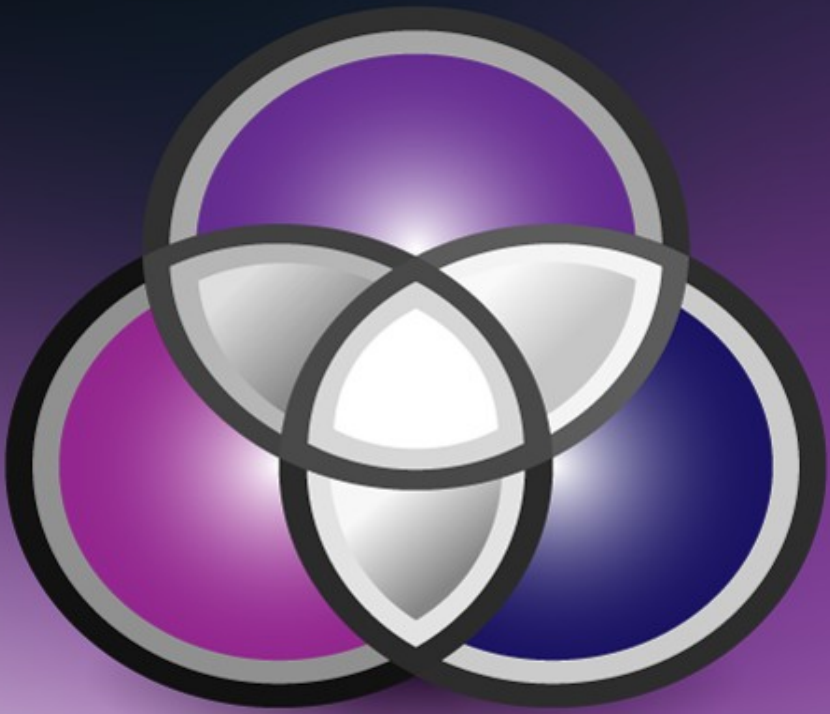
The Psychotherapeutic Relationship:

40 Years of Learning to be with Patients



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The Psychotherapeutic Relationship:

40-Years of Learning to be with Patients

Carlton Cornett , M.S.W.

Created in the United States of America

For Vince Parrish, M.A., M.S.S.W.

An erudite colleague.
A gentle and humble man.
An unfailing friend of over thirty years.

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Preface

A few years ago, I nodded off during a session with a patient. She was someone I enjoyed working with a great deal. Though she behaved as if nothing unusual had occurred, I pointed out what had happened and apologized. We discussed what might have been behind my lapse and reached no conclusion.

Later, that same week, I dozed off with another patient. Again, she was someone I appreciated, and our work was proceeding well (at least when I was awake). Around this same time, I noticed that I found it hard to catch my breath after climbing a twelve-step staircase from the lobby to my office. The Thanksgiving holiday was quickly approaching and though I was mortified by nodding off with my patients, I

convinced myself that I was simply tired and would rest during the holidays. I wouldn't have missed these symptoms with anyone else and would have urged a visit to the emergency room. This is, however, the power of our perspective on life. My grandiose tendencies reassured me that *I* couldn't be having trouble with my heart – that sort of thing is for other people. The other side of grandiosity is self-loathing. This became involved, as well. I told myself that I was just being alarmist, that an ER doctor would consider me hypochondriacal and simply encourage me to lose weight.

Thanksgiving arrived. I don't remember much about that evening except that I was uncomfortable with cramps in my chest and nausea. I vomited to the point that nothing was produced, and I continued with "the dry heaves."

My husband of thirty years pushed me to allow him to drive me to the emergency room. I was two months away from sixty and it just seemed like a waste of healthcare providers' time – during a pandemic no less – to diagnose me with a virus. I did compromise, though, and agreed to go to the ER the next day if I didn't feel any better. I'm not sure whether I slept that night, but the next morning I wasn't steady on my feet. DeWayne, my husband, reminded me of my promise from the previous night and we set off for an urgent care facility (the ER continued to seem too dramatic).

I was quickly and expertly diagnosed with cardiomyopathy (an enlargement of the heart). Equally quickly, I was referred to a cardiologist who hospitalized me. I spent several days in the hospital. Upon release, I felt deeply fatigued. My

release coincided with the early days of the Covid pandemic. My medical instructions were to avoid putting myself in situations in which I could contract the virus, decrease my work hours, and increase my cardiovascular exercise. I began to consider retirement. I've continued to work via Zoom during the last two years but find this more stressful than when I saw patients in my office. I will retire in 2023.

I've written throughout my career – nothing particularly important – but snapshots of what I believed and how I practiced. After my cardiologist pronounced me out of the woods, this current project began to take shape. I decided that I wanted to write something about the development of my career for students and young therapists. Mine has, in every respect, been a career of humble accomplishments. Yet, I've

worked with men and women of genius – some celebrated, some not. They've taught me a great deal about dynamic psychotherapy that I want to pass on to a younger generation of psychotherapists. That is a duty of each generation to the next (Havens 1989, p. 19; Meyer 2000, p. 366). In reviewing these relationships I also hope to understand myself better. Growth never stops – we are always becoming, always emerging. Finally, these pages are an homage to those who taught me, many of whom are now deceased. I'm greatly appreciative of these men and women and I hope that my love and admiration for them comes through clearly.

I believed early in my career that I would be educated in a theory (ego psychology) and would practice it happily ever after. That was, of course, much too simple. What happened instead was

that I ran into life situations that forced me to question my beliefs. I met men and women who believed differently than I and convinced me of the importance of their views. I worked with different clinical supervisors who exposed me to new ways of thinking about human development, how it may go awry, and how it might once again find its footing. Finally, I worked with different therapists in my personal therapy and learned how unique each therapeutic dyad is.

I've been committed to a psychodynamic point of view throughout my career, however, I'm deeply ambivalent toward psychoanalysis. This will be reflected throughout these pages, as well as the reasons for this ambivalence. I've found a psychodynamic view that fits me best in the work of Harry Stack Sullivan and those who followed him – interpersonalists, intersubjectivists, and

object relations theorists. All of those perspectives overlap in multiple ways. However, I'm not a psychoanalyst and also embrace the term 'psychoanalytic outsider'(see Chapter Four). I believe that empirical research can inform the practice of psychotherapy (see Chapter Three) as long as it is approached with common sense. Finally, I believe that no matter what the travails encountered by the human soul may be – including psychosis – help is available when two people sit down to talk candidly and listen deeply (see Chapter Two).

I've not discussed to the same extent as the others in these pages two men who influenced me. The reason for this is largely that I don't trust my memory about them – both having been a part of my graduate education. Norman Polansky, Ph.D. (1918-2002) was a very formal man who

came of age during the earliest years of the professionalization of social work. He referred to the clinical work that social workers pursue as "casework." He was a leading light in ego psychology at the University of Georgia and other universities. His (1982) text was a standard in social work programs. It's interesting, though, that the way he most influenced me was by relating his experiences as a patient with Hellmuth Kaiser, a psychoanalyst trained by Wilhelm Reich. Kaiser reached the zenith of the classical psychoanalytic hierarchy as a training analyst at the Menninger Clinic in Topeka, Kansas. He believed that patients are lonely, and his goal was to make emotional contact with them despite their fear of vulnerability and defenses against it (p. 243). Among classical analysts his lack of interest in 'insight' was not

psychoanalytic but existential and he was alienated from the psychoanalytic mainstream. In a comparison of his time with Kaiser and earlier psychoanalyses he had undergone, Polansky (1982) wrote:

> The most helpful thing I found about treatment with him was I had, this time, full permission to speak freely all I really thought, including my ideas critical of the treatment and the theory behind it (p. 243).

Kaiser influenced both Marianne Horney Eckardt and Leon Lurie, as well (see Chapter Six). Louis Fierman (2006) and Hans Welling (2000) also seem to capture Kaiser's way of working with patients.

A second person who I've not written about is Jerold Bozarth Ph.D. (1932-2018). Jerry was chair of the department of counseling at the

University of Georgia and could not have been more different from Polansky as an academic leader. No one called Polansky 'Norman," but Jerry was confident enough to be casual in his interactions with students. He was an intimate friend and colleague of Carl R. Rogers, Ph.D. I took a master's level class with him, and he invited me to attend his doctoral seminar on person-centered therapy. That was quite an educational experience as every week a leader of that paradigm facilitated the class. What I learned from Jerry that was most valuable concerned the expression of empathy by the therapist. Since Rogers was still alive, there was a reticence to move beyond reflection – his preferred mode of expressing empathy. Jerry (1984) wrote that he "… viewed [empathy] as a way of being for the therapist rather than a particular technique. As

such, therapists' responses may be idiosyncratic to the therapist, to the client, and to their experiencing of each other" (p. 59). He concluded by writing, "Idiosyncratic empathy emphasizes: 1) the transparency of the therapist in relationship to the other person; 2) the person-to-person encounter in the relationship; and 3) the intuition of the therapist" (p. 69). I'm grateful to both these men.

I've elected to write little about my personal therapy and therapists (see Chapter One). This isn't to protect my privacy, but theirs. I hope that I've captured the quality of each experience in a very general way. I am and will remain grateful to these two men for the changes each facilitated in my life.

Finally, a note about terms. I've noticed that traditional books on psychotherapy privilege the

male pronoun. I've decided to use the female pronoun whenever such a pronoun is needed. This may offend some readers who are non-binary in their sexuality. I apologize if this does give offense, however, I found that "they" and "them" make sentences overly confusing.

As always, I thank my husband, DeWayne, for his numerous and incisive editorial suggestions. And, with love, I thank him for his patience with me when I bring my past into the present.

Carlton Cornett
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Chapter One

"Our field of study … examines the travails encountered by the human soul."

In Memory of William S. Meyer, M.S.W.
(1950-2021)

For forty years I've worked with people in emotional distress. With some of these people, I've felt the work was successful — the patient reported more satisfaction in her life, she seemed more confident, described less anxiety and depression. However, I'm also aware that not all my work has achieved this end. As I review my own experiences and listen to colleagues discuss theirs, it seems common for a psychotherapist to perceive her work as sometimes successful, sometimes not, and, in many cases, ambiguous in

outcome. It's been hard to acknowledge the times I haven't been successful and harder still to be honest with myself about how I contributed to those relationships which could have achieved more. Despite its difficulty, examining the outcomes of my work and attempting to grow from this examination to avoid similar mistakes is an integral part of the career (Bruch 1974, p. vii).

Relationships have been the most important source of my learning – relationships with teachers, supervisors, and my own therapists, but also those with patients. I believe that I've learned the essence of being a psychotherapist from patients who generously helped me to understand their lives and how to help them. I've also learned about myself in relationships. For fourteen years I taught third- and fourth-year

psychiatry residents in the Vanderbilt University School of Medicine about the lives and ideas of Harry Stack Sullivan, M.D. and Otto Allen Will, Jr., M.D., both of whom I will describe in more detail below. I also taught in the advanced psychodynamic psychotherapy program of the Nashville Psychoanalytic Study Group intermittently over several years. I've served as a social work field instructor for a variety of universities. From these experiences I've learned that younger colleagues find it helpful when I begin with the assumptions that I bring to my work.

Prior to describing my beliefs – my theory – of psychotherapy, I wish to make it clear that I'm not a formal theorist. I've stumbled onto what I believe to be ideas that are generally applicable to people and to the profession of psychotherapy.

Theories, however, including mine, are highly subjective.

Theories of Psychotherapy

In 2018, there were an estimated 1,245 types of psychotherapy (Allen 2018, p. 332). In one sense that number seems impossibly large; yet it probably *underestimates* the actual number of approaches to therapy. Virtually every psychotherapist has a unique way of performing her craft, based on her experiences, needs, and wants – no matter how she may identify her approach. This has been highlighted by astute clinicians and in the literature of psychotherapy research for decades (e.g., Binder 2004, p. 1; Bruch 1974, p. xi; Havens 1989, pp. 58-59; Henry & Strupp 1992, p. 437; Hirsch 2015, p. 8; Maroda 2022, pp. 5-7).

Every person influenced by a mentor learns from that man or women the basics of a psychotherapeutic theory. However, this basic theory must resonate with the novice's own life experience. If it doesn't, it will be unwittingly altered to do so. Even a resonant theory will change over time. Based on experience, the growing therapist will elaborate and contract the original theory to fit with ever-changing circumstances. Such changes are often not recognized and are considered part of the original theory. This evolving theory guides the therapist's work but is often referred to as what the mentor and the mentor's tradition imparted.

The Influence of Original Families

I don't know how every therapist learns to be with patients, but I suspect it begins long before she is even aware of it. One prevalent theory is

that psychotherapists are created at an early age in their families. In a classic paper, Harold Searles (1967/2017) proposed that those who become psychotherapists do so out of a fervent desire to 'cure' their parents of their difficulties in living. The child lives, "… in order to make mother (or father) whole …" This desire is both altruistic and developed out of "…self-interest, so that he [the future therapist] would have a whole parent with whom to identify, for the sake of his own maturation" (p. 35).

In a similar vein, Karen Maroda (2022) suggests that a "… sensitive empathic child …" is often pressed into service as a therapist for one or both parents (p. 6). "Once identified as empathic and sensitive, then enrolled as the family's therapist, she essentially feels enormous responsibility with little or no power over events

or the behaviors of others" (p. 13). Young adults from families in which they were cast in such a helping role seem to be drawn to psychotherapy as a profession hoping to succeed at helping patients when they couldn't do so with parents.

I believe that a therapist's original theories of psychological functioning develop from interactions between her and her family. Such theories, like archaic values, are notoriously difficult to dislodge. They can, however, be modified and some of the irrational content diminished. Personal psychotherapy is helpful in this task.

In my experience, psychotherapist training has three components: the didactic process of imparting a theory of human development, dysfunction, and remediation. An integral part of this process is also imparting a distinctive

vocabulary to be used with colleagues. The second component of the training to which I'm referring is experiential guidance – supervision. The developing therapist has the opportunity to work with patients under the guidance of a senior clinician. Finally, another form of experiential learning is available to the young therapist through her own psychotherapy (in which I include psychoanalysis).

Of the three forms of training developed for novice therapists, the one with the most potential for harm is personal psychotherapy. Following that is the didactic imposition of theoretical concepts and language to represent what is known about human nature, health, and dysfunction. Leon Lurie (2008) wrote, "Almost any professional paper will reveal this tendency to talk about ideas as if they were facts of life."

Under such circumstances, "… theory becomes a straitjacket" (p. 174). Unfortunately, the world is uncertain and ambiguous, and we all must live with that – therapists and patients. Generally speaking, I believe that this sort of didactic 'training' presents obstacles in the long term and that successful psychotherapists must transcend this training and, at least partially, forget it (Binder 2004, pp. 1-2; Lurie 2008, pp. 173-174; Rubin 2014, pp. 118-119).

Now I'll describe some of the beliefs that guide my practice. As I emphasized above, they are subjective, were formed in relationships with others throughout my life and are subject to modification with the acquisition of new experience.

Experience

Life is a continuous series of experiences with other people, beginning at birth and continuing until death. Human beings act based on what they've learned through these experiences. Early family experiences shape experiences with others, though change is possible throughout life.

Initially, behavior is motivated by the desire to achieve physiological satisfaction and avoid frustration (e.g., eating when hungry, drinking when thirsty, sleeping when tired). As the person develops, the emotional states of security, creative expression, and anxiety increasingly dominate her motivations. She seeks security which is largely the absence of anxiety — threats

to self-esteem and/or the actual diminution of self-esteem (Sullivan 1954, pp. 94-97).

As physical capabilities develop and the human being discovers satisfying expressions of creativity, such expressions also become important motivators. Problems in living (what is also referred to as "psychopathology") are experiences that create blocks to interpersonal success, security, and the expression of personal creativity (Will 1970, pp. 5-7).

Selective Inattention & the Unconscious

I've grown to think of the unconscious as comprised of experiences that were so confusing and overwhelmingly anxiety-provoking to one that they are dissociated (i.e. maintained out of awareness by *selective inattention*). Selective inattention is the automatic defensive process

whereby experiences that *might* create anxiety are not allowed into awareness. The common response to selective inattention is confusion or 'misunderstanding' (Sullivan 1954, p. 207).

"Facts"

We can gather "facts" about another person, though we must approach this carefully. "Facts," at least about people, are always influenced by the environment in which the subject exists at a given moment. As a teacher, I've enjoyed 'rocking the boat,' sowing ambiguity where there seemed too much certitude. This has sometimes raised eyebrows among colleagues and students. Human beings seem to crave certainty and have little tolerance for ambiguity. The ideas I propose in these pages, for instance, have arisen from my experience and are not to be confused with "facts." Ralph Waldo Emerson (1844/1993)

wrote, “As I am, so I see; use what language we will, we can never say anything but what we are …” (p. 98). “Facts” must be sifted and resifted and, even then, treated skeptically.

Uncertainty

For the reasons mentioned above, writing about psychotherapy requires a certain humility. Discussions of psychotherapy require the capacity to tolerate ambiguity, tentativeness, and a lack of finality. There is no last word on what psychotherapy is or means. *There is nothing about life that is certain*. It seems reasonable to think that writing about psychotherapy ought to reflect this state of affairs, but it seldom does.

Language

We generally take language for granted. That is unwise for a psychotherapist. Language

influences both what we can know and communicate about ourselves and other people. Language, itself, can only capture what a given culture allows it to (see Orwell's [1949] novel *1984*). Erich Fromm (1980) pointed out that the word "crazy" is applied when one ventures past accepted, conventional thought and language (p. 6). Words bring obscurity to communication. The more abstract the word or phrase the more space exits for misunderstanding. The more direct and concrete the discussion, the less space is available for misunderstanding, obfuscation, and confusion. As much as we would like there to be, there is no real standardization or uniformity of communication between human beings – nor can there ever be. Every form of symbolic communication – of which the spoken word is our chief means – is an approximate

communication of experience. Words can never fully capture experience. They cannot be taken cavalierly at face value. The more abstract the words and phrases that are introduced into the conversation, the more approximate the description of experience becomes. Abstract words, forming abstract concepts, are a breeding ground for misunderstanding, if not a deliberate means of keeping the experience under discussion obscure. In short, abstract language often hides more than it communicates (Will 1954, p. xiii).

The Limits of our Profession

I believe that it is impossible to fully know a human being. Sullivan (1953a) noted that one human being can never know everything about another – nor about her or himself either (p. xi; see also Will 1989, p. 137). Perceptions of

ourselves and those around us are grounded in complex schemas of previous experiences with people; these schemas may make sense of things for the observer but may have little applicability to the observed. Sullivan's student, Otto Will (1987) also proposed that, in addition to historical experiences, human perception is influenced by current needs and expectations of the future (p. 256; see also Will 1989, p. 132).

Psychotherapy is rife with conjecture. Even the direct observations that we make of others and ourselves are distorted. In practice, the psychotherapist is influenced as much by what she believes that she is supposed to see, what she wants to see, and what is acceptable for her to see as by any other factor. It is, I think, the rare practitioner that can completely transcend her training and perceive what others refuse to.

Psychotherapy, at least as we think of it now, is a young profession, just over a century old. One simple truth is that we don't know enough about the vast complexity of the human mind to be able to assert much about it with confidence. Basic concepts – what comprises psychological 'health' and the nature of psychological and emotional dysfunction — remain unformulated (Gay 2001, p. 81). We can't clearly define such mental building blocks as 'thought' and 'emotion' (Siegel 2012, p. 1-3). Until these and other basic concepts can be formulated and communicated widely there will be no definitive perspective on psychotherapy. In the interim, we will cling to our individual beliefs and work accordingly.

Love

Psychotherapy is founded on a caring, loving relationship (Will 2021). I'm aware that in western culture the word *love* is entwined with romance and the erotic. However, the American psychiatrist, Harry Stack Sullivan, offered another perspective on love. He (1953a) wrote: "When the satisfaction or the security of another person becomes as significant to one as is one's own satisfaction or security, then the state of love exists. So far as I know, under no other circumstances is a state of love present, regardless of the popular usage of the word" (pp. 42-43). Put simply, love imparts responsibility to care for another's emotional security. I have a difficult time imagining a form of psychotherapy not based on such a caring relationship.

The Two Basic Forms of Knowing

In 1923, the theologian, philosopher, and psychologist, Martin Buber, proposed that there are two basic forms of "knowing." Both forms are assumed to be embedded in a relationship, though this may seem odd given the nature of the first form which Buber termed the "I-It" (1923/1970). According to Buber, this is a stance in which the observer treats the observed as an object. This relation relies on the externally observable.

The second way of knowing he termed, "I-Thou." One of his translators, Walter Kaufmann (1970), suggested that a translation of the German term Buber used, *Ich und Du*, as I-You might be more in keeping with Buber's intent than the formal 'Thou' (pp. 14-15). In this form of knowing our perspective is subjective,

determined by the nature of the relationship at any given moment. Though this is a generalization, it is knowing at least some of whom a person is beneath her social presentation.

Our relations with another person flip continuously between the I-It and the I-You. One is not *a priori* "better" than the other. Indeed, the psychotherapist learns to use both in her work. We want to know some objectively verifiable information about patients. However, it is also important that we have some understanding of what motivates a patient's actions so that those motivations may be discussed within the therapeutic relationship. The I-It and I-You stances are best used to support each other. How do we combine these positions? The I-It position requires close observation. These observations can be organized into hypotheses about the

patient. For instance, the patient smiles while talking about sad topics. The I-You position requires consideration of the environment in which the patient and therapist find themselves. It also requires awareness of how the therapist might think and feel in such a situation. It often aids me in trying to maintain the I-You stance to think of how I might relate to the patient if she wasn't a patient, but someone to whom I was introduced at a social event.

Transference

The concept of transference has a long and storied history in psychotherapy. That history includes conflicts regarding how it is defined, how it develops, and how to use transference phenomena to further treatment. I believe that transference is ubiquitous, not limited to psychotherapy. As Per Høglend (2014) writes,

"We all bring something to a new encounter (we transfer) …" (p. 1057). Høglend defines transference as, "… the patient's patterns of feelings, thoughts, perceptions, and behavior that emerge within the therapeutic relationship and reflect aspects of the patient's personality functioning …" (p. 1057).

There are many ways of working with transference. Rather than interpret it, I prefer to be curious about allusions to my similarity with other figures. This often opens up a conversation that allows the patient to decide if she is engaged in transference. I also prefer counterprojective interventions with or without discussion (See Chapter Two).

My Family

As I've suggested above, the therapist's family and developmental experiences may have a lot to do with the approach she takes to therapy. Although it's considered unseemly by some of my colleagues to reveal much about one's background and is sometimes labeled "narcissistic" and "exhibitionistic," I would feel less than intellectually honest not to describe some of my original family experiences. William Meyer (2019) characterized my writing style as grounded in, "… candor, vulnerability, and intimacy …" (p. 7). A clinical social worker and psychoanalyst, I admired Bill because his generosity and integrity seemed unlimited. He was the kind of therapist who now seems only to reside in the farthest reaches of my memory – a man who truly cared about the human soul and

all its travails, willing to engage in loving battle to save it. What I describe below of my family and early life I share with the hope that it exemplifies his description of my writing.

R.D. Laing (1969) wrote, "I still know less about [my family] than I know about many other families" (p. 1). I'm hampered in this way as well but will describe what I do know. I was born to a white, middle-class couple at the beginning of the 1960s, a turbulent time in American history. My parents were born during the depression. They retained scars from their early lives, most evident in their unyielding belief that there was a scarcity of resources in the world. It wasn't just that natural resources were being depleted at a rate that defied replenishment, but that emotions like love were commodities in short supply. One was always in danger of missing out.

I have fond memories of my father from childhood. He enjoyed the outdoors and often took my younger brother (by eighteen months) and I hunting and fishing. He was in his thirties and early forties then. I have a fondness for the autumn that is, no doubt, at least partially the result of the three of us roaming the autumn woods in search of game. My father was a historian by training. He was smart and could be funny, though it was almost always at someone else's expense. I've been so enraged with him as an adult that I haven't often credited him with any redeeming qualities, but he was a better father with youngsters than he was with his adolescent and adult offspring.

I recall my mother as harried throughout my childhood. She had four children, three boys and a girl, ranging from ages four to fifteen. She was

often impatient and highly critical of the imperfections of which all her children had many. Certainly, I understand now that she was depressed. I learned to be a good listener under her tutelage.

The essayist, Emily Ogden (2022), has written that, "… behind the placid surface of the suburbs is perversion and abuse …" (p. 59). There is great truth in that accusation. My mother had the remarkable ability to know exactly how to shame another person and could be merciless with my father. He seemed to believe that violence solved most interpersonal problems and wasn't hesitant to beat my mother. He also raped her on at least one occasion — when I was eight and in the next room feeling helpless to do anything but cry.

I couldn't have described it so simply as a child, but I was constantly anxious. I cried before going to school and often while at school. Many of my teachers were compassionate, though this cost me with peers. Additionally, I had no effective social skills. I was bossy, possessive, and a 'know-it-all.' If other children had friends, I was confused as to why I wasn't enough.

My older brother, ten years my senior, was a bully whose moods were unpredictable. He was merciless in his criticism, especially of my weight. He was prone to physical violence and often attacked me and others with little provocation. I was a child of about six when he decided to put me in a wooden storage box and sit on the lid. My terror was acute and even now I'm claustrophobic. My older brother was one source of sexual abuse in the family.

During elementary school, my grades were excellent. However, as the years progressed, my grades fell. Throughout my school years I retained an interest in history and literature. Mathematics courses were anathema to me. I didn't put much effort into geometry, algebra, chemistry, and my grades reflected it. I still have great difficulty with simple algebraic problems.

As I grew, my family also changed for the worse. Conflicts between my parents intensified and both stayed away from the house as much as possible, my father for days at a time. My mother relied on me increasingly to listen as she described the hardships of her marriage. She accepted no feedback from me, however, which was usually encouragement to leave my father. She often responded that she wouldn't be able to earn a living. My mother was a bright, college-

educated woman who could've succeeded in many areas. Fairly or not, I finally decided that she didn't want to work and perhaps felt that she'd earned an income for life by tolerating my father.

During my adolescence, my father deteriorated dramatically. His incipient alcoholism grew to alarming proportions. When he was home – increasingly rarely – he was drunk. In this state, his interactions with each of us were more sexualized and aggressive. Twice he threatened to kill me – once when I refused to wrestle with him and once after I made a smart remark to something he said. His narcissistic personality reached psychotic proportions during this time. He maintained that there was very little or nothing that anyone could do better than he could. He began chewing tobacco and spitting it

into cups and glasses around the house. My mother stopped cleaning the house. The chaos and disarray of the house reflected the family psychological functioning.

As I review what I've written here I'm aware that I've painted a portrait of myself as a victim. Nothing, though, is as simple as that. I added to the dysfunction in the family. My father, I think, wanted to be idealized, admired. As an adolescent, however, I felt nothing but contempt for him and communicated it in subtle, passive-aggressive ways. I shunned conversation with him and avoided, as much as possible, being in the same room with him. After I ended a phone call, he often asked, "Was that so-and-so on the phone?" "No," I would answer trying to protect what little privacy I could as I left the room.

Actions such as these injured him, and I meant them to. I was a full participant in the family warfare. I grew increasingly aware of my mother's self-absorption and when it was on display, I treated her disrespectfully. When I was disrespectful, she either became enraged or emotionally collapsed into a pool of jelly which I would try to restore to some kind of equilibrium.

One deep-seated belief in my family was that love existed in a finite amount. To put it simply, love was like a pie. If one got a large piece, another's piece of the pie would be proportionally smaller. This set up an environment of competition. I found it virtually impossible to be excited about any of my siblings receiving affirmation – rather, I sought to undermine that affirmation. I remember one such moment with crystal clarity. My younger brother and I were in

the finals of the school spelling-bee. He received a difficult word and misspelled it; however, his voice was so soft that the judge was unsure whether or not he had spelled it correctly. The judge asked the other finalists what they heard. When it came my turn to respond I could've demurred or been unsure but, instead, I confirmed his error. I remember such moments with deep shame. This, of course, wasn't limited to me and my siblings – my parents engaged in this undermining, as well.

Competition of this sort has often been linked to the so-called oedipal conflict. However, Owen Renik, an innovative analyst, questions that. Rather than viewing these dynamics as a universal aspect of development, Renik (2006) suggests they are the result of families which view love "… as a zero-sum game" (p. 153). My

experience convinces me that Renik's view is valuable.

Higher Education

I attended a small liberal arts college in Montgomery, Alabama which encouraged students to diversify their studies across the curriculum. I earned a baccalaureate degree in three years, with three majors – psychology, history, and religion and philosophy – and a four-point GPA. I blossomed in that setting, with professors who cared about me, appreciated my intelligence, and celebrated my achievements.

In the spring of my senior year I had the opportunity to meet for an afternoon with Erich Fromm's widow, Annis Fromm. She had moved to Montgomery after his death to be with her sister. A professor, familiar with my interest in

psychoanalysis, arranged the meeting. She greeted the professor and I at 1:00 with a drink in one hand and a cigarette in the other. As the afternoon progressed, her pain and grief became even more evident. The walls of the small house were covered in photographs of both him and them as a couple. I had recently read *The Art of Loving* (Fromm 1956/2006) to which she often referred. According to Fromm's biographer (Friedman 2013), this was a period of terrible pain for her (p. 336). I often think of Annis Fromm when working with a patient in grief or one who fears relationships because of their inevitable loss. She died in 1983, a year after I graduated.

I began social work graduate school that fall at the University of Alabama. It was a complex time. In addition to undertaking challenging

academic and professional work, I met a young man and a romance developed. He struggled with the research class required for graduation and I believe that institutional homophobia played a role in his finally being expelled from the program. We transferred after the first year to the University of Georgia. Once again, I thrived. I was allowed to take classes in other departments and was exposed to some of the leading thinkers in ego psychology, existentialism, and person-centered therapy.

I graduated from the University of Georgia in the summer of 1984. My relationship ended within a few years of that graduation.

All of these experiences – familial, relational, educational, professional, emotional – helped to form my identity and to shape my perspective on psychotherapy. Additionally, there were men and

women who continued to shape my point of view about assisting patients. In the following pages I will describe who they were and what they did. There will be two, however, absent from this discussion other than the brief descriptions below. These are my personal therapists.

Learning from Therapy

Volney Gay, Ph.D. is a brilliant analyst in Nashville, Tennessee. I began to see him for weekly psychotherapy in the spring of 1990. He was then an associate professor in the departments of anthropology, psychiatry, and religious studies at Vanderbilt University. He was soon a full professor in those departments and a training analyst with the St. Louis Psychoanalytic Institute. He was warm, witty, and we shared a dry sense of humor. He was, and is, an intense man — another quality we shared.

I remember only a very few things he ever said to me. I find that such is the case with many patients. At presentations I will often ask what was the most important quality of audience members' treatment experiences and generally, they respond that it was the accepting emotional environment. For myself, overwhelmingly, it was the emotional atmosphere and not the words spoken. I remember my time with Volney as rich, intimate, and warm. I'm not speaking for him because I don't inhabit his skin, but I felt loved – perhaps for the first time. I was in therapy with him when I met my current partner and husband. Indeed, my partner, DeWayne, was so different from my original family that I almost stopped seeing him because I felt disoriented. Volney suggested that this difference might portend a much healthier relationship than I had with my

family. DeWayne and I have been together now well over thirty years. To return to Volney, I'm still surprised that I'll notice mannerisms of his that appear in my interactions – particularly with patients. Such is the power of identification. I saw Volney thrice for roughly two-year periods of time. In a general sense, he helped me develop the capacity to love.

After I completed my third period of therapy, Volney and I became involved in various projects that put us in regular contact. When I decided that therapy would once again be helpful, I contacted David Wright, M.S.W., a clinician who worked individually with children but also saw adults. He had completed post-graduate training at the psychodynamically oriented Institute for Clinical Social Work in Chicago. I knew David only from interactions at professional meetings and so,

began again at the beginning. David's office was full of toys and in some moments, I would regress and play with some of them. David had a playful manner and loved to tell stories. Often, such stories were about his own life. David taught me how to play. Though I often didn't know it at the time, the stories he told were the delivery mechanisms for complex thoughts about living. Again, I felt valued by David. He would tell me the hard truths: "People have to crawl fifty yards under barbed wire and live machine gun fire to get close to you," he said on one occasion. He was also, however, my greatest encourager. There was no competition when I accomplished something – whether I thought it amounted to an accomplishment or not. I haven't a doubt that David was correct in his barbed wire

analogy; I'm awfully glad that he and I reached each other.

I should add that both Volney and David helped me survive major depressive episodes – periods of unrelenting anxiety, weeping, suicidal thoughts, and interpersonal withdrawal. Both had the confidence in themselves and me to prevent my hospitalization. They made themselves available to me generously and I eventually weathered both storms. I've not had another episode in well over a decade, though dysthymic depression is a constant companion in my life. It is a paradox that, as a young man, I perceived myself as 'tough,' physically and emotionally. In my 60s I'm much more fragile and I count that a gain. As Emerson (1844/2009) observed, "Our strength grows out of our weakness" (p. 144).

Chapter Two

"A Mentor Across Time"

Harry Stack Sullivan, M.D. (1892-1949)

Harry Stack Sullivan died twelve years before my birth so I couldn't have met him. Yet, it's his ideas that have served as a foundation for my practice as a psychotherapist for many years. Stephan Heckers, M.D., M.Sc., chair of the department of psychiatry and behavioral sciences at the Vanderbilt University School of Medicine, wrote of my relationship with Sullivan that he was, "a mentor across time," to me. It is an insightful remark.

It would feel incomplete to me to present something without at least an introduction to

Sullivan and I hope to do that here. This is by no means comprehensive and some of what was highly nuanced about Sullivan's work may not be given the emphasis that it warrants. However, I hope that what I write below will stimulate some curiosity to find out more about this complex man and his ideas.

Family & Early Education

Harry Stack Sullivan was born in 1892 to parents of Irish descent in upstate New York. The family was poor and lived with Harry's maternal grandmother on her farm. Two of Harry's brothers died in infancy. The young Harry showed little aptitude or interest in farm life. Aside from the animals, he had few friends. The family was further isolated because they were Catholic in a predominantly Protestant area (Thompson 1962).

Harry's father seems to have found his son difficult to understand, and, therefore, to relate to. From the available evidence, Harry's mother seems to have had profound problems in living and was unable to care for him on her own. Late in his life Sullivan would remember her as inattentive to who he was and more interested in a son she created in her imagination (Sullivan 1942, p. 813).

Harry was a bright student, popular with teachers but scorned and bullied by fellow students. He understood loneliness from his own experience, and this affected the way he thought about what he called "problems in living." The young Sullivan made one friend in high school; an older boy named Clarence Bellinger. Bellinger, who would also become a psychiatrist, bullied Harry. Some evidence suggests that

Bellinger seduced Harry, but this is unclear. Clarence Bellinger lived with his mother for most of his life and often denounced Sullivan to colleagues as "a homosexual and a son-of-a-bitch" (Perry 1982, pp. 313).

In high school Harry's intellectual acuity resulted in the award of a scholarship to Cornell University. He left the farm for Cornell to begin his studies. However, the education that he received at the rural school had not prepared him for the competitive curriculum he found at the Ivy League college. Additionally, he apparently became involved with an older group of students who encouraged and abetted his involvement in one or more illegal activities. His scholastic underachievement and this involvement in illegal activities resulted in a suspension after his first semester. Though he could have returned after

serving his suspension, he left Cornell at the end of that first semester (Evans 1996, p. 30).

Medical Studies

Not much is really known about Sullivan between his departure from Cornell in late 1909 and his enrollment at the Chicago College of Medicine and Surgery in 1911. The curriculum at this institution was average for the time. Sullivan may have received a few lectures on psychiatry while there, but the school had no department of psychiatry. He completed his coursework in 1915 but was not awarded his diploma until 1917 – probably because he owed the school money (Evans 1996, p. 31).

The years between 1917 and 1921, before Sullivan took a position at St. Elizabeths Hospital in Washington, DC are also blurry in terms of

Sullivan's activities. Some evidence exists that suggests Sullivan attempted to practice general medicine in factories and for insurance companies but was satisfied with nothing he could find (Evans 1996, p.31).

William Alanson White & Psychoanalysis

During the last decade of the nineteenth century and the first two decades of the twentieth century, Sigmund Freud (1856-1939) is credited with the creation of the first theory of human development (the psychosexual theory) and the first method for treating neuroses (psychoanalysis). His accomplishment has affected all Western institutions. And yet, while still a giant, Freud has not had the last word. Creative women and men have come forward to challenge, modify, and replace his theories with their own. This group includes Freud's own

students: Alfred Adler, Carl Jung, Otto Rank, and Sandor Ferenczi.

Freud's ideas made their way from Europe to America. In the United States, the alienist or psychiatrist generally worked in an asylum or other form of institution. Patients in such institutions manifested symptoms far different from those labeled 'hysterics' that psychoanalysis was created to help. American patients included the neurotic, psychotic, and those considered to have character or personality disorders. The latter two groups Freud specifically rejected for psychoanalysis and had difficulty considering psychotics as fully human (Roudinesco 2016, p. 261). Out of necessity, American psychiatrists modified psychoanalytic principles for the treatment of a wider range of people.

Freud's observations of human nature led him to be pessimistic in his conclusions about what help could be rendered to people in severe distress. Many Americans, however, were optimistic that psychoanalytic thinking could be applied to their patients if psychoanalytic theorizing was not considered complete and sacrosanct. One such American psychiatrist was William Alanson White (1870-1937). White was superintendent of St. Elizabeths Hospital between 1903 and his death. Originally named The Government Hospital for the Insane, it was the only federal psychiatric hospital in the United States.

William Alanson White was an innovator. He forbade the use of restraints in dealing with agitated patients, encouraging instead communication and practical problem-solving

between staff and patients (Moore 1976, p. 15). In 1922, St. Elizabeths was the first psychiatric hospital to treat neurosyphilis with malarial fever therapy. White also introduced psychoanalytic treatment to St. Elizabeths by hiring Edward Kempf to the hospital in 1914. His title was Clinical Psychiatrist, and his duty was to provide psychodynamic psychotherapy to St. Elizabeths patients (D'Amore 1976, p.71). White was a staunch opponent of the death penalty and appeared for the defense (conducted by Clarence Darrow) in the Leopold and Loeb case. Like many progressives of the era, White (1933) believed that prison reform was imperative (pp. 77-79).

White considered himself a psychoanalyst, though he had little formal training in psychoanalytic theory. He underwent a brief

analysis with Otto Rank between July 7 and July 19, 1924, for one hour each day (D'Amore 1976, p. 80; Lieberman 1998, p. 254). However, in the United States his credentials were considered adequate to be elected to the presidency of the American Psychoanalytic Association for two non-sequential terms. He and a close colleague, Smith Ely Jelliffe, founded the *Psychoanalytic Review* together in 1913 (Eckburg 1976, p. 148). Though White respected the potential of psychoanalysis, he did not embrace it as unambiguously as many (Perry 1982, p. 232).

Sullivan was thirty years old when he received a position at St. Elizabeths in November 1921. This was not a permanent position and expired in twelve months (Evans 1996, pp. 32-34). His training as a psychiatrist was dubious, having graduated from a medical school which

closed a few years after he graduated (Chapman 1976, pp. 28-30). However, Sullivan was curious and attended the many learning opportunities available at St. Elizabeths and those through the Washington-Baltimore psychoanalytic group. Sullivan embodied Ralph Waldo Emerson's (1844/2009) belief that, "We are by nature observers, and thereby learners. That is our permanent state" (p. 106). Sullivan learned from the best of teachers – the patients with whom he came into contact.

Reading correspondence between Sullivan and White it is clear that the former idealized the latter. Yet, it is also clear that White was ambivalent concerning Sullivan who was only granted a place inside White's inner circle toward the end of White's life. Sullivan absorbed the

humane ideals of White and these would guide his work throughout his life.

Psychobiology & Adolf Meyer

In December 1922, Sullivan's position expired at St. Elizabeths, and he was offered a position as Assistant Psychiatrist at the Sheppard and Enoch Pratt Hospital in Towson, Maryland, just outside Baltimore. The Superintendent at Sheppard-Pratt, Ross McClure Chapman, had trained under White at St. Elizabeths, as well. Chapman was warmly encouraging of Sullivan (Evans 1996, p. 34). It was here that Sullivan studied schizophrenia and developed a perspective that involved the importance of interpersonal and environmental influences on human functioning.

While at Sheppard-Pratt, Sullivan had extensive contact with Adolf Meyer. Meyer was a Swiss émigré born in 1866 who relocated to the United States in 1892 (Perry 1982, p. 234-235). In Switzerland, Meyer had studied with Auguste-Henri Forel at the famed Burghölzli Hospital. In 1893, Meyer accepted a position as a neuropsychiatrist at the Illinois State Hospital in Kankakee. In 1910, Meyer was named Chief Psychiatrist of the Henry Phipps Psychiatric Clinic at Johns Hopkins University (Lamb 2014).

During his tenure at Kankakee, Meyer approached his work as a pathologist might – observing and classifying, looking for patterns. One recent biographer has described Meyer as a "pathologist of the mind" (Lamb 2014). He would later reject such methods as incongruent with getting to know a patient (Perry 1982, p.

238). As he developed a therapeutic technique, he combined close observation with the elicitation of information and reflection to the patient of what he was learning. He was gentle in this regard and careful of the patient's sense of security. In contrast to the psychoanalytic focus of that era, Meyer was interested in the strengths of a patient. As a teacher, Meyer could be demanding but never forced his students to declare their allegiance to psychobiology. He was deeply suspicious of psychoanalysis and believed that childhood trauma was not the cause of all human suffering. Like White, Meyer believed in pragmatism and was critical of arcane Freudian theories (Chapman 1976, p. 40). It's probably from Meyer that Sullivan developed the concept of the interpersonal event as the primary focus of psychiatry (Perry 1982, p. 239). As Ralph Waldo

Emerson (1844/1993) noted even earlier, "The secret of the world is, the tie between person and event. Person makes event, and event person" (p. 170).

It is noteworthy, though, that Meyer and Sullivan were not close colleagues. Meyer thought Sullivan irresponsible and brash. Though Meyer tolerated other points of view, he found Sullivan overly aggressive in his argumentation – a fault many observed in Sullivan. Additionally, Sullivan encouraged Clara Thompson – whom Meyer considered an important protégé – to study psychoanalysis with Sandor Ferenczi. This Meyer never forgave (Perry 1982, pp. 240-241).

Like White, Sullivan served as an officer – vice-president – of the American Psychoanalytic Association but did so with deep ambivalence. By accepting this role, he passively identified

himself as a psychoanalyst, but he preferred the term "psychiatrist." While he administered the Washington School of Psychiatry (see below), he preferred the terms "applied psychiatry" and "intensive personality study" to psychoanalysis. This was the case even though he had been in analysis with Clara Thompson for approximately three hundred hours. Toward the end of his life, Sullivan, like his close colleague Frieda Fromm-Reichmann (1950), referred to his work as "intensive psychotherapy."

Sullivan was uncomfortable with psychoanalytic theory as it was generally embraced. He thought that too many unprovable concepts were reified and treated as facts. Though having something of the Irish poet to him, Sullivan was also a hard-headed empiricist (Thompson 1962 p. xxxiv). He was particularly

suspicious of concepts like Id and Ego. The standard edition of Freud's work was translated by James Strachey who translated *das ich* and *das es* as "ego" and "id" respectively. Students of psychoanalysis have argued that these translations into Latin rob the concepts of *das ich*, more accurately rendered in English as "the I," and *das es*, "the it," of a personal character (Kelen 1990, pp. 5-6). The ego was cast as a structural component (though without distinct location) in the personality. One inherently assumes an experience-distant position when contemplating it. However, if translated as "the I" it becomes not structural, but experiential. It is, then, the essence of all that I as a human being have experienced and am experiencing. One's inherent view becomes experience-near (see the discussion of Martin Buber's work in Chapter

Two). “The it” is not a seething cauldron of instincts in conflict, but instead, that which I do not accept or do not have knowledge of. Sullivan (1953b) made this point of view much clearer with his alternate propositions of “me” and “not me” (pp.161-164). Additionally, Sullivan questioned the universality of the Oedipal Conflict and its efficacy as a concept.

Sullivan objected to Freud’s rigid contention that people were closed systems. Instead, he viewed people as more process than structure; they were open systems, inseparable from an interpersonal context. The brain existed within each individual human being, but the mind is communal (Cornett. 2017, p. 1888). This belief led to one of his most controversial contentions – that human beings may have as many

personalities as they have interpersonal relationships (Sullivan 1950 p. 329).

Sullivan objected to the psychoanalytic preoccupation with the intrapsychic at the expense of real-world phenomena, especially interpersonal relationships. He (1954) believed that inference plays an important part in psychotherapy as the therapist progressively understands the communications of the patient, but that "objective" inference is impossible (p. 97). He found complex psychoanalytic interpretations that range well beyond direct observations unhelpful.

Sullivan strongly objected to the dismissal of a large section of the population needing mental health care as inappropriate for psychoanalysis. Such psychoanalytic rejects included: schizophrenics, those with melancholia

(depression), mania, and those with severe narcissistic disturbances. Further, Freud encouraged rejecting those who were too old, those of limited intelligence, and those who were not psychologically minded. Many such people were rejected as unanalyzable on the subjective assessment by only one person – the analyst. Throughout his writings, Sullivan maintained that all human beings are more alike than different (1953a:16; 1953b:32). This he called the *One-Genus Theorem*.

Participant-Observation & Beyond

One of the important contributions made by Sullivan in conceptualizing the psychotherapeutic process was his idea of participant-observation. Borrowing a concept from physics, the Heisenberg Uncertainty Principle, Sullivan applied it to the therapeutic relationship. The

older psychoanalytic perspective was bound by what we now refer to as a one-person psychology. A one-person psychology assumed that the analyst or therapist could be an objective observer of the patient. Further it also assumed that the analyst's observation had no influence on the patient. Sullivan challenged this idea and proposed, as Heisenberg had in physics, that the very act of observation influences that which is observed. This is especially true with sentient creatures like human beings.

With this application of the Heisenberg Principle, Sullivan conceptualized psychotherapy as embedded in a two-person psychology. A two-person psychology maintains that psychotherapy is not one participant doing to or for another, but a venture between two people, both having strengths, human flaws, and imperfections.

Together they create a mutual and reciprocal relationship in which candid conversation is the goal.

Unfortunately, Sullivan also believed that a psychotherapist could *control* his participation through self-awareness. If full self-awareness were possible, such a distinction could be made. However, self-awareness and awareness of others is always limited.

Sullivan's interest in the nature of the mutual influence of the therapeutic relationship remains almost without challenge today. Within the interpersonal paradigm the emphasis has become participation over observation – "participating observer," "observing participant." The therapist's participation has a real influence on the relationship – perhaps as much as the patient's (Hirsch 2015, pp. 36-37).

Sullivan the Clinician

Sullivan called his clinical work by several names. With some, it was psychoanalysis; with others it was participant-observation. He also referred to his work with patients as intensive psychotherapy and intensive personality study. Sometimes he simply called it the practice of psychiatry. Whatever term he used, the work was characterized by pragmatism, direct communication, and deep respect for the patient's self-esteem. He didn't attempt interpretation, believing instead that if he could help the patient talk about "the data" — the experiences of her life — she would discern interpersonal patterns that kept her unsatisfied and would elect to change these patterns. A young practitioner who studied with Sullivan remembered him as being subtle in this regard: "Look, it's not your task to

present the patient with [fully] formed ideas as to what's going on in them. If you're fortunate you can sort of drop an apple on their head and they'll have the bright idea" (Frederickson, 2001, p. 39). Sullivan (1954) believed that every human being has a *tendency toward health*. The person is always growing, attempting to make use of her creative and adaptive capacities. He (1953a) also held that, "*One achieves mental health to the extent that one becomes aware of one's interpersonal relations* …" (p. 207, italics in the original).

In a paper focused on psychotherapy, Sullivan (1949) described seven activities that characterized his clinical work. The first involved directly offering information that might help the patient correct perceptual distortions. He cautioned, however, that we must differentiate

genuine information from beliefs founded upon our own problems in living (p. 4). Second, the therapist may attempt to correct what she believes to be misinformation. Leston Havens (1979) described this aspect of therapy as "kicking at the underpinnings of ideas" (p. 26). This form of intervention is very similar to what the modern cognitive behavioral therapist might do. Third among Sullivan's list of therapist activities is aiding the patient in identifying and "… rectifying impractical evaluational systems" (p. 4). The focus of this work is decreasing the level of disapproval and rejection of herself that the patient employs (p. 4). William Meyer (1998) described this in the language of ego psychology as "… such a vital and significant portion of clinical work … that an intensive psychotherapy cannot be successful unless the superego of the

patient undergoes a demonstrable change" (p. 353).

Fourth, Sullivan suggested that the therapist model setting appropriate boundaries, particularly concerning "social distance" (p. 5). Fifth, he advocated correcting transference or, what he termed "parataxic" phenomena. I will describe this process in more detail below. Sixth, Sullivan emphasized integrating suppressed or dissociated experiences, "… so that the awareness of the patient as to the situation in which he is living becomes a better approximation to correct information" (p. 5). Finally, Sullivan focused on the importance of direct, clear, and basic communication, modeled for the patient, and clarified when too many abstractions characterize the discussion (pp. 5-6).

One of Sullivan's other technical approaches that I've found useful with patients is what Leston Havens (1979) described as counterprojective interventions (pp. 28-31). A counterprojective intervention is a form of corrective emotional experience (see Chapter Four) that disrupts the patient's expectations for an historical outcome to an interpersonal interaction in the present. A simple example would be a patient who points out to her therapist that a comment he made hurt her. She expects to be ignored – the historical outcome during such interactions with her parents. Instead, the therapist acknowledges the patient's pain and apologizes. Any interaction that disrupts a patient's certainty of an historical outcome may be considered counterprojective.

A Visionary

Harry Stack Sullivan remains a controversial figure. That he disrupted the status quo was enough to alienate him from colleagues. He, however, also had personality characteristics for which others rejected him. He could be abrasive and sarcastic, as well as dismissive of others. He was a functional alcoholic, which added to his irascibility. He didn't trust other people quickly or easily.

Despite his interpersonal inadequacies, Harry Stack Sullivan's ideas were miles ahead of his time. He sowed the seeds of the "relational turn" that began in the 1980s as I completed my graduate education (Hirsch 2015, p. 10). Perhaps because of his difficulties in living, he has not gotten proper credit for his immense

accomplishments. The politics of our field are highly partisan and formidable. Yet it seems that this complicated man, and his visionary ideas are finally coming into their own.

Chapter Three

"Sitting With Patients"

In Memory of Lewis Lipsius, M.D. (1938-2022)

In 1985, I was twenty-four years old and had been out of graduate school less than two years. I held a romantic – and naïve – notion of what it would be like to work with seriously psychiatrically impaired patients. I thought that being a psychotherapist to those considered mad by society, would facilitate my becoming "… a great spiritual journeyman, a pilgrim brave enough to plunge into the wildest oceans of the soul," as one biographer described Samuel Taylor Coleridge (Wilson 2004, p. xv). Offered a position at a residential treatment facility for

adolescents, I accepted it. There I learned that my grandiose vision of what it meant to be a psychotherapist was illusory. Yet, I also learned a way of being with people that aided them in overcoming and/or managing their problems in living. This experience has aided me in organizing my thoughts about psychotherapy for nearly forty years.

The patients at this facility ranged in age from twelve to seventeen. I was assigned ten patients between thirteen and sixteen years old, all with diagnoses of schizophrenia or schizoaffective disorder. They were like all of us, some large, some small, some thin and others obese, some had pleasant demeanors, others were hostile and aggressive. They shared a characteristic, though. All were teenagers struggling to achieve those developmental tasks that characterize

adolescence. Despite the challenges of their emotional, cognitive, and interpersonal impairments, they wanted to grow. They expressed a desire to be like other adolescents – to date, dance, go to the movies. However, real people terrified them. They were thus burdened with a crushing contradiction – craving love and human contact internally while fleeing it in the external world.

The facility was composed of two units – a locked unit for those patients whose symptoms required constant observation and frequent intervention and an open unit where less observation and intervention were needed. Locked unit patients had three psychotherapy sessions weekly and open unit patients had two.

Kyle

When I met my first patient, Kyle, on the closed unit, he was sixteen. I was initially impressed with his bright, cheerful smile. It was almost radiant. However, when we began to talk, I noticed that his dark eyes seemed like two deep pools without emotion. Aside from his smile, he communicated almost no emotion. There was an incongruity that alarmed me. What, if anything, did that smile hide? Out of my awareness I decided that his smile hid rage and he was not so much smiling as displaying his teeth, a primitive but savage line of defense. I began to think of him ripping me apart with his teeth and then devouring me. Despite my growing anxiety in our first weeks together Kyle did nothing overt that would account for my anxiety or fantasy.

My assigned supervisor, a clinical social worker, was a few years older than me, though under thirty. An attractive woman, she seemed to have little interest in psychotherapy. I attempted to discuss my anxiety with her, hoping to understand it better, especially as it might, at least partially, be information about Kyle. She was dismissive of my fantasy, reassuring me that I was perfectly safe – "no reason to be anxious." Such reassurance left me feeling inadequate and, in a word, "crazy." Over time she confirmed that she found exploration of all but overt behavior pointless. She rejected what she called, "that analytic stuff," including multifaceted, symbolic communication. The milieu of the facility was founded upon positive and negative reinforcement and my supervisor's only real interest seemed to be teaching me how to teach

my patients to achieve the former and avoid the latter.

Like all therapists, I had a conception of psychotherapy. I considered it to be a process in which a patient explored her role(s) in her family of origin. Of particular interest were those lessons learned in the family environment which did not serve her well in the larger world. I believed psychotherapy to be an experience of intense emotions as patient and therapist explore the past in the present through replication of original family interactions and learn about each other. These emotions and interactions also form complex forms of communication to be clarified so that they are intelligible and communicable. This conception still approximates my view of my work.

After several weeks of consulting my assigned supervisor without an improvement in our success together I considered supplementing this supervision. Perhaps unfairly, I considered her not "psychologically minded enough."

The facility's associate medical director, Lewis Lipsius, M.D. was a short, sturdy, bald, middle-aged man who received his medical education at Emory University. I regret now not learning more about his background, but I watched him work with patients during clinical team reviews and was deeply impressed with his patience, gentleness, modesty, and respect. Erik Erikson (1940/1987) believed that any therapist working with a child or adolescent must enter that "… child's world as a polite guest …" (p. 141). It was the sort of deep humanism that

compelled my admiration for Erikson – and for Lewis who embodied such an approach.

After one of these clinical meetings, I asked to speak with Lewis. I told him of my interest in clinical supervision with him. He asked quietly, "And what would you hope to learn from our supervision?"

I was fortified by his use of the word *"our*." There was so much that I wanted to learn, but I could not organize the words. The unvarnished truth was that I felt so anxious when with my patients that I simply wanted to provide some form of help to them without disintegrating into my own anxiety. But I couldn't bear to hear myself say that, so I reached for jargon and responded, "I want to learn how to restructure the ego." My reply was empty. It gave no sense of action (e.g., "I want to learn what is important to

listen for," "I want to communicate understanding," "I want to say things in a way that my patient can most easily hear them"). My response was untethered to common words that would assure at least an approximate shared understanding.

My anxiety was escalating rapidly. At that moment, I expected to be obliterated by it. I noticed that Lewis was looking at me closely, clearly trying to understand. His round face seemed both sensitive and compassionate. I'm sure that it was only a few seconds (that seemed like hours) and he responded quietly, "I don't really know anything about 'restructuring the ego,' but I can help you learn to sit with distressed people."

It was not so much the words which, said without Lewis's presence, could have been a

dismissal – a sarcastic one at that. It was his compassionate presence, his clear desire to understand, and his gentle tone that made it a helpful response. In those few moments with Lewis, I experienced his expertise and knew immediately that I wanted to emulate it with my own patients.

Presence

Over the months I worked with Lewis, I learned how much was covered by the phrase "sitting with patients." At its most fundamental level, "sitting with patients" meant being physically present with the patient — keeping appointments, being on time, sharing physical space with the patient. I often think of Woody Allen's quip that, "ninety percent of life is just showing up." Our physical presence means something to the patient. When we arrive on time

for appointments, avoid distractions, etc., that is a silent communication of her importance and, hopefully, strengthens her self-esteem. When we're late or forget appointments or take calls, texts, so forth we also communicate something to the patient about her value to us. Physical presence, of course, doesn't guarantee emotional or psychological presence but is the initial step toward both. Like many young therapists — then and now — I seriously underestimated my presence and overestimated technique (Havens 1989, p. 88).

Erik Erikson (1981/1998) pointed out that relationships are the fundamental building blocks of self: "The beginnings of the sense of I itself, one should think, can only emerge in a newborn out of the counterplay with a sensed You in the maternal caretaker …" (p. 287, italics in the

original). The interplay of self and other in relationship is replicated infinitely throughout life and each replication offers the potential for growth. Though the name Otto Will, is relatively unknown, he was an important analyst trained by Harry Stack Sullivan (See Chapter Two). Will served as medical director of the Austen Riggs Center for a decade. He (1981), wrote, "If therapist and patient meet together over a long enough period of time at regular and frequent intervals, relational bonds – the foundation of understanding, growth, and betterment – will form" (p. 208).

I learned with Lewis and my patients that the only thing worse than anxiety is loneliness, or what I conceive of as suffering alone with anxiety. As a therapist I've learned that the diminution of anxiety requires the presence of

another person. Eric Plakun (2021), the present medical director of the Austen-Riggs Center, has written that, "… words are often of less value in psychotherapeutic work than being with our patients physically and emotionally, listening so that we may see things as they see them, coming to know them in that way" (p. 18).

In a series of interviews with Kim Chernin, one of his supervisees (See Chapter Five), Otto Will described hearing about an interaction between a friend of his who was in therapy with Harry Stack Sullivan. He recalled that this friend was "… having a hard time and wasn't getting anywhere." According to Will, during the last moment of a particularly desolate session, Sullivan said, "…I sure wish I could give you a helping hand, but right now I don't know how, so I guess we'll have to sort of totter on together."

Will described his friend as buoyed by this comment. *He was not alone*. Such comments eventually create an internal representation of the therapist who is present during painful moments even if the real therapist is not.

The Relationship as Foundation

After the importance of just showing up, the next lesson I learned from Lewis was that developing a relationship with the patient is the foundation of psychotherapeutic work. The time spent with a patient must mean – or come to mean – something to both involved. It must resonate with each emotionally. Sometimes, working with a psychotic patient can seem dull or boring, especially if her emotional expression is inhibited. The sense of boredom often means that therapist and patient are retreating from anxiety they feel with each other. The British analyst,

Donald Winnicott, used boredom as a diagnostic tool. Adam Phillips (1988) relates that when Winnicott talked with helping professionals not trained as psychotherapists (e.g., clergy, teachers, nurses, etc.), he told them, "If a person comes and talks to you … and listening to him, you feel he is boring you, then he is sick and needs psychiatric assessment. But if he sustains your interest, no matter how grave his distress or conflict, then you can help him all right" (p. 25).

Lewis and I discussed building relationships. I remember being surprised at how much of what we discussed seemed at once mundane and brand new. Over the years, I've formed a hypothesis that this simultaneous contradictory response reflects the lip service paid to the importance of relationships in our culture with the more pervasive, though covert, message that

relationships cannot be allowed "to get in the way" of financial success, personal development, or, more generally, "what one wants."

Therapeutic relationships, he maintained, were constructed by responding to the patient with respect, compassion, honesty, and tact. Further, he challenged the notion that intention is the key determinant in assessing whether what we say or do is actually respectful or tactful. Certainly we intend our words and actions to capture those qualities but can't always rely on what the patient says to confirm whether they actually did. We live in a culture in which only a small portion of what occurs is visible and overt, the much larger part being hidden and covert. He suggested that self-observation and observation of the patient were more effective forms of assessing the impact that my words and actions

had on patients (see Levenson 2017, pp. 9-10 for a critical differentiation of intention and action). *Our bodies don't lie*. Lewis encouraged me to be aware of how I said things, what posture my body took, did I use my hands, etc., and to note when my vocalizations were incongruent with my physical actions. The same process of observation is helpful with a patient. Erik Erikson, believed, "… it is a human relationship in which the observer who has learned to observe himself teaches the other to become self-observant …" (Schlein 2016, p. 145).

I've described a variety of ways that Lewis guided me, but I want to be clear that he often said that there was no *right* way to sit with a patient — only multiple possibilities. His approach to supervision was very affirming of my ideas and creativity.

Anxiety

I remember discussing my anxiety with Lewis, particularly my fantasy of Kyle tearing me apart and eating me. Unlike my assigned supervisor, he was intrigued by what this might mean about Kyle – and me. I wanted him to offer me a magical interpretation that would dissolve both the fantasy and the anxiety beneath it. However, he urged patience, suggesting that I, "sit with my anxiety." Lewis emphasized that an important emotional aspect of time spent with patients was managing my anxiety. Again, the therapist teaches by doing. However, as the therapist becomes more aware of what arouses her anxiety, she may use that awareness to form a comment to the patient, modeling expression of anxiety rather than resolving it through action.

In my work with Kyle such an interaction took place a few weeks after Lewis and I discussed it. Internally interrogating my fantasy, I discovered something about why I was stymied. It occurred to me that I was searching for an interpretation that would *explain* why Kyle smiled so often and so incongruently. I was hunting for a phrase such as, "Kyle, you're so angry with your parents that you'd like to destroy them but hide that anger behind your smile." I shared something like this interpretation with Lewis. He wondered aloud if it was my responsibility to explain Kyle's life to him and suggested instead a simple comment that his smile often seemed not to match what he was discussing and that made me anxious. This approach to psychoanalysis and psychotherapy has also been a focus of Owen Renik's (2006)

work, a progressive analyst, who wrote, "The only thing an analyst really has to offer, and the only thing a patient can really use, is the analyst's account of his or her experience – especially the analyst's account of his or her experience of the events of treatment" (p. 50).

During our next session, I noticed my anxiety rising and noted Kyle's smile as he described a conflict with his mother. At an appropriate juncture in the conversation, I said something like, "Kyle, you're telling me about what seems an unpleasant conflict with your mother but you're smiling; I feel uncomfortable that you smile no matter what you're talking about." Over succeeding sessions I learned that Kyle perceived his parents to disapprove of any display of emotion other than a vacuous smile. My anxiety then became understandable to me. My father

treated my emotional life in much the same way. Most likely, my fantasy of tearing people to pieces represented my anger projected onto Kyle.

Listening for Surprise

One particularly helpful suggestion that Lewis offered about listening was to listen not for what I expected to hear, which might be a theoretical or personal preconception/bias, but to listen for what surprised me (see Rubin 2014, pp. 116-117). Such moments of surprise, he suggested, were moments of genuine contact between Kyle and I, devoid of roles and defensive maneuvers (see Chapter Six). Similarly, he suggested that there might be moments in which Kyle said something that surprised himself. Again, he suggested that such occurrences merited a comment like, "What you

said seemed to surprise you," "Was what you just said a new thought," and so forth.

Concluding Thoughts

I have discussed my time with Lewis so often during the last forty years that it seems just like a bit of clinical lore, devoid of the excitement and hope it activated in me. But it was a crucial time in my development as a person and a psychotherapist. Ralph Waldo Emerson wrote in *Spiritual Laws* (1844/2009) "[a] man may teach by doing, and not otherwise. If he can communicate himself, he can teach, but not by words. He teaches who gives, and he learns who receives." Lewis 'sat' with me and out of his understanding, respect, and caring opened up a part of me that I hope — and sense — has made me more present and emotionally available in all the relationships of my life. I can't perform

healing miracles, but I believe that my commitment to being there has been powerfully sustaining and reassuring to my patients. I've altered Lewis' phrase from 'sitting with patients' to 'being with patients' but those early, basic lessons still form the foundation of my work – gifts from an expert psychotherapist.

Chapter Four

"A Clinical Art"

In Memory of Hans Strupp, Ph.D., ABPP
(1921-2006)
& For Jeffrey Binder, Ph.D., ABPP

When I met Hans H. Strupp in January 1990, I was twenty-nine years old and still at the beginning of my career. He was sixty-nine and nearing the end of an extraordinarily productive and successful career as a psychotherapist and psychotherapy researcher. His success was the result of several aspects of his personality that I was able to witness – his drive, his passion for the field of psychotherapy, and his thoughtful, sensitive, and modest approach to others. In a field rent by conflict, Hans was an effective and

respectful mediator between factions (Anderson 2007, p. 287).

The Vanderbilt University Psychotherapy Research Center

I was introduced to Hans by Jeffrey L. Binder, his co-author on *Psychotherapy in a New Key* (1984). Jeff employed me in December 1989 on an adult interpersonally oriented hospital unit he created at a progressive institution which gave primary responsibility for patient care to psychologists and clinical social workers. Jeff encouraged me to take part in studies at the Vanderbilt University Psychotherapy Research Center, where Strupp was director. Jeff was aware that such a perk would be motivating to me – and it was.

The research team was composed of doctoral students, post-doctoral fellows and practicing

clinicians and researchers. Aside from myself, all were psychologists. The group met on Monday mornings. Other social work colleagues told me, ominously, that "Strupp is no friend of social work." Attempts to gather further information about this warning were met with evasion. I never knew what made him seem "unfriendly" and I experienced him as kind, thoughtful, and respectful.

Hans wrote two autobiographical studies (1984, 1990/2014) and I refer the reader to those papers for more on his background. Of most interest to me were two facets of his life. The first was how closely he came to danger in Nazi Germany. Though born well before the Nazis rise to power, as an adolescent he narrowly escaped disaster. When he was seventeen, the Nazis launched *Kristallnacht*, literally 'night of crystal,'

or more commonly known as 'the night of broken glass.' For two days – November 9-10, 1938 – the Nazis launched their first coordinated wave of terror against the Jews. Hans was picked up by the Gestapo, but later released. Others were not so fortunate and were transported to concentration camps, particularly Dachau. In 1939, just months before the beginning of the Second World War, he, his mother who was in fragile health, and brother emigrated to the United States. Hans had a total of ten dollars in his pocket when he arrived at Ellis Island (Anderson 2007, p. 290).

Hans worked days to support his family and attended college in the evenings, first in New York attending the City College of New York. He completed his baccalaureate, masters, and doctoral degrees at George Washington

University in Washington on the same schedule. I was in awe of the kind of courage and what I think of as emotional sturdiness (the ability to prioritize, compromise, negotiate, persevere, and stand firm when required) that such accomplishments demonstrated.

My father and older brother (ten years my senior) weren't idealizable men and seemed to hold me in contempt. My maternal grandfather died when I was two years old. My paternal grandfather was a person who I loved and respected – who, in turn, respected me — but I seldom saw him. I believe that every boy requires a man to idealize, to emulate, and with whom he may identify. Such a figure helps form the foundation of the boy's self-esteem and masculine aspects of the self. Since I had no such reliable figure, I'm prone to idealize men – even

in my sixties. The idealization is stronger if, as Harry Stack Sullivan (1954) wrote, "… you are treated as worth the trouble …" (p. 29). In 1990 I idealized both Hans and Jeff. That idealization no doubt influenced my estimation of their research work, though thirty years later it continues to inform my clinical work.

The second aspect of Hans' development that captured my imagination was his fascination with psychoanalysis which led him to matriculate at the Washington School of Psychiatry, founded by Harry Stack Sullivan and colleagues (Henry & Strupp 1992, pp. 436-437; See Chapter Two). Though he had no classes with Sullivan, Sullivan's writing and his public speeches were inspiring to him. While at the Washington School, he studied with Frieda Fromm-Reichmann, Clara Thompson, and Otto Allen

Will, Jr. He graduated in 1952 at the age of thirty-one (Strupp 1990/2014).

When I joined the research group in 1990, they were in the final year of a study called Vanderbilt II, focused on the efficacy of manualized training in the provision of psychotherapy. The manual used was Strupp and Binder's (1984) *Psychotherapy in a New Key*.

A previous study, Vanderbilt I, focused on the relative impact of specific factors (i.e., technique) and non-specific (also called common or interpersonal) factors on therapeutic outcome. This study demonstrated the importance of the therapist's basic interpersonal skills in achieving a positive therapeutic outcome. If therapist and patient *liked* each other, the outcome was more likely to be positive. Further, one study demonstrated this dramatically. College students

with neurotic difficulties – as demonstrated by scores on the Minnesota Multiphasic Personality Inventory (MMPI) — were assigned randomly to one of three groups. One group talked with college faculty members known for their warmth, interest in students, and listening skills. The second group talked with experienced professional psychotherapists. The third group was the control group and received no 'treatment.' The number of 'sessions' for each group was the same and predetermined.

The first statistically significant result was not surprising – participants who talked with either a faculty member or a therapist demonstrated improved functioning. Participants in the control group did not. The second result was surprising. There was no statistically significant difference between outcomes for the group with faculty

members and that with the professional therapists. One conclusion that can be drawn from this research is that therapeutic technique is inseparable from basic interpersonal skills and that adherence to established authoritative recommendations (e.g., remaining a 'blank screen,' or 'therapeutic neutrality') may interfere in achieving positive outcomes (Henry & Strupp 1992, pp.436-442).

Hans held what was a controversial view of successful psychotherapy for that time. He believed that what the patient received from helpful psychotherapy was a *corrective emotional experience*. The phrase, coined by Franz Alexander, the first graduate of the Berlin Psychoanalytic Institute, suggested that:

> The patient, in order to be helped, must undergo a corrective emotional

> experience suitable to repair the traumatic influence of previous experiences. *It is of secondary importance whether this corrective experience takes place during treatment in the transference relationship, or parallel with the treatment in the daily life of the patient* (Alexander & French 1946, p. 66, italics added).

Thus, the corrective emotional experience was hypothesized to be the reenactment within the therapeutic relationship of childhood conflicts with parents. However, rather than the therapist restricting herself to neutrality and interpretation, she could be much more creative, something as simple as answering a question posed by the patient. It's striking how seldom parents apologize so that an aspect of a corrective emotional experience can also be the therapist apologizing for an error. A similar gesture for

patients who were overly dominated as children (i.e. parents making decisions that should, in fact, have been the child's) is to give them time and encouragement to make their own decisions.

Of course, Alexander and French also hypothesized that one need not be in psychotherapy to experience a corrective emotional experience. It's the height of grandiosity, but I've sometimes forgotten that growth occurs outside the consulting room. The designation of 'psychotherapist' doesn't preclude people of good will from having, sometimes momentous, impact on the lives of others in distress.

Some therapists took the idea of the corrective emotional experience to the level of a caricature, assuming personas that were foreign to their basic natures, playing non-authentic roles

to behave differently than what they hypothesized parents had done. In the end it was play-acting, and patients discovered that. This form of interaction with patients, as well as the move away from relying strictly on interpretation, brought the concept into disrepute.

Evaluating all the data that emerged from the Vanderbilt I study, Strupp (1995) described competent therapists, ("… that is, individuals who are able to provide the patient with a 'corrective emotional experience'") as capable of patience, respect, empathy, sensitivity, and so on (p. 71). In this way, Strupp and Binder's model demonstrated its foundation in Sullivan's (1954) work, particularly in the latter's contention that a psychotherapist must be an "expert in interpersonal relations" (p. 11). Research supported the idea that the real healing potential

of the corrective emotional experience lay in deep awareness of the unfolding therapeutic relationship.

The Vanderbilt II study, the data of which were being analyzed when I joined the group, questioned how much interpersonal awareness could be 'taught' using a standardized manual. There was little support for the idea that training by manual translated into clinical effectiveness. Further, I believe that both Vanderbilt studies dealt a fatal blow to the notion that therapists are interchangeable, simply following instructions. Recognizing that empirical research can inform clinical practice – but must not dominate it beyond common sense — Hans (1992) described psychotherapy as having much in common with medical practice and described it as "a clinical art" (p. 307).

Henry and Strupp (1993) summarized the findings of both studies, "In short, the composite picture of the 'good' therapist drawn by our respondents was more 'human' in contrast to the stereotype of the impersonal, detached analyst" (pp. 437-438). Often, patients experience such qualities emotionally as *indifference* rather than 'neutrality.' Further, Strupp (1995) wrote that therapist skills, "… rather than being specific techniques, are much more accurately described as the ability to manage complex human relationships …" (p. 71).

Strupp's research argued for the ability to integrate various forms of psychotherapy that had, for decades denounced each other (Demos & Prout 1993; Stricker & Gold 1996). While this remains a controversial contention, the research that Hans Strupp began – and Jeff Binder (2004;

Binder & Betan 2013) has continued – provided a blueprint for thinking about psychotherapy as an organic experience shaped by both participants. 'Technique' grows out of this relationship and offers the therapist more freedom to respond without undue concern about the 'rules.' The research of both men challenges the idea that psychotherapy may be learned from a book. My experience of exploring the data amassed in the Vanderbilt II study suggested to me that 'expertise' as a psychotherapist is using one's life experience in creative ways to inform empathy and emotional connection to patients. Paradoxically, even then supposed weaknesses become potential therapeutic strengths.

"Nobody is …"

Hans often shared anecdotes from his career and quotes from those who influenced him. I

never perceived it as 'bragging' but as wisdom he could offer from his long involvement in the field. During one team meeting he quoted Harry Stack Sullivan as having said, "Nobody is schizophrenic when he's talking with me." I was electrified. Later discovering that Sullivan's quote is largely dismissed as an expression of his arrogance or naiveté and was laughed at by his contemporaries (Havens 1993, p. 141), I was mildly disappointed but my excitement about such a humanistic outlook never left me. It is still a sentence that sends a shiver of excitement along my spine. Sullivan asserted that human beings aren't divisible. There is no 'Us' and 'Them.' Each of us has the potential to see *beyond* – beyond skin color, gender, sexual orientation, behavior that defies social and cultural rules – to the person who is like us. As Neville Symington

(2006) puts it in an almost celebratory tone, "So this person sitting opposite me in my consulting-room is what I am" (p. 79). There is no one who is so simple as to be describable by only one quality. As a clinical social worker, I've been exposed to a variety of formulaic values – often just sanctimonious platitudes – but Sullivan captures a truth that the clichés and bromides can only hint at – we are all deserving of respect.

With the inspiration that Hans offered me I began to research the life and work of Harry Stack Sullivan intensively. The first fruit of that research was published in 2008 – with a dedication to Hans. I was proud that Peter Rudnytsky (2008), Editor of *American Imago*, described it as "… a comprehensive reinterpretation of the life and work of Harry Stack Sullivan …" (p. 162).

A Corrective Emotional Experience

Finally, I'd like to describe a corrective emotional experience that occurred during my relationship with Hans. Like many gay men of my generation, I hid my sexuality – from myself and others – until I became independent of my family in my early twenties. I came out gradually – first with trusted friends, then with my family, finally, by the time I met Hans and Jeff it was no longer a secret from anyone. My younger brother was the first to whom I came out and he was supportive. My mother accepted my revelation with a quiet, "Honey, I already knew that." I approached my father with the knowledge that he had secretly engaged in homosexual activity but spoke of gay men as "fairies," "faggots," and "homos." I came out to him last. His reaction was predictable, "I don't mind homos if they leave me

alone." His narcissistic reaction was, of course, about him – there was no room left for me in his equation. As I write this, there is a small part of me that is bewildered that he couldn't respond any more genuinely since he had been engaged in homosexual activity covertly for many years. In early adolescence I found a cache of his homosexual pornography. My mother claimed to have walked in on him in *flagrante delicto* with another man on one occasion and I have no reason to doubt my mother's report of this. Despite awareness of this information, however, I expected the reaction I received. My father held on to his many deceptions – of himself and others – and one of my assumptions about the world (though I wasn't fully aware of it) was that all men did the same.

I was aware that earlier in his career, Hans had described homosexuality as a neurosis, capable of being "cured" by psychotherapy. In 1993, I was invited by Jason Aronson, the owner of a large publishing house specializing in books on psychoanalysis and psychotherapy, to put together an edited volume of gay psychotherapists writing about their work with gay men (Cornett 1993). This was a rewarding opportunity to work with some of the pioneers of gay affirming psychotherapy, including Richard Isay, M.D. (1934-2012) and Charles Silverstein, Ph.D.

Dick Isay was a psychiatrist and psychoanalyst who fought within the American Psychoanalytic Association to change the way analysts approached homosexuality. He faced a vociferous, sometimes hysterical, group of

analysts led by Irving Bieber (1912-1992) and Charles Socarides (1922-2005), whose son was gay. This group was determined to maintain the idea that homosexuality is a 'perversion' (Myers 1991). Ultimately, Dick allied with a larger group of progressive analysts and the American Civil Liberties Union (ACLU) pragmatically defeated the Bieber/Socarides group with the threat of legal action and the restriction on gay and lesbian people being trained as analysts was lifted (See Chapter Five; Grady, p. B8). In addition to his advocacy, Dick (1989) wrote one of the first studies of gay men which assumed that their sexuality wasn't, in itself, pathological.

Charles Silverstein, who I never got to know as well as did Dick Isay, was a legend in the gay and lesbian mental health community. In 1973 he presented what Ronald Bayer (1981) described as

a "… mixture of academic discipline and passion …" paper to the nomenclature committee of the American Psychiatric Association (APA) that aided in the effort to have homosexuality removed from the APA's Diagnostic and Statistical Manual (p. 119). Later that year, he founded the Institute for Human Identity in New York and, in 1976, *The Journal of Homosexuality*. Though not getting to know him well, I enjoyed his sense of humor and found his memories of the 1973 APA struggle captivating.

When the manuscript for Aronson was completed, I offered it to Hans to read and comment upon. His response surprised me – and yet didn't. He wrote, "It seems eons ago that psychoanalytic psychotherapy sought to change patients from being homosexual to heterosexual … Since that time, psychodynamic thinking has

expanded and become liberated from the shackles of orthodoxy" (1993). He also shared this with the publisher, and it became an advance review for the book. I speculate that this was a way of publicly asserting that he was no longer shackled by orthodoxy. If, indeed, this was an act of liberation for Hans, it had the effect of simultaneously liberating me from an assumption that I brought to all my relationships with men. It added complexity to my relationships. Now, rather than assuming all men operated as my father did, I became obliged to understand each man with whom I was in a relationship more fully, discover his values and incongruencies – to be surprised at times.

In the sixteen years before his death at eighty-five, I enjoyed every opportunity I had to interact with Hans. One can accuse me of 'idealization,'

or ‘hero-worship,’ or something dismissive along those lines and, as I’ve indicated, there is evidence to support that, but such dismissals don’t negate the very real gifts that he gave me.

At Hans’ funeral in 2006 I was a little saddened that the speakers focused almost exclusively on his many professional accomplishments. Perhaps that was how he wished to be remembered. Yet, the qualities he possessed as a man – his kindness, thoughtfulness, sensitivity, curiosity – were the foundation of his professional accomplishments. A modest, unassuming man, he was a professional giant. Yet, alongside this professional stature, he was of equal stature as a human being.

Chapter Five

"Psychoanalytic Outsiders"

In Memory of Kim Chernin, Ph.D. (1940-2020)

I was thirty-four when I first met Kim Chernin in the pages of her book *A Different Kind of Listening* (1995). I later learned that she was a prolific writer, authoring twenty-two books of fiction, non-fiction, and poetry over her long career. She was a psychotherapist with interests in eating disorders and psychoanalysis. I would discover her many interests over time but, initially, I was absorbed with this book. Part memoir and part critical contemplation of psychoanalysis, the book also struck me as a

definitive statement of psychoanalytic therapy as she viewed it in mid-life.

Prior to continuing, it may be helpful for the reader to know something of my relationship with psychoanalysis. From the outset of my career, I'd wanted to become an analyst. In the earliest days, there were only a few training institutes that accepted clinical social workers. When that barrier was removed, there were even fewer institutes that accepted gay candidates. Ten years passed before all the obstacles – aside from the financial – were cleared. By then, I no longer wanted the designation 'psychoanalyst' enough to make the sacrifices necessary to achieve it.

A "Psychoanalytic Outsider"

The first aspect of *Listening* that I found compelling was Kim's description of herself,

simply and directly, as a "psychoanalytic outsider" (p. 149). For many years, she studied psychoanalysis outside its formal structures – the institutes founded by each 'school' of psychoanalysis to ensure that only the *correct* interpretation of its literature and lore are promulgated. As an outsider, she was critical of some of the most basic psychoanalytic tenets. With *Listening*, Kim emancipated herself from the pressure to conform to that which she found unhelpful with her patients.

As I read, I became increasingly aware that Kim's declaration of herself as a psychoanalytic outsider could be applied to me, as well. This awareness was bittersweet. I talked with Hans Strupp and discovered that an early experience with psychoanalysis left him deeply ambivalent about that form of psychotherapy and he refused

to describe himself as an analyst. Kim embraced her 'outsider' status with pride. I began to realize that I might be in very good company.

Soon after I finished *Listening*, I contacted Kim by email to thank her for writing the book. I've always admired intellectually courageous women – though I'm no less a misogynist in some areas than are most American men. Kim was both intellectually honest and courageous. I was fascinated by her family background. She was the daughter of a communist labor organizing mother who achieved some notoriety; some of her writing concerned this complicated relationship. As a Democratic Socialist, I appreciated the courage of both Kim and her mother. I found Kim brilliant and gracious. Her voice was melodious, her laugh easy and

infectious. We shared our thoughts about our status as 'outsiders.' I felt a kind of kinship.

Otto Allen Will, Jr., M.D.

A second aspect of *Listening* that I appreciated was her introduction of Otto Will (1910-1993). She had described him (generally referring to him as "the old man") in such a way that he came to life for me on those pages. Though she had been in treatment and studied with other luminaries in psychoanalysis, she wrote that it was Otto Will who challenged her to become herself. Finding herself growing, changing, she began to contemplate the questions which every therapist must answer.

The most fundamental of these questions concerns the nature of what we do that can be helpful to others. I'd learned from Lewis how

important my presence is and to listen for moments of surprise. I'd learned from Hans and Jeff to maintain a focus on the nature of the therapeutic relationship – particularly as difficulties or ambiguities develop. Ultimately, Kim wrote that the most prized clinical tool of psychoanalysis – interpretation — was insufficient to the task of helping troubled people. "Little by little," she acknowledged, "I gave up interpretation in favor of curiosity" (p. 155). Lewis had begun to challenge my reliance on interpretation by pointing out that it wasn't my responsibility to *explain* a patient's life. Rather, my responsibility was to help her understand her life better, providing her own explanations where needed.

For fourteen years (2007-2021) I served as a clinical assistant professor of psychiatry at the

Vanderbilt University School of Medicine where I gave lectures on Harry Stack Sullivan and the interpersonal approach to psychotherapy. I emphasized the difference between curiosity and interpretation. I've found that the best way to describe that difference is to suggest that curiosity is the process of getting to know a patient through open-minded observation and questions. These observations may then be reflectively offered to the patient for correction and elaboration. Curiosity is tentative by nature. Interpretation is the organization and presentation of material to the patient which describes *why* the patient acts as she does. It often focuses on 'unconscious' motivations and, though often presented tentatively, purports to tell the patient something of which she has been hitherto unaware.

Curiosity can become contagious. The therapist's curiosity often activates curiosity in the patient, as well. Curiosity leads to the introduction of deeper and deeper levels of oneself to oneself. *Understanding* and *acceptance* of these increasingly deeper levels is the heart of growth. Through her work with Otto Will, Kim concluded that psychoanalytic theory "… came to seem largely irrelevant to the encounter between two people for fifty minutes in a quiet room." (p. 155).

Another aspect of the book that I found deeply thought-provoking and useful were her conceptions of transference and countertransference. We discussed these ideas at length both through correspondence and conversation. Traditional psychoanalysts still consider interpretation of transference

phenomena the fundamental goal in dynamic clinical work. Kim, however, turned these concepts on their heads. She wrote that psychotherapy, "… must involve the struggle to be oneself in the presence of another person, even against that person's tendency to turn one into someone else, or one's own inclination to play a 'therapeutic role'" (p. 155). It's not interpretation that facilitates growth, but the *experience* of relating to the therapist being who she is — despite pressure from the patient (transference) or from herself (countertransference) — to assume a persona or role. It is therefore not an *intellectual understanding* that occurs, but a *new experience* within the therapeutic relationship.

In my view, Kim offered another way to consider the corrective emotional experience (See Chapter Four). Her view of transference and

countertransference described a sort of creative tension that permeates all aspects of the relationship, whether commented upon (i.e. interpreted) or not. The therapist's attempts to be simply who she is creates a companion for the patient who can be emulated or rejected, depending on the patient's needs. The ever-present tension of the therapist as a person in her own right will, at times, conform to the patient's expectations based on earlier experience, but will disrupt these expectations at other times. Each disruptive moment forces the patient to make a choice – does she continue to relate to the therapist as if she is someone from the past or attempt a different kind of interaction – perhaps securing more of what she wants and needs emotionally? Kim's view supported the approach that Lewis Lipsius helped me begin to learn and

suggested that the therapist's authenticity is inherently healing.

Self-Awareness

The ultimate goal of working in this way is to aid the patient in developing self-awareness, especially in regard to her interpersonal functioning. To work in this way requires a therapist willing to be an active participant in the process — facing herself with the same honesty that she does the patient — because therapists are also vulnerable to self-deception. Indeed, deception seems endemic to the human condition.

Psychotherapy also requires the courage to weather the exposure of our own difficulties in living. We all have difficulties in living and, though we may think that we keep them in hand, patients are remarkably astute at shattering that

illusion. Many traditional dynamic therapists refuse to respond to questions from the patient. As I suggested above, one important goal of the therapist's work is development of the patient's curiosity: what better person to be curious about than one's therapist? However, to have our own dilemmas pointed out to us can be embarrassing. Often, we don't respond to such questions or the patient's comments on our flawed functioning. Our silence can result in what R.D. Laing (1967) called *mystification* (pp. 55-76). Mystification is a defense often used by parents when they experience anxiety with their child and wish to shut the child down. It involves undermining the child's perceptions, changing the subject, or negating her curiosity.

I remember as a child of five or six asking my mother if she cried when her father died. Her

response still reverberates in my mind, “I was an adult.” It meant nothing except that she was not going to answer my question. She employed mystification — perhaps because the question embarrassed her, perhaps she didn’t want to explain conflicted feelings toward her father, perhaps it meant any number of things that I would never learn. Because her response blocked my understanding more about her, it decreased emotional intimacy between my mother and me. Further, her response left me with the sense that I’d done something wrong by asking the question and, thus, to some extent, inhibited my curiosity.

It's inevitable that a therapist who practices dynamic psychotherapy will, at least occasionally, feel exposed with the patient. Although in these moments I feel a high level of

anxiety, I attempt, not always successfully, to see the opportunity to learn more about myself.

A Resplendent Act of Generosity

Kim and I maintained a warm correspondence over several years. She was generous with her time and open to discussing almost anything. I shared my admiration for her capacity to acknowledge that she was an outsider to psychoanalysis but not reject the knowledge accumulated through it. I have difficulty with ambivalence of this sort. If a person or idea disappointed me, I tended to reject that person or idea. It is still difficult to recognize and acknowledge that 'good' and 'bad' may co-exist within a single person or that a flawed idea may still harbor some wisdom or utility. Yet Kim had a wonderful way of balancing opposites, and,

through our interactions, I developed the capacity to do so, as well.

As I completed my first biographical work on Sullivan, I decided that I wanted to write more about him, but also to include biographical information on Otto Will. I hoped to embed this information in a more general discussion of the clinical ideas of both men. I shared this idea with Kim. Though she was less familiar with Sullivan than Will, she was supportive of my project. It was then that she told me that she had conducted over two years' worth of interviews with Otto Will about his life and work. Having begun to schedule interviews with those still living who knew one or both men and searching for other primary sources, I was learning that some were quite willing to share such material with me without charge, while others required

compensation – some required significant compensation. Without any prior discussion, Kim offered me the cassette tapes on which the interviews were stored and the transcripts she'd prepared in return for digitizing the information on the tapes. It was one of the most generous professional gestures I've experienced.

I've spent many hours reading over those transcripts, listening to those tapes and preparing transcripts of some interviews that had not already been transcribed. It's been an invaluable learning experience.

The experiences I enjoyed with Kim Chernin, from reading *A Different Kind of Listening*, correspondence and conversations concerning clinical ideas, were of great assistance to me as a human being and psychotherapist. From her I was able to accept that I wasn't simply a failure for

not having achieved the designation 'psychoanalyst' but that professionals such as she, Hans Strupp, and myself provide an important service as 'outsiders' to psychoanalysis. My experiences with Kim increased my confidence (and, hopefully, my competence). Her ideas about authenticity prepared me for the next important influence on my career. The San Francisco analyst, Owen Renik, who worked with Otto Will, told me that Will "… was not given to theorizing and concentrated always on the importance of humanity and caring in the therapist" (personal communication, May 14, 2007; see also Will 1970, 2021). I think that such a description is perhaps the highest praise that can be given to a psychotherapist. I believe that it's equally fitting as a description of Kim.

Chapter Six

"Conversations from the Heart"

In Memory of Leon Lurie, M.S. (1915-2012)

Leon Lurie was a profound thinker who had a deep impact on my work and doubtless the work of many others. The two years I worked with him helped me integrate my previous experiences and take the lessons learned in those experiences even further. Leon was not famous, nor even celebrated outside the Washington School of Psychiatry (WSP). He wrote little but he was one of those people who spread his ideas by the conduct of his life and through his work as a psychoanalyst, psychotherapist, supervisor, and teacher.

An Uncertain Beginning

Leon and I met in November 2006. I was researching the life of Harry Stack Sullivan and came across an interview that Leon had done for the Washington School of Psychiatry *Newsletter* a year earlier. The interview was a recognition of Leon's sixty-year tenure on the WSP faculty (Frederickson 2005). Rich in content concerning Leon's clinical thinking, I was most interested in the simple acknowledgement that Leon had been trained by Harry Stack Sullivan. I added Leon to the list of people who I hoped to interview as part of my research.

I first contacted Leon by letter in the early fall of 2006. I lived in Nashville, Tennessee at that time. By email we scheduled a time to discuss my interest by phone. During that short phone conversation, Leon described a deep ambivalence

toward Sullivan. He had learned a great deal during his time at the WSP but found Sullivan to be "a son-of-a-bitch." This was a reaction to Sullivan that I had encountered in several interviews with others who knew him, so I was not surprised.

Leon also described to me his ambivalence concerning history. He made it clear that it would not be of interest to him to describe his impressions of Harry Stack Sullivan the historical figure. That did surprise me. As the process of studying Sullivan continued, however, I would find a similar perspective among others I interviewed. Leon didn't think of himself as part of a revolution in psychotherapy. As I grew to know him in a deeper way, I also sensed the somewhat common perspective that, since *he* had

been a part of this era, it wasn't historically significant.

Leon made a counteroffer that was intriguing. He suggested that I visit him and bring some of my own case material with me; he suggested that he would *show* me how Sullivan worked. Although the idea of describing my own work aroused anxiety, I could see the value of his suggestion.

Leon knew virtually all the early interpersonal psychoanalysts: Sullivan, Clara Thompson, Frieda Fromm-Reichmann, Otto Will, Harold Searles, Robert Cohen. I wanted to breathe that air and often pushed for anecdotes about these men and women. I think for Leon there was too little oxygen in that air; I have only gradually grown to surmise that he didn't view these women and men as colleagues. They were

superiors. More importantly, he perhaps felt that he had not earned their respect. He shared an anecdote early in our relationship about an interaction with Clara Thompson that led me to infer this.

It was Christmastime one year early in his career. His analytic work was being supervised by Thompson. Like many faculty members at the Washington School of Psychiatry, she divided her time between Washington and New York City. Either by design or circumstance, she found herself in Washington on Christmas Eve. Leon and his wife decided to entertain her for the evening, and they went out dancing. As Leon and Thompson shared a dance at some point in the evening, Thompson whispered to him, "Leon, you're a wonderful dancer!" He responded, "I

would rather you said that I'm a wonderful analyst." "When you *are*," she rejoined, "I *will*."

An Introduction

In early November 2006 I knocked tentatively on the front door of a house in a fashionable area of McLean, Virginia. Within a few moments the door opened to reveal an older man who smiled while extending his hand. His grasp was firm and confident. We introduced ourselves.

Once inside his home I began to study my host. At that point I had no idea of his age, though I now know he was ninety-one years old. At forty-five, I was less than half his age. He struck me as vigorous. Though his back was mildly stooped, his gait was steady and purposeful. His communication was articulate, direct, and free of jargon. His blue eyes were

clear and vital. They communicated warmth, a seriousness of spirit, and compassion.

Leon wore a snow-white beard. He also wore a beach hat – the hair protruding from under it matching the color of his beard. He was gracious and I felt very welcome in his home.

Family & Educational Background

Leon's parents were born in Lithuania – his father in 1871 and mother in 1879. The Jews of Lithuania – differentiated from other Lithuanians as 'litvaks' — were vulnerable to discrimination and abuse, often through formal pogroms. Such pogroms by the government and Christian establishment, involved violent riots in which Jews were killed and their property confiscated. This was especially true after the assassination of the Russian Tsar Alexander II in 1881, which was

blamed on the Jews. For three years following, 'litvaks' were particularly vulnerable to violence. Leon's parents emigrated separately to the United States in the last decade of the nineteenth century. In 1900, they were introduced by a professional matchmaker and married soon after.

Leon was born December 26, 1915, the youngest of seven children — six boys and a girl. At the time of his birth, the family lived in Gloversville, New York, located approximately two hundred miles northwest of New York City. Leon's only sister, Zelda, died at the age of two soon after his birth. His mother withdrew from Leon in grief and depression. This withdrawal, I believe, was the first experience of loneliness that would shape much of his clinical thinking.

After what he described as "lackluster" performances in elementary and high school,

Leon matriculated at Pennsylvania State University and majored in sociology and math. A poor student, he often refused to go to class. "All I cared about was looking cool and reading literature," he explained. His favorite author was Dostoevsky. He described himself as an auto-didact and related that his study of literature was quite helpful in his career as a psychotherapist. He maintained that "Novelists are the real psychologists – they think about how human beings are" (see also Coles 2010, pp. xiii-xiv; Vanier 1998, pp. 16-17). He graduated with a Bachelor of Arts degree in 1937.

Leon began graduate school at The New York School of Social Work in 1938. The curriculum of the school was built around psychoanalytic principles and captured his imagination. During his time at the New York School of Social Work

the school began discussions with Columbia University regarding a merger. In 1940 Leon was among the first class to graduate from Columbia University with a Master of Science degree in social work.

In 1942, he was drafted. The Second World War resulted in staggering psychiatric casualties. What is now generally labeled as Post-Traumatic Stress Disorder was then called combat fatigue. With his training as a social worker, it was determined that Leon would be stationed at a neuropsychiatric hospital. In this environment, Leon's interest in psychoanalysis intensified. His commanding officer had been a New York City psychoanalyst before the war.

Leon remembered both admiring and learning from him.

Leon was discharged from the Army in 1944. He visited his family and then enrolled at the Washington School of Psychiatry. This was one of the few institutions that accepted social workers for post-graduate training in psychotherapy.

The Washington School of Psychiatry

The Washington School of Psychiatry was unique among post-graduate psychotherapy training centers in the United States. The brainchild of Harry Stack Sullivan and a few dedicated colleagues, the WSP was created in 1936 as part of the William Alanson White Psychoanalytic (later Psychiatric) Foundation. The goals laid out by the Foundation's trustees were ambitious and included education and research. Most unusual, however, was its willingness to accept non-medical practitioners.

At present, turf wars are among those from different professions (psychiatry, psychology, social work, etc.). During the early part of the twentieth century the central conflict was between those with medical degrees and those without. In the United States, psychoanalysis was considered the province of medical professionals. Non-medical psychoanalysts were referred to as "lay analysts."

An arrangement with the training division of the Washington-Baltimore Psychoanalytic Institute provided that graduates of the WSP's three-year program received a certificate in psychoanalysis as well as a certificate from the WSP. Physicians could earn a certificate in 'Intensive Personality Study.' Non-Physicians earned a certificate in 'Applied Psychiatry' (Bever 1993, pp. 71-72; Evans 1996, p.47). By

1948 the WSP, which qualified under the G.I. Bill, had approximately 400 students enrolled (Evans 1996, p.47). One of these was Leon, another was Hans Strupp.

To be successful at the WSP one had to come to terms with Harry Stack Sullivan and his philosophy. As vice-president of the American Psychoanalytic Association, Sullivan was a powerful voice in psychiatric and psychoanalytic training. He was, however, highly controversial. Further, Sullivan could be interpersonally abrasive, critical, caustic, and demeaning. Leon observed these traits in Sullivan. Coexisting with this side of Sullivan, however, were kindness, generosity, and deep understanding. It was almost universally agreed that Sullivan was brilliant with patients (Cornett 2008 p. 273; Thompson 1962 p. xxxiv).

Leon found Sullivan's core assumptions acceptable. Sullivan met with many of the enrollees and after an interview would direct them to a training clinician to work out the "warps" in their personalities. He directed Leon to a retired naval captain with whom he spent approximately six weeks. He found this contact useful and determined that he would undergo a full analysis. He found Miriam Francis Dunn and began an analysis with her in 1947. Dr. Dunn was a warm Washington analyst, reputed to have expertise with patients deemed unanalyzable by other therapists.

Leon did quite well at the WSP. He graduated in 1950 and was immediately nominated to become a member of the WSP faculty. The vote by the other faculty members was unanimous. He

was, in fact, the youngest member ever elected to the faculty.

However, 1950 was not a year without pain. It was in 1950 that Leon discovered Dr. Dunn had died in an accident. The loss itself was painful, but that he discovered it in the newspaper added to the loss. It was the second loss of a maternal figure.

With his diplomas in hand, Leon began a practice in New York City, where he could also be certified as a psychologist. He continued supervision with Clara Thompson and found it helpful. Yet he also found their personal relationship unfulfilling. Thompson maintained a summer house on Cape Cod. She often entertained the celebrated in psychoanalysis, music, and the arts. She became involved with the Hungarian artist, Heinrich (Henry) Major, and

they shared this house every summer for many years. They were unable to marry because Major was already married.

For Leon, this house was full of painful memories. It had a large porch. He never moved past this porch and into the house because he feared that he was not really wanted. He would sit there, outside the house. Parties would often spill out from the house and Leon would hope that another guest might engage him; this rarely occurred and, when it did, it was short-lived. He did not recall Thompson showing much interest in him and he often experienced loneliness on these occasions. Leon concluded supervision with Thompson in 1954 and she died in 1958.

After losing Miriam Dunn, Leon searched for another analyst and found Marianne Horney Eckhardt, Karen Horney's youngest daughter. At

the age of ten she was analyzed by Melanie Klein. As an adult in psychoanalytic training, her analyst was Erich Fromm. Leon described this as the most therapeutic of his analyses. He remembered great anxiety in remaining prone on the couch without the ability to see her face. He began to take a position which allowed him to remain on the couch but also to see her face. He chuckled remembering how unfazed she seemed by this arrangement. In a final interview, Eckhardt described the importance of making the analytic session a conversation (Rubin 2014, p. 117). As we will see below, the making of a conversation during the analytic hour was of much importance to Leon, as well.

Theodor Reik & the National Psychological Association for Psychoanalysis

Leon was practicing in New York for a few years when he was approached by a member of the National Psychological Association for Psychoanalysis (NPAP). The NPAP was founded in 1948 by Theodor Reik. Reik completed his doctorate in psychology (the first ever awarded by the University of Vienna) in 1912.

In 1934, Reik, a Jew, sensed that disaster was coming with the rise of Nazism. He left Germany for Holland. In 1938, the fifty-year-old analyst left Holland for the United States.

Reik found the American medicalization of psychoanalysis repugnant and in 1948 created the NPAP in New York. It would become and remains today an important training center for

non-medical professionals wanting to become psychoanalysts (Whitman 1970, p. 21). Leon joined the organization as a training analyst. He admired Reik. I inferred from our conversations that Leon admired Reik because his approach to clinical work was not doctrinaire. Reik was interested in the communication that occurs between the unconscious of the patient and the unconscious of the analyst. In Reik's writings, particularly *Listening with the Third Ear* (1948/1983), he began to outline his ideas in this regard. Leon described being deeply impressed with these ideas.

Naropa Institute and Chögyam Trungpa Rinpoche

In 1970, an exiled Tibetan monk and teacher emigrated to the United States. He had an impressive lineage in Tibetan Buddhism. Indeed,

he had also been given the honorific Rinpoche ("Precious One") reserved for profound, inspiring teachers or those considered an incarnate llama. He wanted to build an institute of higher education which incorporated both Eastern and Western traditions. In 1974, Chögyam Trungpa Rinpoche founded the Naropa Institute - now Naropa University, in Boulder, Colorado, named for an 11th-century Tibetan teacher. Chögyam Trungpa wanted this to be a non-sectarian space open to all faith traditions. However, he did embed the academic program within an ambiance of mindfulness and contemplative/meditative practice (Scheffel 2012).

One of the institute's first programs was poetry and Chögyam Trungpa invited several beat poets to join the faculty. Among these were Allen Ginsburg and Anne Waldman. After their first

term teaching, they suggested the name, "The Jack Kerouac School of Disembodied Poetics." In 1975-1976 the Institute offered its first degree programs. One of these was a Master of Arts in psychology. Leon was on the faculty of the psychology program (it was, at that time, a summers-only academic year). Other faculty that Trungpa recruited included Alan Watts, Gregory Bateson, and Marvin Casper (who would eventually chair the program). Naropa was an intellectually and emotionally stimulating space in which to pursue ideas (Scheffel 2012).

Naropa was also a place where Leon could give a developed outline of his views on psychotherapy. In an interview with David Joel in the journal *Loka 2* (1976), Leon proposed that his goal for psychotherapy was to aid patients in discovering and accepting who they are beneath

the defenses and the wish to be only their best selves. In attempting to disavow aspects of ourselves we essentially become caricatures. His approach involved attempting not to bring about change but to accept a patient where she is. He sought to discourage students from pushing patients to change. For Leon, the important task was to help a patient discover and then be who they are. As he communicated his beliefs in this regard, he found that other faculty involved with the program found his perspective congenial to their own.

He offered a definition of psychoanalysis as one becoming used to herself. More precisely, as a patient being willing to look at who lives beneath the cultural, societal, and family conformity that prevents her from acting on her real wants, needs, and values.

Conversations from the Heart

Leon told me that he believed most people who consult a therapist do so because they find themselves in "… self-destructive, persistent, ubiquitous patterns of thinking and acting." These patterns of motivation, thought, and action interfere with "positive and nourishing ways of being with oneself and others." He related that resolving such patterns involved, "… a concerned therapist who has the skill to create a relationship *enabling the participants to speak from the heart*, i.e. to have a real 'conversation,' in contrast to the usual exchanges where strategy is the main concern. This nourishment is the antidote to the emotional starvation that so many of us suffer from."

To create such a healing relationship Leon maintained that the psychotherapist must be

authentic with the patient. Authenticity is something of a buzzword among psychotherapists. Edgar Levenson (2017) has written, "Authenticity has become a cliché. Threadbare from overuse, shabby from misuse, it has lost its austerity" (p. 9). I agree with this lament, though Levenson and I might not agree on how the term 'authenticity' reached this state. I believe that too many psychotherapists employ this term in the safest sense possible. For instance, one influential analyst, Nancy McWilliams (2004), wrote "As several analysts have commented in recent years, we try to be our 'best self' with our patients, not our whole self." (p. 39). Having worked with Leon, I've come to regard such descriptions of authenticity with skepticism.

In *Self-Reliance* (1841/1993), Ralph Waldo Emerson asserted that: "We pass for what we are. … Men imagine that they communicate their virtue or vice only by overt actions, and do not see that virtue or vice emit a breath every moment" (p. 25). Although his description is hampered by something of a moral squint, Emerson explains why the bifurcating of selves into "best" and "whole" is impossible. Leon explained why it is not desirable, even if possible. In the 2005 interview with Jon Frederickson, Leon explained the centrality of authenticity in his philosophy of psychotherapy. "…you [the psychotherapist] can help a person learn more, and more about himself, and after a while get used to himself, and begin to accept himself." Leon ended the interview with a controversial thought. "… If you feel free to show your worst

side, you are showing your better side. Your acceptance of all of yourself is an example to the patient of how he might come to accept himself too" (p. 4). His view holds that attempts by psychotherapists to be only a part of themselves with patients —ostensibly the "best" part — ultimately interferes with growth. Leon's was a conception of radical authenticity.

As psychotherapists we hope to create a relationship with a patient in which the latter can strive to be honest, candid, and transparent. This, of course, is ultimately an unattainable goal in any complete sense. Human beings will never fully relinquish the strategies they employ – both those within their awareness and outside of it – to protect their self-esteem and manage their anxiety.

While being aware of the limitations that a patient's humanity places on full disclosure, we must also be aware that what we are striving for is to assist the patient in becoming more deeply acquainted with herself. The closer the patient comes to fully disclosing what she knows and believes of herself, the more effective will be the psychotherapeutic work. As psychotherapists we can make this already difficult task even more difficult by expecting a patient to bring her 'whole self' to sessions, while we attempt to bring only our 'best self.' In such a situation it will be more difficult for a patient to share what she may consider the *darker* side of her nature – particularly with a psychotherapist unwilling to acknowledge hers. Thus, the attempt to maintain a 'best self' in psychotherapy serves primarily – perhaps solely – the defensive needs of the

psychotherapist. To the extent that the satisfaction of these needs prevents the psychotherapist from accepting all of herself, it interferes with assisting the patient to do so, as well.

A Way of Being

Early in our acquaintance Leon said to me, "My life and my life's work are the same thing." Initially, that statement irritated me. I began to dismiss it as an expression of what I view as a destructive American work ethic, more evident in Leon's generation than mine, but inescapable in either. However, something about the statement also intrigued me and I considered it further.

This consideration led me to an idea that was not altogether comfortable. Being a psychotherapist is not simply a *job*; it is a *way of being* in the world. If we are honest about it, it is

an unusual, even strange, way of being. It requires a form of self-awareness not encouraged or valued by our society. It requires an acceptance of difference that is difficult, if not impossible in any comprehensive way, to achieve. Psychotherapy promotes imagination and creativity in a culture that revels in materialism. It requires the capacity to tolerate uncertainty in a society that worships the illusion of certainty. It supports intimate relationships in an environment increasingly disposed toward viewing relationships as transactional. Psychotherapy often involves the willingness to care – indeed to love – when that caring will not necessarily be reciprocated. Psychotherapy requires the acceptance of loss, the heaviest of human burdens.

Psychotherapy is neither the domain of heroes, nor the refuge of scoundrels, though it has its share of both. It is a profession with risks – especially emotional risks. Although this is seldom communicated to the young or novice psychotherapist, it is nevertheless a reality. Irvin Yalom (2002) outlined some of these risks, including a potential for social isolation (pp. 251-255). When one's days are filled with deep conversations about pain, love, sadness, longing, hope, and hopelessness, social small talk can become banal, trivial, and unwelcome. The British psychoanalyst, Neville Symington (2006), suggests that the process by which we emotionally understand a patient's distress is, at least to some extent, by "suffering with" that patient (p. 87).

What we have come to call compassion fatigue and vicarious trauma must be eluded daily. As I have grown older, I have also found that, after a day filled with patients, my capacity – or, perhaps more honestly, my willingness — to listen to friends and my partner — I mean to really *listen* — is significantly diminished. I crave quiet and safety.

Jack: Hiding Behind a Role

Over the course of two years, I shared information with Leon about my work with several patients. One was Jack, a man slightly younger than me who set up an appointment to discuss his lack of success in relationships. During our first session, he revealed some of the basis for this difficulty. He was highly sarcastic and dismissive of much that I said. He

acknowledged this as one aspect of his typically defensive interactions with others.

Leon suggested – and I agreed – that such responses were dismissive. He asked how I might feel if someone who wasn't a patient responded to me in that way? He then asked, "Have you told him how you feel when he responds to you like that?"

"No," I responded. "I'm afraid he will ask me why I'm so thin-skinned. It seems so … *unprofessional*."

"It's not unprofessional," Leon insisted, "it's the essence of what we do. He treats you dismissively because he also treats others dismissively – that's why he's come to see you. He doesn't do well with other people. If he asks you why you're so thin-skinned, you might tell

him, like I've done with some of my patients, that 'I'm a thin-skinned therapist and I doubt I'm the only thin-skinned person in your life.'" This was, of course, another example of how crucial it is for the whole psychotherapist to be present in the room.

Psychotherapy is always about the relationship between two human beings and how deeply present they are for each other. Did I know that? Of course. But I had become unaware of it in my anxiety with this patient. I also realized that, because of my anxiety, I had retreated behind a professional role with this patient. That role left me unaware of all my options and unable to respond with all my voices. As another interpersonal psychotherapist, Martin Cooperman (1983), wrote about the participants in psychotherapy: "Initially one will present with

symptoms and signs, the other with technique. As the venture prospers, both of these artificial and stereotypical presentations will diminish to be replaced by collaborative functioning" (p. 22). I had not given up my role as 'the professional' with Jack yet.

An Invitation to Curiosity

At various times during our work, Leon offered observations or asked questions about my actions, noting sometimes how our actions with each other were similar and dissimilar. During one session he asked, "Why am I asking these questions and making these observations about *you*?" Continuing, he asserted, "It's the basis of being able to know what you bring to the table. It's part of the process of learning to be yourself with patients. It's also part of the process of learning how you and I are with each other." He

added a reminder of how important the idea of authenticity is, "The closer that your social and professional selves are, the more authentic you'll be with your patients. A lot of therapists are aware of what their patients are doing, but don't pay much attention to themselves. They only know half — or less than half — of what's going on in the room."

There was a second aspect to the way that Leon did this that I have thought about a great deal. My initial training was founded upon ego psychology, the dominant psychodynamic model of that time. Consequently another emphasis of my training was my being aware of and understanding my internal, intrapsychic processes. I, like my fellow students, was encouraged to seek out the real motive for particular responses to patients. Unfortunately,

for a motive to be considered real it was necessary that it reveal a way in which I had been deceiving myself. Examples of such real motives include sadism hidden by altruism, sexual seductiveness hidden by acts of compassion, or anger based on the frustration of unresolved infantile needs.

There is no suggestion here that the psychotherapist be inattentive to her complex internal motivations. Indeed, the opposite is true. Nor am I suggesting that there are not a great many deceptions involved in these motivations. There is also no suggestion intended that one be inattentive to actions (which obviously include verbalizations) that seem out of one's norm. However, what I am suggesting that I experienced with Leon was much more basic. It was an invitation to become acquainted with

myself, as I was perceived by another human being. Potentially, as I may sometimes be perceived by patients.

The invitation that I am describing also encouraged my curiosity. Anything that heightens a psychotherapist's curiosity is, I believe, to be welcomed. Curiosity is that quality which keeps us attentive to and accepting of our patients.

As a result of my sharpened curiosity I became much more interested in my basic demeanor and manner with my patients. This will be no significant revelation to the experienced psychotherapist, but to a large extent, these small repetitive patterns of action comprise who I am. And, of course, these are the aspects of me that patients experience most readily and upon which they base important decisions (e.g. my trustworthiness, compassion, honesty, as well as

my emotional states, and, particularly, how I feel toward them).

More is communicated non-verbally than verbally throughout our lives. Societally, we have chosen to make a statement such as this one counter-intuitive. We believe that what we say is most important. Yet, the first two years of life are founded upon non-verbal communication. That early experience remains, and we rely on it more than seems to be comfortable to acknowledge. To be a successful psychotherapist it is necessary that we not only acknowledge this, but also carefully attend to the many dialects embedded in our non-verbal actions.

Aaron: Sexual Attraction

Some months into our work, I presented some work to Leon with a patient about which I felt

very vulnerable. I was then an openly gay man in Nashville, Tennessee and my practice drew many gay men. I often find my male patients sexually attractive. I cannot remember a single instance of a psychotherapist acknowledging this in any public way. Therefore, aside from my conviction that Sullivan (1953a) was correct in his assertion that, "In the most general terms, we are all much more simply human than otherwise …," I have no way of knowing with any certainty whether or not this is a common phenomenon (p. 16). This lack of acknowledgement strikes me as a further manifestation of the illusion that psychotherapists are their 'best selves,' rather than whole selves with patients.

However, this dynamic also describes a great deal about me. It testifies to the manner in which the past lives in the present. My family's overly

sexualized nature no doubt plays a part. It is also part of my tendency to objectify people to make them feel safer to me. Paradoxically, it also maintains my interest in them. I feel a constant struggle between "I-It" and "I-Thou" relationships with attractive male patients.

I began describing a patient, Aaron, that I had worked with for some months. "I feel very attracted to this man," I began. "And, on some level, I'm sure that he knows that." Leon listened silently but attentively.

"During one session he was describing a tattoo that he had gotten the previous weekend. He was very proud of it and offered to take off his shirt to show me. Although to be completely honest that would have been delightful for me, I knew that his taking his shirt off in front of me would involve an old pattern." This young man's

history was noteworthy for the amount of sexual abuse and exploitation that he had undergone.

"I decided to respond to his offer with something like this," I continued: "I think that you've gotten a sense that I admire your body. I think that perhaps you are offering to show me your body both as a way of pleasing me and as a way of ensuring that you still have my attention" (This was more of a comment on my own projected dynamics). My patient's response indicated a sense of confusion.

I expect that some of my colleagues would label such an open acknowledgement of attraction as seductive. Perhaps on some level it is. Leon seemed thoughtful throughout my presentation. He finally spoke, "I think that what you did was okay," he started, "but you missed part of the interaction, I think."

"Yes, you see you focused only on his body. Is that all you like about him?"

After some thought I responded, "No, he's intelligent, funny, a writer – I like him as a person very much." Given what I have said about the safety of people, this response surprised – and yet did not surprise me.

"What would have been the problem with bringing *those* feelings into what you said? Instead, you both stayed focused on his body."

Leon continued, "You didn't talk with him about friendship. I think that part of what he was doing was reaching out from his loneliness for a friend to show his new tattoo. In a way, you both replayed the central pattern of his life – 'people only want me for my body' — because that's all you talked about." I had engaged in an *enactment*

with Aaron – we acted out feelings that were too difficult to discuss, though difficult for each of us for different reasons.

Leon pointed out to me that, rather than having an intimate conversation with my patient, I was avoiding intimacy. It was easy for this patient to talk about his body – even to hear me talk about his body. What he would not have been accustomed to, and what would have indeed been a more intimate conversation, would have been an open discussion of his desire to be seen for more than a body and my genuine liking of him as a person. That conversation would have been much harder for me.

As Leon would later say to me, "Loneliness is ubiquitous. It is part of the human condition and human dilemma." Conflicts and anxiety regarding

closeness certainly form a significant part of the dilemma of my life.

Grace: The Less We Expect

During one supervisory session, I began to describe the work with another patient. I experienced ambivalence toward this very bright, young professional woman, Grace. I thought that our work was going very well in some ways. A father who could be witheringly critical and had great difficulty being close to his daughter had dominated her development. She felt rejection on a regular basis. Through dreams that she related and the general tenor of the work, I believed that she was viewing me as another kind of man in her life – a man who dealt with her very differently than her father. Some of her hostility toward herself and lack of self-confidence had mildly receded.

Yet, I also had no sense that this was freeing her in any substantial way. She remained devoted to her father, leaving her vulnerable to his moods, criticism, and controlling nature. I wanted to be of more help.

Leon listened quietly. Occasionally, he would ask something about her and her father. Some questions balanced the picture, as he would ask about other important figures in her life. Our session ended that day with Leon reminding me of something that I knew intellectually but was still having difficulty allowing to become fully a part of me. He said simply, "Change is not inherent in the process; your patient has somebody in the world who values her and hopefully that carries over into the rest of her life. *Remember, the less we expect, the more that is possible*."

I struggle with this idea. Although I am intellectually committed to it, I often find my actions in conflict with it. I find it very difficult to watch someone who has assumed an important place in my life struggle painfully. Some supervisors have rebuked me for becoming overly identified with my patients. Some have suggested that 'analytic neutrality' is the remedy for this. It is natural for me to want to ease a patient's suffering. And yet I am constantly reminded that to believe I can actually do that is foolhardy and reckless. I could try to impose my personal philosophy on the patient but then I take from her the right to find her own path in life.

Leon reminded me of this a couple of times. At one point he commented that, "As therapists we are not expert in knowing the philosophical answer to the question of how to live a good

life." At another point he put it more forcefully, "People expect us to know how to live 'a good life,' and that, of course, is ridiculous!" *We are no different from our patients*. We have no magical answers for our lives, nor do we have any for *theirs*.

Feeling 'Grounded'

One of the truly helpful things that supervision can offer is a sense of being 'grounded.' While all my supervisors helped me inculcate that ability, Leon was a master of it and, over the last fifteen years, that has become a part of me. My neurotic conflicts and developmental deficits remain – though I perceive them as less powerful in my life – problems in living are never "cured," no matter how much education, therapy, or supervision we pursue. They create difficulties with patients, but the sense of being

‘grounded’ aids me in sitting with my patient, being fully present, and curious about the state of the relationship, being aware of the pressures I feel to play a role and avoiding assuming that role.

Chapter Seven

"The present is unstable and the future uncertain."

Otto Allen Will, Jr., M.D. (1910-1993)

In this book, I've attempted to describe how I learned what I know about dynamic psychotherapy. I hope that it communicates a sense of how I've developed a psychotherapeutic perspective – no doubt containing flaws as well as wisdom. In developing this perspective, I've grown to believe that life is largely what I make of it. It will always be uncertain because so much of it is out of my control. It can only be approached ambivalently because we all suffer as well as celebrate. Yet, life is often celebratory, loving, gentle, and satisfying (Will 2021, p. 1).

For four decades, I've been trying to help others balance the suffering in their lives with celebration.

This perspective developed from a mixture of listening to patients, seeking out people that I respected, who taught by example and who, in turn, respected me. It's no different in my relationships with patients. These grow organically as long as I respect, listen carefully and deeply, treat them with sensitivity, and are unusually aware of not injuring their self-esteem. In short, I must treat them lovingly (Will 2021; Plakun 2021).

As the relationship develops, it's incumbent upon me to be aware of my presence. It sounds almost amusingly simple, but it's difficult work being present. Inevitably, my presence means that I am vulnerable to rejection, sometimes

loneliness as the patient carefully assesses my trustworthiness or withdraws after a painful interaction. As I monitor my presence, I must be aware of keeping appointments and how I do so. Do I often arrive late or end early? Do I distract myself with phone calls or external communications? I've certainly fallen well short of perfection in all these areas. I've then seen it as my responsibility to address such behaviors, by listening to the patient's feelings and thoughts about them, and responding as an adult who, as Sullivan notes, thinks the patient is worth the trouble.

Though I cannot guarantee the patient a specific outcome, my reliable presence can communicate that I will be with her as she comes to know herself more fully. I have no magic

answers but will 'totter along' with her (See Chapter Three).

The patient will learn more about me as the relationship continues to develop. She will learn more than I realize I've communicated – or more than is comfortable. As what she learns is introduced into sessions my job is to acknowledge her perceptions, accept what is true, and be curious about what I'm not sure of. I hope to make curiosity a central element of the process. Of course, at moments I will feel vulnerable. At such moments it's important not to hide behind a role or a persona (See Chapter Five). It's perhaps in these moments more than any other that I can provide a 'corrective emotional experience.' I am who I am. I model acceptance of myself. Hopefully, the patient will feel comfortable to be herself.

Often, I feel confused by what happens during a session. As a part of my attempt to be myself I'll share that with the patient. I'm often surprised that my patient will ask, "Where did you get lost?" and return us to a point close to that moment.

Surprise is a signal to me that we're making contact – real person to person contact. Over time I learn how my patient typically responds to certain subjects and she learns the same about me. When one or both of us surprise the other we are 'talking from the heart' (See Chapters Three and Six). Such moments are a goal of therapy.

A relationship between two people can be healing but requires constant care. The mistakes I make require a direct approach to repair, even if the patient would prefer to ignore them (see Chapter One – my nodding off with my patient).

Almost invariably in a two-person psychology, I will miss my mistakes and wind up in an enactment (see the vignette concerning "Aaron" in Chapter Six). It is perhaps because I've abandoned who I really am and assumed a role or persona that enactments occur. It is then through the action of reclaiming my authenticity in the relationship that the patient and I resolve the enactment.

I've always found Otto Will's writings helpful (See particularly Will 1970; 1971; 1979). As the quote that begins this chapter (Will 2021, p. 2) attests, he doesn't embrace a superficial, "It will be alright," perspective on life. He believed that we must face life head-on, expecting neither perfection nor disaster but working toward satisfaction. Relationships make us who we are and most of our path in life is determined by the

interpersonal choices we make. I hope that in the preceding pages I've described how I learned to help patients find satisfaction, first in the relationship between us and then in their interpersonal environment. Sullivan (1954) wrote, "… there is no fun in psychiatry" (p. 9). With the amendment that psychotherapy is part of his understanding of 'psychiatry,' I generally concur (though there are some fun moments). There is, however, a great deal of satisfaction in the work.

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