these techniques at hand in many other clinical situations, too. Distancing oneself from the projection of difficult parental introjects is frequently useful during critical juncture points in psychotherapy (and analysis). It is also well to have in mind that many transferences and transference neuroses are much more solidly imbedded than the word neuroses would suggest. Finally, these techniques can greatly facilitate the recovery of actual traumatic events and relationships.