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JOSEPH TUDOR BELANGER

1977

OPERATIONALIZING PARTICIPANT OBSERVATION

by

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ABSTRACT

Operationalizing Participant Observation

by

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In this pilot study, psychotherapists who had either been supervised by or in training analysis with Harry Stack Sullivan were interviewed as to their developing understanding of the term 'participant observation'. The interviews were semi-structured in format and covered eight main topic areas. These interviews were then analysed in two ways. Firstly, they were digested for their content and compared both with each other and with the author's summary of Sullivan's writing on this subject. Secondly, it was hypothesized that an attitudinal set that furthered the work of participant observation would be present in these senior psychotherapists. A trait-rating scale was devised which tested for the presence or absence of this psychotherapy furthering attitude. Each interview was rated by two judges acting independently of each other; statistical tests of reliability and validity were conducted. Significant results were not obtained though there was a noted tendency in the predicted direction. The two analyses were discussed and a model of therapeutic error that would be in accord with the principle of participant observation was proposed. The model was illustrated with clinical material derived from the author's work. A way of furthering one's capacity as a participant observer was suggested.

TO MY MOTHER

"The expertness of the psychiatrist refers to his skill in participant observation of in contrast to mere participation in the unfortunate patterns of his own and the patient's living ..."

(Harry Stack Sullivan, 1949(b), P.12)

"If your mind is empty, it is always ready for anything; it is open to everything. In the beginner's mind there are many possibilities; in the expert's mind there are few."

(Shunryu Suzuki, 1970, P.17)

TABLE OF CONTENTS

Chapter I : A Rationale for and Introduction to Operationalizing Participant Observation

- A. Introduction Page 1
- B. Development of the Concept:
Participant Observation Page 15
- C. Operationalizing the Participant-
Observational Way of Psychotherapy . . Page 23

Chapter II: Sullivan: His Historical Context and a Review of his Writing about Participant Observation

- A. Intellectual Influences Page 30
- B. Clinical Influences Page 33
- C. Personal History Page 38
- D. Sullivan, The American Page 40
- E. Strategic Operations Page 43
- F. Tactical Operations Page 59
- G. Diagnosis Page 63

Chapter III: Method of this Study

- A. Background for my Hypothesis:
The Techne Page 70
- B. My Specific Hypothesis:
Attitudinal Set Page 80
- C. Procedures and their Rationale Page 88
- D. The Statistical Analyses Page 100

Chapter IV: Abstracts of the Interviews Along with the Author's Personal Experiences as a Participant

- A. Abstracts Page 103
- B. Author's Experience as a Participant . . Page 110

Chapter V : Analysis of Data and Discussion of Participant Observation

- A. Analysis of Data Page 114
- B1. Theoretical Discussion of Participant Observation with Clinical Illustrations. Page 120
- B2. Preliminary Communication on Contemplative Practice (zazen). Page 135

APPENDIXES

Appendix A.	The Data Base	
	The Interview with # 1	Page 143
	The Interview with # 2	Page 154
	The Interview with # 3	Page 171
	The Interview with # 4	Page 215
	The Interview with # 5	Page 232
Appendix B.	The Introductory Letter	Page 269
Appendix C.	Enclosure:	
	Synopsis of the Proposal . . .	Page 270
Appendix D.	Rater's Code Book	Page 276
References		Page 297

TABLE OF ILLUSTRATIONS

Illustration #1	Page 8
Illustration #2	Page 77
Table #1	Page 115

Chapter 1

A Rationale for and Introduction to Operationalizing Participant Observation

A. Introduction

In 1931 Harry Stack Sullivan wrote: "Psychiatry, for the present purpose, is a largely intuitive* art that some of its practitioners are striving to convert from this artistic, highly personal character to a body of interpersonally valid verbal formulations." (p. 978) Forty five years later there has been an almost astoundingly small amount of change. Lithium carbonate treatments have been dramatically successful for a not well defined group of individuals roughly describable as manic-depressive. (Schou, 1963) The neuroleptics, a rather heterogeneous group of drugs including phenothiazines, butyrophenones and thioxathenes have been almost equally successful with a larger group of persons suffering psychotic disorders. (Klein and Davis, 1969) Desensitization treatments have on occasion been spectacularly effective in ameliorating circumscribed phobic reactions. (Bandura, 1969)

But on the whole, very few generalized principles and almost no specific techniques of psychotherapy have been formulated in the past forty five years that will, when measured by any reasonable outcome measures, demonstrate an efficacy that demand their adoption by any ethical practitioner. (Meltzoff and Kornreich, 1970) Further, when viewing the field as a theoretician, the theories tend to be replete with such elementary errors as anthropomorphisms, and mixed levels

*Italicized in original

of discourse, as has been amply documented by Eysenck (1971), Fodor (1968), Loevinger (1969), and Sherwood (1969) among others.

What has perhaps changed most dramatically is the tenor of the times so that I feel mildly compelled to justify yet another attempt to move psychotherapy one step closer to a scientific endeavor; science no longer appearing as an unquestionable good. Artists, great psychotherapists, and great scientists cannot be mass produced, but if there were a set of general operating principles of psychotherapy it would be perfectly possible to educate any number of competent therapists given a minimum of goodwill on the part of the educators. The need for such psychotherapists is self-evident. In addition to the utilitarian justification, there is a justification of formal elegance. Anyone who has been astounded at a mathematical proof knows that the attempt to understand formally any work of art is not cavalier reductionism but sincere appreciation.

The difficulties in the attempt to clarify this field are numerous. Firstly, the kinds of data that can be observed are of two distinct classes, organismic and individual. Organismic data are those that relate to the person as organism. By organism, I mean the living body that exists in time and space, is composed of identifiable parts such as arms, legs, G.I. tract, and the like, and whose parts work together as a whole. Some organismic data consist of what can be recorded upon the careful observation of this 'object',

the organism. Lazarus' (1972) recommendation to make videotape recordings of facial muscle set is an example of this kind of organismic data. Other organismic data consist of all that can be learned from making various and sundry manipulations of this 'object'. A knee-jerk reflex test is an example of this latter type of organismic data.

Individual refers to the resultant of that learning which has rendered certain behaviors and patterns of behavior more probable in any given situation. It does not directly refer to maturational or traumatic changes to the organism which also affect the probabilities of behavior. I say "directly" as such maturational and traumatic changes can create or eliminate the possibilities of learnings whose resultant as expressed in behavior is individual.

To illustrate this point, consider the adult human organism in a state of need for water. The organism is simultaneously an individual who goes about seeking water in ways that are learned in a particular culture and which, if they are complicated enough, may allow for sufficient variation in their application that we can speak of individual differences of style. For example, the Australian aborigine in his desert reads "signs" of bush color, dirt color, etc. The New Yorker in his apartment turns on the tap and hopes. Instances of the sort of individual data that a psychologist might generate include attitudinal questionnaires, transcripts of conversations, and statements of the therapist's hunches.

The relationship between these two kinds of data is unclear. For example, Schachter and Singer (1962) administered

epinephrine to their subjects, (clearly an organismic manipulation), instructed a confederate to model certain behavior patterns, (clearly individual), and gave misleading instructions to subjects about epinephrine's effects. (an ambiguous case) How then should their results be interpreted? If their conclusions about the relationship of emotional state and bodily state are accepted, then how much do they generalize to the non-drugged condition?

Secondly, when we consider individual data, the data are explicable only in terms of the intentionality and the particular history of the individual(s) involved. For example, couples often develop a quasi-private language that can be remarkably opaque to outsiders. The following is an illustration which I have constructed to illustrate this point. Given the single statement, "It's a crispy present", a hypothetical rater might not feel competent to judge, but would surely consider the possibility of a psychotic word salad.

Given the complete dialogue,

"I got the paintbrush."
 "It's a crispy present."
 "You're welcome."

our rater would not find himself particularly illuminated, and might consider this to be indicative of the pseudo-conversation of deteriorated schizophrenics. Only when the dialogue is expanded to include the shared history and understood assumptions of the speakers does it make sense.

"I got the paintbrush." (which we saw last week in Flax's window, and which you thought that we

would not be able to afford this month.)

"It's a crispy present." (This surprise is as delightful as Christmas presents were when I was so young that I mispronounced Christmas as crispy.)

"You're welcome."

This annotated edition of the dialogue would still be insufficient for some purposes if the reader were from a culture totally removed from the celebration of Christmas as there would be some loss of the nuances of meaning of Christmas present. So the third area of problems is that it is impossible to simply view a statement as some given fact which you observe as you might pick a pebble from the beach. Statements are only understood through the means of a shared culture.

The extent to which our direct perception of the world is a product of enculturation may be illustrated by contrasting the effects of looking at two pages of script, one English, the other Arabic. The page in English is read. In fact, it is quite difficult to do anything other than read it. It is extraordinarily difficult to see the page as the Arabic script is immediately seen, namely as marks on paper.

Enculturation not only poses the hazard of missing the obvious (script is marks on paper), but also involves the learning of assumptions concerning the nature of reality. These assumptions (e.g. I have a true self) may or may not be true. The fourth problem in this field is therefore that, in order to understand a person (client or patient) we have to share a culture with them which involves the sharing of assumptions that

might in and of themselves be the source of the person's difficulties.

Fifthly, there are problems inherent in the interaction of observer and observed. Consider the self-fulfilling prophecy effect. Operating within the American cultural understanding, it is not infrequent that a person consulting a professional such as a physician or a psychotherapist will wish himself to be seen as good by the professional. (Sullivan, 1954) So he adjusts what he says to what he believes the other person thinks of what he has just said. (Laing, Phillipson, & Lee, 1966) If the person is sensitive to those non-verbal communications of affect which it seems so many psychotherapists are insensitive of emitting, then the person can have his verbal behavior shaped by the psychotherapist.

Assume for the moment that the therapist is more or less anxiously attempting to diagnose this person. A suitably anxious therapist may settle upon a particular diagnosis on the basis of a favored sign, and then ignore large amounts of contradictory information waiting for substantiating facts. (Sullivan, 1927, 1940, 1947, 1956) If the therapist is waiting somewhat anxiously, his non-verbal behavior will shape our anxious patient toward the fact for which the therapist is waiting.

To ignore information does not necessarily mean to consciously snub. There are relatively automatic cognitive filtering operations that prevent some stimuli from being perceived. This is evidenced by the fact that a tape record-

er will record and play back background noise of which I was completely unaware while making the tape.

Further, there is good reason to believe that not only are some stimuli which are potential information filtered out, but also that those stimuli of which we are aware have undergone some preliminary cognitive processing of which we are not aware. There is an illusion which was first demonstrated by Boring, Langfeld, and Weld (1939) in which a line drawing may be seen as a portrait of a young woman or as a portrait of an old woman. For many people, including myself, the percept young/old woman changes. When the picture shifts, we know that something active must have occurred to occasion the shift, and equally obviously the shift has occurred neither in the actual arrangement of lines on paper nor in the clear focal awareness of the experiencer. (See illustration #1)

More than one theory associated with clinical practice, such as the Freudian psychoanalytic, has claimed that it is these inferred cognitive operations with which we should be primarily concerned. (Freud, 1915/1959) The sixth difficulty in clarifying this field of study then is evaluating this claim, and formulating the rules of evidence on existence, nature, and function of inferred cognitive operations.

The seventh difficulty is that there already exists a voluminous literature which allegedly guides the apprentice practitioner. If this literature is unthinkingly accepted or rejected, it moves from the status of theory to that of dogma. This, in turn, ultimately results in the creation of non-com-



municating camps of believers, each camp having its associated jargon. These camps may or may not be describing similar phenomena.

The eighth and last difficulty is that the phenomena which are brought to the professional attention of the clinician change over time. This is partially a product of cultural drift, and partially changing conception of the professional role of the clinician. By cultural drift I mean the change, typically slow but occasionally sudden, in that loose set of more or less shared assumptions that actually constitutes the weltanschauung. At the turn of the century, glove paralysis was, apparently, a not uncommon symptom. Today it is practically non-existent. I consider this to be an example of cultural drift. I further get the sense that there had to be something specifically wrong with you in order for you to consult a professional at the beginning of the 20th century, i.e. you had to have symptoms. Today you do not need a symptom, the feeling of malaise is sufficient. This, I think, represents a specific change in the role of the psychotherapist. With both of these changes occurring more or less simultaneously, it seems clear that the data base for a theory of psychotherapy has not remained the same over the past 100 years.

Given these problems, one sensible approach is to investigate the process of data generation. This approach has several advantages. It spotlights the basic problem of what is a datum. It maximizes the possibilities of data replication. It minimizes the proliferation of constructs de-

finer in terms of each other but not sufficiently coordinated with data. If the argument that the primary data of clinical psychology are conversations is accepted then as Harry Stack Sullivan (1927) wrote, this approach provides a common field of research and practice. 'Conversations', by the way, is used here not in its ordinary usage. It actually refers to those conversations in which the therapist is acting in his role of expert trying to identify troublesome and characteristic problems in the client's living while the client is participating with some expectation of benefit.

The argument that individual data (conversations) are primary is that while there are two classes of data, organismic and individual, the organismic is not generated unless and until individual data has tagged the human under consideration as fit to be considered as organism.

Two examples should clarify this. General paresis is a clear example of an organic psychosis. (Diagnostic and Statistical Manual, 1953) But before the person in question is tested for this condition, there has to have been a sequence of events which involve the observation of the individual. In the most probable case, Sam Smith will have had to have been behaving badly in a manner and style which led others in a position to do so to diagnose him as "crazy" and take him to the mental hospital. The individual, Sam Smith, has to be "crazy" before anyone brings him to a situation in which the causative organic disease is recognized. In this sense the individual data are primary.

Similarly, complicated tests on serotonin levels

are not performed until the individual in question has long since been involved in situations with other individuals which resulted in him/her being diagnosed as a schizophrenic.

Having established the primacy of individual data, I now need to consider the ways in which the terms 'individual', 'personality', and 'interpersonal' are interrelated. I have defined the term 'individual' in a rather loose way so as to accord with the common usage among psychologists, as for example, in the phrase "individual differences". I hope to show that whenever we are speaking of the 'individual' we are typically speaking of the 'personality' and that when we speak of the 'personality' we are speaking of the 'interpersonal'.

Consider those patterns of behavior, recurrently demonstrated in situations composed of the two (or more) group that are subject to variation. For example, there are noticeable variations of greeting to one's workmates. "Hi." "Hello." "Good morning." "How are you?" "One more day in the salt mines." "Thank God it's Friday." It is the expectability of behaviors and patterns of behavior that cannot be more parsimoniously attributed to organismic factors that constitutes the 'personality'.

For example, this author has a very slight ambulatory disturbance that is the result of a knee injury. The ambulatory disturbance though definitely an observable pattern of behavior is not, by this definition, part of my personality. The fact that certain hospitalized persons on my unit can be relied upon to quite regularly greet me by com-

menting on my funny walk is a facet of their personality. My jocular acknowledgment of the truth of their observation along with a characteristic "How are you today?" is likewise a facet of my personality. By this definition of personality, it and interpersonal are virtually synonymous, interpersonal being defined as that which exists between persons.

Hermits, incidentally, would lack personality according to this definition. This seems patently absurd. Nevertheless, I think it is true. While I have never spent the necessary amount of time in total isolation from members of my own species to qualify for the title 'hermit' the circumstances of my life have led me on occasion to spend relatively long amounts of time by myself. Whenever I then resume contact with another human, I have noticed a curious phenomena which I believe may be widespread. I have a certain difficulty in playing my role even though I know it very well. I attribute this to a temporary lack of personality.

Now, consider any data that look to be 'individual' but not interpersonal such as the former example of the aborigine seeking water. There are without a doubt individual differences in the way that water is sought. But the great majority of these differences are learned in the time of socialization of the child and hence are directly interpersonal. Probably only those differences of style that the person in question created for himself during periods of isolation from the other tribal members could be considered as 'individual' differences as opposed to expressions of the personality. Indeed, even these individual differences show the effects of

personality as they are the result of styles of problem solving which are almost certainly learned in an interpersonal context. So not only is the individual data primary, but the vast bulk of this data is interpersonal.

Further a single datum can be fruitfully considered as a component in an action-reaction sequence. Consider me sitting in a room with someone else. The room is empty save for us and the chairs. I say "What seems to be the problem?" Inferable from this first statement are the declarations:

1. You have problems. 2. This is the time and place, and I am the person with whom to speak of these problems. 3. You might not know the true nature of your problems. The other is now free to do one or more of three things: refute at least one of the inferable declarations ('I don't have any problems.'), state with a greater or lesser degree of clarity the problem ('It all began when') or do something which appears to be non-sequitur ('I like your tie.')

The first two cases are clearly and *prima facie* sequential. It is the third case that is most interesting. Assume either that an apparent non-sequitur is indeed non-sequitur (he's just changing the topic.) or that it is not non-sequitur (he's just resisting.) and I will have deprived myself of an ideal opportunity to learn more about the other. But if I assume that whatever the other says or does may be related to what I have just said or done, my curiosity is piqued to devise a verbal experiment to discover if what he or she has said/done is, in fact, related to what I have just said/done and if so, how.

But when I have assumed that anything that the client may say or do which follows temporally my action may be a reaction, I have implicitly accepted the assumption that the observer of the data generated is, irrevocably, a participant in the process of generation of data. This seems to me to be at least similar to the understanding of the nature of science of Bridgman (1961) and of Polanyi (1961, 1966). A felicitous way of expressing the understanding that the observer interacts with the observed is to consider this two group as an interpersonal field.

What is particularly felicitous about the expression 'interpersonal field' is that it has the connotation of interdependent events more than that of separate things that are linearly arranged. It has always struck me most forcefully that in the study of persons the variables are so interconnected that no one variable can be varied without simultaneously affecting several others. Consider for example the Hawthorne effect in which Roethlisberger and Dickson (1939) diligently varied payment systems and work conditions in a study of work productivity. The net result was that these could not be varied without simultaneously affecting such things as self-esteem, the sense of personal responsibility for production, and the role of the work supervisor, the personality-type variables being stronger in their effect than the originally intended independent variables. A useful terminology for this phenomena is to call the variables highly coupled.

Participant observation may then be used as a short-

hand for the formal acknowledgment within a theory of persons that such a variable system is highly coupled - i.e. that the observer is a participant in the generation of the data that he observes. I believe that Sullivan used participant observation in this sense and also in reference to the actual process by which the data of conversations is generated.

To say that the variables are highly coupled is not to say that they are reciprocal and equal in their influence upon one another. For the well functioning client it might be possible and even quite profitable to hold up as an ideal that the therapist shall do all that is possible to minimize his influence¹. I shall return to the topic of mutual though non-reciprocal influence with illustrations from my own work with flagrantly psychotic patients in Chapter 5 section B1.

In summary, I was initially struck by the lack of a universally accepted theory and method of psychotherapy, and also by the numerous difficulties in studying the process of psychotherapy. I decided to investigate the very way in which the data of conversations were generated. But when I thought about how such data must be generated, I was impressed by how that seemed to be strikingly like what I had read in Sullivan as participant observation. I, therefore, set about reading all of his works that I could and making a detailed study of his use of the term.

B. Development of the Concept: Participant Observation

From the group of slightly over 250 non-redundant references to participant observation which I have gleaned

1. See for example, interviewee #4's comments on not muddying the water.

from the published material of Sullivan, I have chosen five quotes to illustrate the development of his thought, and one quote which, initially, seems to contradict my thesis.

As early as 1927, Sullivan was saying "Perhaps these brief references suffice to preface a statement that the common field of research and clinical psychiatry is found in the observation of patients." (p. 313) But it is apparent that even at this date, Sullivan did not think that this observation could be undertaken in blissful unconcern of the effects of the observer. He goes on to say, "The personality of the observer must either be exterior to the scientific observations which he secures or be represented explicitly in their context when it enters into them." (Sullivan, 1927, p.315)

In 1931, Sullivan wrote

Some ten years rather close contact with sufferers of schizophrenic disorders culminated in the firm conviction that not sick individuals, but complex peculiarly characterized situations were the subject matter of research and therapy. (Sullivan, 1931, p. 980)

Implicit in his 1931 formulation was the idea that the observer of the schizophrenic situation is also one of the necessary conditions for the existence of the phenomena and hence is a participant in the generation of the observed data.

By 1937 he had become more articulate and explicit about the inevitably participant nature of the clinician researcher role.

The skill of the investigator resides not in achieving some fancied aloofness but in being free from serious inhibitions of his awareness as to the stream of events which involve him. The most general category of these inhibitions of awareness is the overweening conviction of authentic individual selfhood which permeates all the implicit and explicit communicative efforts of nearly everyone. (Sullivan, 1937, p. 848)

One of the many intriguing aspects of this statement is that as the role of participant observer begins to become clearly defined there appear corollary prescriptions for maximum role utilization.

Throughout the rest of his relatively short career Sullivan developed his notion of participant observation. In a lecture published in 1940, he defines psychiatry as follows:

We can study the phenomena that go on between the observer and the observed in the situation created by the observer participating with the observed. I hold that this is the subject matter of psychiatry; some rather remarkable results have already come from its definition.

(Sullivan, 1940, p. 12)

The following quote is one of his last and most refined statements on participant observation.

That which can be studied is the pattern of processes which characterize the interaction of personalities in particular recurrent situations or fields which 'include' the observer.

(Sullivan, 1948, p. 106)

In this very late work there is a definite theme that participants and observers are useful abstracts made from the more fundamentally existent interpersonal fields. These abstracts which are essentially the sense of "I" and "You" are created through the process of participant observation as ways of marking heuristically useful divisions between processes which in reality only nucleate in the organisms involved.

This idea is simpler than it sounds. It is similar to the way in which we abstract from the continuously changing flow of the weather four seasons, and assign these seasons semi-arbitrary boundaries. Once the seasonal categories are established, they quickly become reified to the degree that it can become difficult to notice that not all days of winter are

uniformly cold, or spring uniformly warm.

The following passage seems, initially, to be at variance with my interpretation of participant observation. This would be of particular importance as it is from the last series of lectures given by Sullivan prior to his death. As Sullivan continually modified his views and presumably refined them, it can be assumed that this represents his necessarily ultimate view of the matter.

The probable correctness of this particular inference - that the infant differentiates his experience with a 'real' mother into two personifications, that of the good mother and that of the bad mother - is suggested by the course of developmental events in which we can participate with increasing sureness from late infancy onwards. In other words, from later data - the implication of which is quite certain - I make inferences regarding what can be observed in the young infant that seems (sic) closely and logically related to these later data, even though the actual events at this early stage are beyond participant observation and therefore beyond a type of knowledge which is very convenient to have.
(Sullivan, 1953, p. 119)

Notice that it is possible to interpret this passage to mean that one cannot engage one's self in participant observation with young infants. One might even infer that such participant observation is impossible because infants do not speak. I think that an alternative interpretation is more nearly correct. "Actual events" may refer back to the putative cognitive operations personifying a good and a bad mother. Cognitive operations are unobservables, so while participant observation with young infants is possible, it is not possible with the actual events, the putative cognitive operations, under discussion in this passage.

There are three other aspects of participant observa-

tion that I would like to emphasize. It is important to note that the data of conversations are not entirely contained in transcripts of the statements involved. Secondly, if a theory of psychotherapy is created which includes participant observation as a concept, then the same theory cannot also include dualism as the two are logically incompatible. Thirdly, participant observation is compatible with the philosophy of science called operationalism; in fact, Sullivan almost certainly wrote a great deal of his theory with operationalism in mind as he specifically quotes P.W. Bridgman, a proponent of operationalism, for his definition of what constitutes definitions.

To illustrate how transcripts are not isomorphs of conversations consider that when A says to B "I loved it", B may sometimes correctly understand A to have meant "I hated it". A may have successfully communicated this reversal of meaning to B by an intonation which means roughly: understand this statement as its opposite. I, as a native language speaker of English, can usually recognize this intonation and typically distinguish between ironic and sarcastic intonations, but I have a hard time describing the intonations involved.

Simultaneous with the intonational modifiers are gestural modifiers. As Ekman and Friesen (1968) point out, a gesture alone may be a strong statement. Bending the fingers repeatedly toward the palm is sometimes the functional equivalent of the statement: "Come here". A gesture may become so forthright that it is more properly called an action.

For example, there is the instance of the rape victim who upon asking "Why me?" is told "Because I love you." The action of raping strongly modifies the meaning of that person's statement.

Given the evident modifications of meaning that intonation, gesture, and action can signal, I believe that it is proper, though unusual, English to speak of a conversation with no statements. This means that it is feasible, though hazardous, to engage in participant observation with a young infant. The hazard is that statements are, potentially, an instrument to increase the precision of a conversation; so conversation without statement typically increases the difficulties of attaining any given standard of precision.

Turning to the second aspect, dualism is defined as "A theory that divides the world or a given realm of phenomena or concepts into two mutually irreducible elements or classes of elements: as... "mind and matter". (Webster's Third New International Dictionary, 1971, p. 697) There is a sense in which participant observation is dualistic in that propositions are divided into the irreducible classes of observables and inferences. The more common understanding of dualism, however, is that there are minds and bodies, irreducible, and both necessary in a description of the universe. (Feigl, Maxwell, & Scriven, 1956)

Whatever the theoretical status of minds, bodies are objects. The primary descriptive¹, however, of participant

1. Primary descriptive is my neologism. I am unaware of any pre-existent term which is a name for that class of statements which are simultaneously underivable from any other statements in a theory and which 'point to' what in the outer world a theory is 'about'.

observation is interpersonal field. As field and objects are not members of the same logical class, it is erroneous to think in terms of minds and bodies at the primary descriptive level.

It is possible to abstract from the primary descriptive, secondary descriptives. When the primary descriptive is interpersonal field, the secondary descriptive is dynamism. In accord with Fuller's (1975) considerations on the geometry of thinking, I have redefined the term dynamism in a way which I think retains the 'spirit', so to speak, of Sullivan's definition. A dynamism is a pattern of events. This pattern is recognizable and definable by its emergent synergies.

Synergy is a term which, I believe, was used originally in medicine, to describe the effect of two differentiable organs working together, e.g. biceps and triceps working to bring about movement of the lower arm. I am using the term more generally to refer to all those cases in which the whole is distinctly more than the sum of the parts - e.g. a hand is more than a collection of fingers. Synergy is that which emerges when all the parts are assembled, giving a pattern its patternness. That which emerges is generally new functions or capacities. For example, guitar music is not possible without a guitarist playing a guitar.

At the primary descriptive level of interpersonal field, one would properly speak only in the rather awkward circumlocution me-and-you. At the secondary descriptive level, one abstracts from me-and-you, the dynamisms "me" and "you". This secondary descriptive level is the familiar realm

of persons. It is still mistaken at the secondary descriptive level of dynamisms to think in terms of minds and bodies for dynamisms, exemplified by "persons", are neither minds nor bodies.

As previously mentioned, it is not infrequently the case that some activity of a person 'within' the interpersonal field 'tags' him as fit to be considered as organism. At this level dualism is denied in favor of a monism in which minds are eliminated.

It appears that the actual nature of reality is such that the organism is prior. But the work of Piaget (1953, 1955) strongly suggests that, experientially, the original construction of the world is of an interpersonal field. It is only because we have lived so long with our later construction of a world of individual persons that the whole notion of interpersonal field seems strange and alien.

At the familiar secondary descriptive level of persons (dynamisms), it is useful to speak of operations. Operations are those actions of persons which are done wittingly, that is with full focal awareness.¹ What I mean by full focal awareness is more or less what is meant by doing something deliberately. If one is engrossed in the newspaper during breakfast and rather hazily reaches out, gropingly finds the coffee cup, and drinks the coffee in such a fashion that if one were suddenly interrupted and asked how

1. This use of operation is easily confused with the use of the word in cognitive operation. In cognitive operation, operation is used in the sense of an inferred function or transformation, not at all the same thing as an action.

much coffee is left, one would have to say 'I don't know', then one is not acting deliberately or with full focal awareness. Seeing the cup, smelling the coffee, feeling its weight and heat in your hand, tasting the coffee is acting with focal awareness or deliberately. This definition of operation seems reasonably in accord with the considerations of such philosophers of science as Kuhn (1962). By virtue of their being actions or performances, operations are, in principle, observable.

By the definitions of participant observation and operation, participant observation as a means of generating the data of conversations consists of an indefinitely large number of operations. In this way participant observation is compatible with operationalism. The operations that constitute participant observation are by and large observable because they are actions; being observable they can be described. This process of stating the operations involved in a process or method is called operationalizing. It is the aim of this thesis to begin the process of operationalizing participant observation.

C. Operationalizing the Participant-Observational

Way of Psychotherapy

Operationalizing the participant observation way of psychotherapy is an important first step toward achieving a reliable method of psychotherapy as an operationalized method is repeatable. Such repeatability does not, of course, extend down to the microscopic level of action. Operations are repeatable in Wittgenstein's (1953) sense of bearing a strong

family resemblance to each other.

Unfortunately such repeatability in no way guarantees reliability. Any psychotherapeutic intervention, copied from a supervisor or teacher, may not achieve the same result. The reason for the difference in results is that the actual number of variables affecting the psychotherapy situation at any given moment is quite large. The operation which appears to be appropriate upon consideration of variables 1 through n is actually incorrect upon consideration of variables $n+1$ through $n+q$.

Operationalizing participant observation has, at least, two other noteworthy values. Such a list might function as an admirable teaching aid in the education of a psychotherapist. Secondly, the act of operationalizing will give perspective on the question of whether there can actually exist a self sufficient theory of psychotherapy or if psychotherapy theory is necessarily either an application of personality theory or an adjunct to a cosmology. (Dubin, 1969).

As a first preliminary to operationalizing participant observation, some features of operationalizing and of the operations in themselves must be noted. Operations are rather typically nested. The statement "Go to the store and buy a quart of milk" is an example of what I consider to be an operation. It has nested within the implicit operation "Go to the dairy counter".

Operationalizing is subject to a reductionist criticism in which every putative operation is met with the ques-

tion "How do you do that?" It is true that reductionist criticism is sometimes helpful in exposing the shared cultural assumptions which are the actual source of the problem at hand. It is also true that reductionist criticism can be carried to a degree that is merely obstructionist.

My earlier example of an operation (buying milk) may, in some circumstances, be profitably reduced to the level of operation that would begin: "First, stand up." If this in turn were met with the question "How do you do that?", I would think it incumbent on the questioner for him to demonstrate that he does not know how to stand up. Thus, it is my intention to list operations in ordinary English, such as an intelligent native speaker of the language might be credited as knowing and formulate such precision of meaning 'within' the rather loose ordinary language meaning as seems helpful.

Thoughts, per se, are not operationalizable.¹ Statements which are instructions to think a particular thought are. Equally operationalizable are statements that offer as the reason for an observable action an unobservable thought. Neither of these types of operation is subject to the immediate observational test that an operation of the form "Go to the store etc." is. Therefore, statements concerning thoughts are less precise but nonetheless admissible as operations.

As a second preliminary, some facets of operational-

1. The fact of thinking may well be operationalizable with measures such as the E.E.G. Knowing that another is thinking does not, however, tell us what he or she is thinking, so thoughts per se are not operationalizable.

izing with regard to psychotherapy must be stated. I have assumed that the universe of psychotherapy is an extraordinarily complicated one, consisting of a large number of highly coupled variables. This means that it is impossible to formulate an exhaustive list. Therefore, no list is exclusive. Any list of operations of psychotherapy is prescriptive, but, except in rare instances such as a list of elementary operational ethics, these prescriptions would contain relatively few rules and a rather high proportion of heuristics because of the above mentioned complexities.

While any psychoanalyst, psychiatrist, or psychotherapist would probably agree that there are ethical considerations in this practice, I rather strongly suspect that I would be unable to state anything that all would agree upon as being one of those ethics. The general principle seems clear enough. The professional is there to render the service of psychotherapy/psychoanalysis. At the very least, he or she should do nothing that will worsen the patient/client's condition. (*primum non nocere*) It is when we attempt to translate this principle into operationalized rules that the bitter controversies begin.

As a third preliminary, it is necessary to make an opening statement on psychotherapy: something which is not quite a formal definition but which hopefully can be clarified into a definition after suitable study. People have problems, that is to say difficulties, for which the solution is not at all apparent, in their living. In the simplest case, a person, having problems in living which he believes are un-

necessary, solvable, and what he might describe as 'personal', (That is recurrent mistakes in the interpersonal fields.) hires the services of a psychotherapist. The psychotherapist works with him to formulate those factors which ultimately eventuate in these recurrent mistakes. Depending upon the school of psychotherapy, the therapist may also render professional assistance in the implementation of the solutions.

It seems to me that to say problems in living is to entail some notion of anxiety. A problem about which a person is not anxious may well be a puzzle with no ready solution. It is not, however, typically the sort of issue for which a rather large number of people would invest great amounts of time, effort, and money for no return other than the solution.

It is, if not necessary, extremely helpful to assume that the practitioner will not simply be given all the information needed to solve the problem. One aspect of this has already been mentioned in the observation that persons tend to adjust their communications to what they believe to be their listeners opinions of them. (Laing et al, 1966, Sullivan, 1954) This adjustment is or leads to a distortion of the information. Another aspect is that it is quite likely that the client/patient simply does not have the information to give. It is my personal opinion that human beings are so extraordinarily capable that whenever we have the relevant information at hand we quite readily dispose of our problems in one way or another. It is becoming quite clear on what the problem actually is that is, typically, the biggest problem

of them all.

As Fodor (1968) points out, there is considerable precedent for the kind of definitional unclarity which is exemplified by my statement on psychotherapy and by my omission of a definition of anxiety. It was after all the Pre-Copernicans definition of "planet" that was the ultimate source of the problem in coming to a workable theory of the spheres. (Kuhn, 1962) At their best, scientific definitions are after study and for the moment only.

To summarize: In the past forty five years there have been relatively few general principles of and almost no techniques for doing psychotherapy that have been universally recognized as efficacious by licensed practitioners of psychotherapy. Progress has been slow in articulating principles and techniques because of numerous difficulties such as the fact that data are of two types, individual and organismic, and that such data are only understood in terms of the intentionality of the doer and the history of the people involved. Further difficulties include the biasing effects of enculturation, the interaction of observer and observed, the preliminary cognitive processing of information, and dogmatic adherence to schools of psychotherapy. Lastly the data base itself may well have changed due to general cultural drift and the changing role of the mental health practitioner within that culture. I, therefore, decided to investigate the process of data generation.

First I attempted to demonstrate that individual data are primary, that the bulk of such data are interperson-

al, and that any datum can be considered as a member of an action-reaction sequence. I then argued that such sequencing implied that the observer of such data is an irremediable participant in its generation. This led me to review Sullivan's writings on participant observation from which I concluded that he thought that participants and observers were abstracts made from the more fundamentally existent interpersonal fields and that participant observation was his term for the means by which data was generated in such fields.

Finally, I made some preliminary statements on operationalizing in general, on operationalizing psychotherapy in particular, and on the nature of psychotherapy itself. Among these statements I would like to emphasize the following three: thoughts per se are not operationalizable, but statements about thinking are; any list of psychotherapeutic operations is neither exhaustive nor exclusive and will consist mainly of heuristics rather than rules; psychotherapy may be considered pro tem as that process through which problems in living accompanied by anxiety are alleviated by clarifying the formulation of the problem and (optionally) by helping to implement possible solutions. e.g. desensitization.

Chapter 2

Sullivan: His Historical Context and a Review of his Writing about Participant Observation

A. Intellectual Influence

The first step in operationalizing participant observation is to review the literature already existent on the subject. I concentrated upon the work of Sullivan for two reasons. It was Sullivan who originated the term, participant observation, and so his work, if anybody's, should be representative of this method of psychotherapy. Secondly, I have specifically avoided the work of the Sullivanians to obviate a potential problem. Sullivan (1953) states that one of the principle difficulties in the field is that it is relatively easy to come to use the same terms as another researcher or clinician, but extremely difficult to arrive at using these terms in such a way that they have the same meaning for both speakers.

To the best of my knowledge, Sullivan never stated directly how he arrived at the idea of participant observation. I think that it may have been one of those things that appeared to be so obvious that it never occurred to him that he should explain it. It seems most probable that there were four main influences upon him: his wide-ranging and intensive reading, his extensive clinical work, particularly with schizophrenic patients, his unique and personal history, and, perhaps most subtly, his position as an American.

The two most seminal intellectual influences may very well have been the Heisenburg Uncertainty Principle and

the combined work of the loose knit group known as the Chicago Social Scientists, most notably that of Thomas, Sapir, and Laswell. The uncertainty principle may be rather simply stated that it is impossible to specify that a particle such as an electron is at a given instant in time at such and such a point moving with such and such a velocity. The reason for this uncertainty is that the more you specify the one the less you are able to specify the other; the instruments that you are using to make the specification themselves exerting an influence on that which is to be measured.

I consider the following quote to be indicative of the way in which Sullivan took quite seriously the idea that you yourself are the primary apparatus in this work. "But if one is intent on refining one's self as an instrument of participant observation, it is necessary to pay the greatest attention, at least retrospectively, to those fleeting movements of anxiety." (Sullivan, 1953, p. 378) To me there is a nuance in this sentence and literally hundreds of others like it to the effect that Sullivan frequently had an eye on physics as being a model of the science that he would like to make out of psychotherapy. If this is so, then it is not any great inference to think that his knowledge of the effect of a physical measuring instrument on that which is being measured may have led him to think of the possible effects of that psychological measuring instrument - the clinician.

Sullivan's great familiarity with and abiding interest in the discipline of social science is not a matter of speculation but of simple fact. His personal friends included

Thomas, Sapir, and Laswell, all of whom are noted for their work in social science. (Perry, 1963) Thomas was in fact at one time president of the American Sociological Society. It is a matter of record that Sullivan was a prime mover at the First and Second Colloquia on Personality Investigation (1928, 1929), the avowed purpose of which was to survey the common ground, so to speak, of psychiatry and social science. (Perry, 1963) When he (Sullivan) helped found the William Alanson White Psychiatric Foundation in 1933, it was a social psychiatric institution from its inception. The same may be said for his journal, Psychiatry.

It seems to me that the area of social science has run considerably ahead of other person related scientific endeavors in its understanding of the interactive nature of personal encounters. There are several reasons for this. First, there is an implicit assumption that you automatically understand the meaning of an action of another when it is a familiar action to you. But when the other is doing something more or less alien to you as is more likely to be the case when you are in a different culture, then there is a greater chance of understanding that while what you are seeing is definitely patterned you do not yet understand the meaning. In this case the observer is more likely to feel that he must somehow understand the action from 'behind the other's eyes' as it were which is to say that there must be at least a vicarious sort of participation.

Further, the anthropologist in the field is more likely to see how his or her presence inevitably disrupts the

pre-existent patterns of life in the people whom he is observing. So the anthropologist is perhaps more aware of the inevitably participant nature of his observation. I say that the anthropologist is more likely to see the disruption because he or she is so obviously "the other" to whom some accommodations are being made.

Thirdly, the social scientist is not in much of a position to run controlled laboratory experiments so the emphasis on exact detailed observation must be greater. Where there is a conscious acknowledgment of his or her participatory impact, there may be guiding of this phenomena as a small scale experiment. Where there is such a guiding of the interaction, participant observation has come to full flower. But even without such an effect there is still an emphasis on staying awake, on using yourself as a scientific instrument.

Sullivan not only recognized the implications of those studies that demonstrated cultural relativity (a fact which I shall elaborate upon in the section, Sullivan as an American), but I think that he came to see very early in his development that what was true between cultures was also true within a culture. He thought that the behavior of the schizophrenic was not independent of the surroundings in which the person who demonstrated the schizophrenia lived.

B. Clinical Influences

This leads me to a discussion of the second great stream of influence upon Sullivan, his extensive clinical work particularly with persons suffering schizophrenic dis-

orders. Though I am describing the clinical work as if it were a separate stream of influence for the sake of expositional clarity, in fact the various influences are not so distinct. For example, William Alanson White, who was one of Sullivan's main teachers, was not only an exceptional teacher of clinical skills who had studied Freud at a time when he was almost literally unknown in this country, but was also extremely interested in social psychology. (Perry, 1962)

Some of the more important events in Sullivan's clinical career are these. He was hired in 1923 as an Assistant Physician to work at the Enoch and Sheppard Pratt Hospital. In 1925 he was made Director of Clinical Research, holding this position until 1930. It seems quite likely that he had some continuing contact with Sheppard Pratt until 1933. This work was predominantly with patients suffering schizophrenic disorders. Incidentally, Sullivan must have had considerable contact with schizophrenics prior to his accepting the position at Pratt because he says in his paper "Socio-Psychiatric Research: Its implications for the Schizophrenia Problem and for Mental Hygiene" that he had had intensive contact with schizophrenics for ten years. Since this paper was published in 1931, the latest that Sullivan must have begun his work with schizophrenics was 1921, a full two years before he was hired at Pratt.

In 1929 Sullivan opened an office on Park Avenue in New York City. He claimed that it was for the purpose of studying the obsessional disorder in the office patient. This

was undoubtedly true to some degree as Sullivan felt that the obsessional and the schizophrenic bore a considerable family resemblance to each other. (e.g. Sullivan, 1954) Nonetheless, I find it difficult to believe that anyone who came from the farming district of upstate New York could open an office on Park Avenue and be totally removed from a sense of status and prestige in so doing. With the move to Washington in the late thirties, Sullivan seems to have become less involved in the day to day contact with patients, though he remained in considerable contact with the clinical situation at one remove by his work as a supervisor, or what he would call a "chronic consultant". At the very least, he had some 16 or 17 years of prolonged and intensive work with patients.

At first glance, it would seem that the really quite unusual performances, which are characteristic of the schizophrenic, would not be the most fertile field for a researcher to discover the interactive nature of the psychotherapeutic relationship. It is, I should think, the schizophrenic who is the original for the cultural concepts of "the crazy".¹

But it is my opinion that the person who is suffering from schizophrenic disorder is at one and the same time exquisitely sensitive to what he or she feels to be the evaluations of the other, and flamboyantly responsive when he or she becomes anxious thinking that the evaluations of the other are

1. I am quite aware that the term schizophrenic is almost certainly a catchall for a variety of disorders and further that the signs which we label as a schizophrenia may very well be a final common path for a variety of psychological and/or physiological processes, and that not all of the fundamentally causal disorders may be interactive, but some are and it is this subset of the schizophrenias to which I am referring when I use the term.

negative. For example, one of my hospitalized patients was finally able after some weeks of intensive effort to attend a psychotherapy session in my office instead of in an on-unit room. The day of our next session I chanced to be ill. That night this patient requested that her status be raised by two levels, then paced the corridor gesticulating and grimacing until 4 A.M. following which she lapsed into silence. I believe that she felt my absence to be a negative evaluation. I think that an apt metaphor for this can be that the schizophrenic can be like a fun house mirror, distorting, enlarging, minimizing but definitely reflecting what is there.

Further, the effect of a timely and wise intervention may be dramatic. The person suffering from the disorder, suddenly released from some mistaken belief about social reality, will become much more coherent. Let me illustrate this with sections of the transcript of Sullivan's interviews with Mr. G.H., a young man of 24 whom Sullivan saw during his period of time at Pratt.

Here Mr. G.H. is discussing a former doctor who was quite curious about some possible incestuous homosexual relations between Mr. G.H. and his brother. Mr. G.H. is speaking with Sullivan.

G.H. - I slept with my brother 'till the war*** that homosexual feeling H- (the former doctor) spoke of. I'd tell him... anything, and... it seemed I got worse and worse. All our actions and talks were tensions between us, you see. (Sullivan, 1925)

Sullivan does not explain his use of asterisks and dots but after reading the transcript out loud I would say that asterisks indicate deleted material from the transcript and dots in-

dicade pauses in the conversation. The transcript continues

G.H. - I'm more or less... ambitious... and think more about getting out in the world and doing my share. I suppose you gain more by living than by sitting in a hospital*** I was thinking of my parents and wanting to be with them... that, and... then I felt I should have left... felt about well enough to leave, and I don't know why I didn't leave.***

H.S. - Are you unhappy?

G.H. - (smiling) I certainly am... the fact of being here... I suppose I feel it my duty to be out and ...*** I don't care to stay here, and I can't find the way out... (Sullivan, 1925)

The context to this particular discussion, is that Mr. G.H. had been attempting to leave by the simple expedient of walking out the door. Needless to say, this did not meet with the wholehearted approval of the attendants and nursing staff. His confusion as to the way out is definitely an indication of a certain concrete approach to problem solving, but I feel quite sure that it simultaneously reflects, in a distorted and exaggerated way to be sure, staff confusion as to exactly how one "gets better". Is Mr. G.H. a patient, who has to wait patiently until his mental illness heals, or a student who has to learn new ways of behaving and thinking?

Sullivan feels the fundamental unhappiness, comments on it, and sees the conversation change to a more straightforward discussion of Mr. G.H.'s feelings and thoughts. Countless experiences like this must have gradually impressed upon him how much of an effect he had on the people around him, and how senseless the notion of the observer was. At the same time, the generally confused presentations of schizophrenics must have forced him to develop his capacities for observation. He states directly in a much later paper (Sullivan, 1935) that

the major benefit of hospital training is that it teaches you to stay alert.

In yet another way, his experiences with schizophrenics may very well have led him to feel the participant nature of his situation with them. I cannot read the transcripts without feeling a variety of emotions most strongly. Confusion, irritation, pity, caring, shock, disgust, humour, liking, are all responses of mine. To speak colloquially, these patients really put you through the mill. The personal responsiveness, which I have and which I imagine Sullivan must also have had, blends into the third influence that may have led him to his formulation of participant observation, his personal history.

C. Personal History

Sullivan was born and probably raised as an Irish Catholic. As I, myself, was raised within this tradition I shall speak with rather more authority than I could possibly justify about some of the cultural values of this group. To begin with there is a particular texture to his use of language, namely the modifying of subject and predicate with a series of linked clauses, which clauses are roughly equivalent in both scanning and logical importance, that I consider to be peculiarly catechismal, not in the sense of proclaiming a somewhat dubiously revealed truth, but in the sense of reflecting the language style of Catholic catechisms. The sentence immediately prior to this is self-consciously and somewhat facetiously catechismal.

The cultural values which are reflected in this all

derive from a sense that things are very rarely clearcut and simple. Life at its best is delightfully complicated and obscure. While a rose is most definitely a rose, to call a rose, a rose, is to slander its nature which is a far grander thing than the word 'rose'.

Along with this sense that the unmodified noun is faintly perjorative, there corresponds a literary and intellectual style in which the many facets of a situation are presented in as near simultaneous fashion as possible. James Joyce epitomizes the style, and Helen Swick Perry has called Sullivan's prose Joycean. (Perry, 1962) I believe that both of these aspects of Sullivan's cultural heritage tend toward a sense of the interrelatedness of events. This feel of complex, obscure, simultaneous happenings seems to me, at least, to be a precursor for the understanding that anything you can isolate out as 'such and such' is actually dependent upon and also the source for many other things. This in turn is a very short distance from the concept of participant observation.

Sullivan was also raised on a farm with animals and without playmates. As anyone who has lived with cats, dogs, horses or what not can testify, there can be a very lively exchange between animal and human in which the animal has a quite good, though 'animalized', sense of the differences among persons. The same horse who is extremely gentle with the child rider seems to have dedicated his life to the bedevilment of the experienced rider. Living with animals can definitely result in a sharpening of the capacity for observ-

ing one's effect on the world, particularly as there is no maze of words surrounding the obvious. The animal balks or trots, no explanations given or received.

Growing without playmates can also sharpen one's capacities for observing though under distinctly less happy circumstances. It becomes most quickly apparent to the isolate when he or she is finally thrust into the rough and tumble of peer interactions that there are both rhythms and rules to these matters which had best be learned quickly lest one suffer further devastations. When Sullivan says, "The working out of isophilic tendencies (by the isolate) is not satisfactory and is ... (achieved) usually with caution learned by disappointing, if not actually painful experiences." (Sullivan, 1932, p. 161) I get the sense that he may be remembering his own development most acutely. While it is possible for the social or cultural isolate to become quite adroit at social relations, I think that the initial lessons must, inevitably, be extremely painful. This may well have been true for Sullivan. If that is so, he may have been vividly impressed by the fact that the world reacts to one's actions, which changes one's actions, which are followed by different reactions.

D. Sullivan, The American

The fourth and last influence upon Sullivan was that he was an American. This is actually a vast and complex set of influences, but I shall refer to only three: our cultural values which are pragmatic, empirical, and democratic, the clash of these values with the fact of an increasingly strati-

fied class society, the cultural upheaval incumbent upon the sudden exposure of radically different cultures to one another in the great American cities.

Sullivan's work is imbued with a highly democratic belief system. Nowhere is this more evident than in what he calls the one genus postulate, "Everyone is much more simply human than otherwise." (Sullivan, 1953, p. 32) Participant observation is an equally democratic notion in its implicit sense of equality. No one is an observer set apart like a king in his castle or a professor in his university but all are participants in the situation. There is to me, at least, a nuance of the democratic notion that he who works hardest becomes richest in the emphasis on becoming an observant participant.

Participant observation seems to be of a piece with the pragmatism of James and Dewey and the empiricism of Hume, Berkeley, and Locke, who, if not American, have nonetheless developed a philosophy which seems to be the verbalization of the American Weltanschauung. If knowledge originates in experience (a basic empiricist doctrine), and if truth is tested by the practical consequences of belief (a basic pragmatist doctrine) than what better way could there be for a psychiatrist to gain knowledge than by participating in situations with his patient? What better way could he use to arrive at truth than by observing the immediate practical consequences of his belief?

If America is the land of the democratic (though sexist) value that "Any boy could grow up to be President.",

it is also a nation whose frontier closed around the time of Sullivan's birth. It seems to me self evident that rapid upward mobility for many where the upper classes are defined by more possessions is only possible when there is a equally rapid expansion of availability of raw materials. Sullivan was born into one of the first generations of Americans who were raised with a belief that was becoming harder and harder to actualize. I think it axiomatic that if you are raised with a particular belief and slowly learn that it is not so, you tend to place a greater trust in and emphasis upon your own powers of observation than you otherwise might.

Lastly, America is a nation into which there have been large immigrations. The result of this is that people from as radically different cultures as Irish, Sicilian, Middle European Jews, and British have been living within blocks of each other. One result of this is that many of the things that you take so much for granted as being "the way things are" that you are never very aware of them suddenly become glaringly highlighted when you see someone doing it quite differently. This is particularly poignant when you are trying to adapt sufficiently to the mainstream culture so as to "make it in America".

For example, I have been told that older orientals and especially Japanese are disgusted by the use of a pocket handkerchief instead of disposable paper tissue. To them the idea of blowing your nose into a piece of cloth, refolding the cloth, and placing it in your pocket is only one step removed from defecating onto a piece of cloth, folding the cloth

around the feces, and placing that in your pocket.

When such cultural contrasts occur, I think only one or more of three outcomes are possible. The person denigrates his own culture, belittling it and feeling ashamed of his or her heritage. The person develops an elaborate system of stereotypes and prejudices particularly where the majority of the members of the other culture have a different appearance. The person becomes aware of different ways in which life can be lived and begins to wonder just how much he actually creates the familiar world in which he lives. This last outcome seems to me intimately related to participant observation, for it implies that we participate in the creation of that which we observe.

Having formulated four influences that I believe to be the most probably instrumental in leading Sullivan to formulate his concept of participant observation, I shall now present two final preliminaries before listing the operationalizations of participant observation that are present in Sullivan's published works. They are a description of what I believe to have been the actual theoretical status for Sullivan of "participant observation" and an overview on what Sullivan thought he was doing in psychotherapy.

E. Strategic Operations

In chapter one I spoke of participant observation as referring to a belief in a philosophy of interconnected variables and also to a way of doing psychotherapy that is based on that philosophy. I have also somewhat loosely referred to participant observation as a "concept", an "idea", or a "no-

tion", using these last three terms in a roughly synonymous fashion. But neither "belief" nor "concept" adequately characterizes what I believe to have been Sullivan's own view of the matter. I think that if he gave much thought to the matter at all, he simply saw participant observation as a descriptive phrase like "peach tree" or "phototropic response". It was for this reason that I believe he never stated from whence he had developed the idea. The influences upon his life were so pervasive that it was simply not an idea.

The simplest way to detail Sullivan's views¹ on what the actual work of psychotherapy consisted of is to let him speak for himself.

"My work with a stranger soon becomes a mapping of the areas in interpersonal fields in which he becomes anxious-which can be said to mean that he there tends to "pull away" - to explore many leads as to the historic why and distorted present that account for these incidents of anxiety: to elevate what I observe to lucid attention, when and if that can be done without a defeating degree of anxiety, and then, by stating the problem as I have surmised it, establish a beginning collaboration for its remedy." (Sullivan, 1950/1964, p. 331)

Some of the following do not exactly meet the criteria of operations, but they are extremely close and seem to imply actual operations, so I have chosen to include them. I believe that the correct term for these near operations is aphorisms.

I have grouped the operations into two types, strategic and tactical, with numerous subgroupings within each type. Strategic operations are those which are either general

1. I am not claiming exclusivity or originality for Sullivan's views, but only that these are his views. See for example Chapter 3 Section B for a discussion of 'participant observation' vis-a-vis 'transference and counter-transference'.

procedures to be kept in mind more or less throughout the course of psychotherapy or procedures which establish one or another of the fourfold division that Sullivan (1951) makes of a course of psychotherapy. This latter group is included within the strategic because the procedures that establish the divisions have to be maintained throughout in order for the divisions to actually exist. Strategic operations tend to be heuristic except for the operational ethics.

Of these strategic operations, the most general might be called the principle or procedure of tripartite functioning. The therapist has three tasks: to understand what is being communicated to him; to see that he is understood; to watch for the possibilities of the immediate future of the ongoing interpersonal relationship. (Sullivan, 1951, 1952, 1953, 1956) This is an example of an aphorism, I believe.

In elucidating the task of understanding, Sullivan (1954) says "It is simply incredible how wrong you can be if you simply assume that what a person says about his earlier jobs means what you think the words do." (p. 175)

A principle difficulty in attempting to understand what a person means by what he says is that one must be doubly wary of those statements which are truisms. Sullivan (1954) believes that the more closely a person's statement conforms to the cultural convention, the less sure are you of what he might have meant. For example, a man may say "My wife is great" more or less without any reference to anything the woman might or might not be doing. Sullivan (1954) was careful

to emphasize that in this situation especially, the therapist must covertly question himself as to whether any statement might not mean something other than his first impression.

One counteractive to this problem of the client who speaks in cliches is to make rather sudden transitions in topics. This is done to break the "set" of the client in order that he might really consider the question. (Sullivan, 1954) Hopefully, the transitions will not be so sudden or so great that they leave the client completely befuddled as to what is going on. (Sullivan, 1954)

This introduces the fact that there are several different ways for the psychotherapist to verify much of the material being presented to him. Sullivan (1954) emphasizes that much of this verification should be done covertly. Obviously, if the therapist is to be aware of the most probable future of this particular interpersonal field (Sullivan, 1951, 1952, 1953, 1956), he would quite soon notice that there is hardly a better way to ensure its rapid disintegration than by continual questioning of the client as to what he means by such and such.

Sullivan highly recommends the use of the indirect question as a verification procedure.

"The indirect question, composed of running comment, additions, corrections, and so on which imply what you want to know, or suggest the information desired, is perhaps the ideal way of getting information in such a way that you can be reasonably certain of what is communicated." (Sullivan, 1954, p. 222)

At first blush it sounds as if Sullivan is recommending a method which is essentially leading the witness, but actually, this particular procedure is partially a guard against the self-fulfilling prophecy effect. The key word is indirect.

Consider the following hypothetical dialogue. It is the opening session; client, an adolescent male, is discussing his family.

Client: "...I have two brothers..."

Therapist: (Expecting number of sisters, if any) "...and..."

Client: "Nyeah, I never did like either of them."

Part of the process of attempting to understand, but also a major part of the work to prevent the interpersonal relationship from disintegrating is the ability to become and remain aware of what you are doing. (Sullivan, 1935, 1951, 1952, 1954) As Sullivan puts it:

"It is much more accurate to say that the experience of the psychiatrist is synthesized into an aptitude to do nothing exterior to his awareness which will greatly handicap the development of the interview situation..." (Sullivan, 1954, Pp. 68-69)

He does not state exactly how this aptitude is learned or maintained, but he does say that it is developed in the course of hospital training. (Sullivan, 1935)

One operation that Sullivan considers useful in the attempt to understand is that the therapist should look for changes in attitudes, topics, and the like by the client and make a particular note of what he might have been doing that could be causally related to the observed change. (Sullivan, 1954) One aspect of being prepared to note changes in attitudes which might not be immediately apparent is that the therapist should have a reasonable idea of the usual impression that people have of him in this situation so that he may be sensitized to changes among particular clients. (Sullivan, 1954)

By this watching for changes, the psychotherapist may be more aware of when the client is adjusting his communi-

cative efforts (distorting information). A procedure in several parts then follows. First, attempt to get some idea of the theory concerning the therapist that may be motivating the person to so change topics, attitudes or the like. (Sullivan, 1940, 1954) Second, review the situation covertly so as to check for the exclusivity of your hypothesis concerning his theory. (Sullivan, 1927, 1940) Speaking less exactly but more colloquially: before you act, think it over to see if you may have missed something. The similarity between this and Laing et al's (1966) conception of perspective, meta-perspective, and meta-meta-perspective is, by the way, striking. Third, make a judgment as to the most likely amount of anxiety to be produced by your calling this possible belief of his to question. (Sullivan, 1954) Fourth, do something to check your hypothesis, but which is calculated to not arouse such overwhelming anxiety as to lead to the disintegration of the interpersonal field. (Sullivan, 1954)

The operation of the therapist by which he checks his hypothesis is by no means necessarily indirect. It all depends upon his evaluation of the probable amount of anxiety to be generated 'within' the client. Sullivan has said things as direct as "Well, am I supposed to think very badly of you because of that?" (Sullivan, 1954, p. 225)

If the clinician ascertains that the client is, indeed, cherishing some delusory belief, a second multi-step procedure has to be instituted.

"He (the client) has to be led to observe closely, to catch on to the exact functional activity concerned - the "personal use" of the belief to him;

then to see that the formula is by no means the best for achieving a useful end; and only then can he go about using his abilities to be "more realistic" less defensively vulnerable in the field of collaboration." (Sullivan, 1950, p. 138)

Sullivan's phrase "defensively vulnerable" is apt, but perhaps a bit too terse. I think he means to say that the very things that we do to defend ourselves from interpersonal anxiety (our security operations) frequently have as their overall effect an increase in our anxiety. For example, I clearly recall from my own adolescence feeling anxious while courting a would-be sweetheart and hence exaggerating some capacity of mine. I then lived in utter terror at the prospect of having to demonstrate this non-existent capacity. My security operation had rendered me "defensively vulnerable".

What is perhaps the single greatest interference both in the process of making one's self understood and in understanding is that of anxiety. Sullivan (1953, 1954) felt intensely that for a client to be experiencing either too much or too little anxiety would be distinctly counterproductive. Sullivan (1954) mentions two operations in which the therapist can engage himself so as to increase his sensitivity to the client's anxiety. The first of these is to be alert to minor movements of anxiety 'within' himself with a very careful eye to identifying the causes of these movements. (Sullivan, 1954) Searles (1965) advocates this kind of self awareness also. The second operation is to listen quite closely to the tonal quality of the client's voice as Sullivan thought that the voice was the most sensitive leading indicator of anxiety. (Sullivan, 1954)

If it was his judgment that the level of anxiety was too low to be productive, Sullivan (1954) would increase the client's anxiety by changing the flow of questions, or by showing mild irritation. This latter is to be feigned as Sullivan (1954) also thought that a reactive display of anger was tantamount to a shortcoming in interviewing skills.

If, on the other hand, he felt that the client's anxiety was increasing too rapidly, Sullivan would try one of several operations designed to decrease anxiety. As detailed above he might challenge an idea of the client's that he (Sullivan) was thinking badly of him (the client). (Sullivan, 1954) Another possibility was to acknowledge the anxiety and change the topic as follows: "You're getting quite anxious, aren't you? Well, what's the hurry about this? We can drop it and go on about so and so, can't we?" (Sullivan, 1954, p. 224)

A third procedure designed to minimize the increase of anxiety is that in the situation when the therapist is about to make an interpretation to the client, he should wait until this interpretation is almost self-evident. (Sullivan, 1956) This is most likely to work well if the psychotherapist does not have his own prestige "bound up" in the interpretation. (Sullivan, 1940) Matters of prestige are least likely to be involved if the therapist can typically maintain two alternative interpretations (delivering the most likely) and if he or she can maintain a fundamental commitment to observing the client-therapist situation as it actually is. (Sullivan, 1940, 1954)

There are two operations in which the therapist can

engage himself so as to maximize the possibilities of being understood. The first is that the therapist should try to keep the meeting focused on rather clearly formulated issues. As Sullivan (1954) puts it "Insofar as the work permits, the psychiatrist should try to proceed with simple clarity."

(p. 220) The second operation is that the therapist must continually make judgments as to the attention span of the client and be very careful that his statements not exceed in length this most probable attention span. (Sullivan, 1940)

Turning to the third function of the psychotherapist, Sullivan writes of two main ways in which the clinician prevents the disintegration of the therapy relationship. The first of these is the already discussed group of operations designed to prevent the untoward growth of the client's anxiety. The second is to attempt to construct each interview situation in such a way that the client may realize some immediate benefit.

This latter is, of course, an aphorism from which many operations may be derived. For example, if you think that the most likely prognosis for a person who is experiencing some delusions is a rather rapid progress into an openly psychotic state, you do not warn him of his imminent danger. You rather suggest how he might profitably reconsider some aspects of his life situation.

Another major type of strategic operation is that of the operation specific to a particular phase of the psychotherapy. Sullivan (1951, 1954) defines the four phases of a psychotherapy session or group of sessions as the formal incep-

tion, the reconnaissance, the detailed inquiry, and the termination.

Although the attitude of great alertness is to be maintained throughout the period of contact with a client, Sullivan (1940) mentions its especial value during the formal inception. One way to ensure this attitude of alertness is to remember that the person whom you are about to meet is a stranger and is to be treated as such. (Sullivan, 1951, 1954)

This has several aspects. The therapist should be wary of extending his prejudices onto a person if he or she happens to fit a stereotype. (Sullivan, 1956) Secondly, one does not treat a stranger with the same kind of chummy closeness that one treats a friend with whom there has been a considerable prior relationship. Thirdly, a stranger is treated with respect. (Sullivan, 1954)

The formal inception is followed by the reconnaissance. Sullivan (1940) emphasized that in this reconnaissance or initial formulation of the problem, the psychotherapist would be well advised not to deal with such hypotheticals as personality, but rather to make a considerable effort to discover how the person has come to arrive in this particular situation. In order to facilitate this, the therapist should shift his behavior with a person not on the basis of a (perhaps) pre-determined diagnostic statement, but on the basis of the observed facts of the relationship as they unfold during this interview. (Sullivan, 1954)

Sullivan (1954) asserts that the reconnaissance should be concluded with a summary statement which is to con-

sist of what the psychotherapist has appraised to be problematical and susceptible to the efforts of psychotherapy. Needless to say this appraisal of what is a problem should be based on what has actually been participantly observed as opposed to a set of preconceived notions. (Sullivan, 1954)

For example, let us say that a woman in her mid-twenties has come to you with the complaint that people at work do not like her. By the conclusion of the reconnaissance you feel that she might be justifiably described as a paranoid schizophrenic. It would certainly be reasonable to assume that difficulties with the care givers during her early development most probably occurred. But if there has been no mention of mother you do not haul her in as a diabolus ex machina during your summary statement. Such a sudden change in the cast of characters can only leave the client either mystified as to why you would say such a thing or awe-stricken at your clairvoyance. Neither attitude will make your job any easier.

It is during this summary that the requirements that the therapist be a source of unusually accurate information and that he so construct the situation that the client be able to perceive a constructive step must be most carefully balanced. Sullivan (1954) warns that the frank delivery of a negative prognosis can be extremely destructive.

In the delivery, and especially in the covert preparation of this summary, Sullivan mentions that the psychotherapist may frequently feel despairing. He believes that this experience of despair originates in the fact that summarizing more directly than most other activities of psychotherapy draws

on the life experiences of the therapist and hence spotlights the clinician's own problems in living. (Sullivan, 1954)

The summary is concluded with a contract in which clinician and client agree to work on one or more of the problem areas as formulated by the clinician and as amplified and amended by the client. With this contract, the psychotherapist begins the detailed inquiry. Sullivan believes that it is during this phase that the psychotherapist will have to call most heavily on his skills and abilities in recognizing and maintaining an appropriate amount of anxiety. This is rarely a matter of increasing anxiety. More typically, the task is to avoid arousing a hindering degree of anxiety while obtaining reasonably reliable information as to what the client believes to be 'going on in' the problem area. (Sullivan, 1954)

The detailed inquiry is concluded with a termination. The recommendation of Sullivan is that this termination be made clearly and formally. The ideal termination includes a sort of summary statement of this time period's work and a prescription for action which implies a constructive perception of the situation. All of the considerations with regard to the summary of the reconnaissance apply to the summary of termination. (Sullivan, 1954)

The last major group of strategic operations are the strategic "not" operations. These are general behavior patterns which are so typically followed by disasters that Sullivan singled them out as examples of what not to do. The first and most important of these is to avoid precipitate and rigid application of technique. (Sullivan, 1931) One sure example of this is the

sign-significator fallacy.

As a hypothetical illustration, a clinician might decide on the basis of a single instance of suspiciousness that a person was habitually and unduly suspicious. The clinician by following the 'Sullivanian rulebook' would then proceed to be disagreeable to this person in order to facilitate the acquisition of further information. Suppose that the person in question is fundamentally shy and has chanced upon a particular device in this instance to bolster him or her self against shyness. The device is to question the comments of the clinician. The clinician interprets this questioning as paranoia. Disagreeableness, in this situation, could do little other than convince the client that psychotherapy was at best a hazard.

A second "not" operation is to not allow a client or a hospitalized patient to disclose some profoundly disturbing event at the end of a session. The reason is that it is necessary to ascertain that the person is neither contemplating drastic action in remorse nor believing that his disclosure has precluded any further relationship with the psychotherapist. (Sullivan, 1940)

Sullivan (1954) strongly and repeatedly emphasizes that the psychotherapist is not to appear surprised at any communication he receives from a client. His rationale is that the clinician is supposed to be an expert in interpersonal relations and experts are not surprised in the course of duty. I can understand this more easily on the basis that it is not uncommon for the client to be hypersensitive of and

hyperreactive to the psychotherapist's opinions. One would not wish to exacerbate any disturbance by appearing surprised or, especially, shocked at its disclosure.

Fourthly, there arises the situation in which the client appears to be deluded. A delusion may be defined as a relatively fixed belief about the nature of reality that is grossly discordant with reality as socio-culturally defined, that is not subject to change by rational argument and that is not in keeping with the person's subculture.¹ Sullivan suggests that one should not simply say "ummmmmm" or even worse, ignore the delusion. He prefers that you should first confirm that your understanding of what the client meant by what he said is correct. You should then say something on the order of "I can scarcely believe it. What on earth gives you that impression?" (Sullivan, 1954, p. 234)

Sullivan's recommendation contrasts strongly with the findings of Ayllon and Haughton (1964). They theorized that delusional utterances are primarily maintained as utterances by the reinforcers they receive. Working with a 47 year old woman who had been hospitalized for 16 years, delusional references were extinguished by withdrawal of the reward of attention while more normative speech behaviors were rewarded

1. I have always been uneasy with this, the accepted definition of delusion. I think that we should make a distinction between idiosyncratic culturally-deviant beliefs that are not subject to proof or disproof by reason e.g. demonic possession and idiosyncratic beliefs maintained despite disproof by reason e.g. my patient's belief that electronic listening devices were implanted in his teeth despite negative x-rays. The fact that any number of people should hold a belief of the second class does not, in my opinion, render the belief any less delusional, only less immediately troublesome.

with cigarettes and attention. What is unclear to me is whether the woman in question was simply rendered less of a management problem or whether she experienced herself as receiving some benefit from the procedure. Further, as anyone who has spent much time around a psychiatric hospital is well aware, cigarettes are usually the main medium of exchange. So the question arises as to whether the woman actually experienced fewer delusions, and hence voiced less delusional utterances, or whether she learned to keep her mouth shut in order to earn the cigarettes.

Questioning a delusion need not and, I think, should not have an inquisitorial element. Sullivan gives an example which shows nicely the balance between questioning and consideration.

"Let us take, first, the concept of the patient, say Johnnie Jones who comes to you (the psychotherapist) "because" he says "someone is trying to poison me"... You say "So! What makes you think so?" The ejaculation "So!" we shall assume conveys to him a hint of astonishment and chagrin." (Sullivan, 1947, p.359)

Fifthly, the psychotherapist is advised to not begin a manner of acting toward the client which may likely prove to be impossibly difficult of maintaining. (Sullivan, 1954) In practice, this means the adopting of a consistent manner which is comfortable enough for the clinician that he will feel relatively secure of his ability to maintain this manner under a wide variety of circumstances.

One of the few aphorisms which is a rule is that the clinician is not to gain personal satisfactions or enhance his self-esteem at the client's expense. (Sullivan, 1954) This implies obvious operations to be avoided such as neither bor-

row money from nor have sexual intercourse with your clients. There are less obvious injunctions implied such as not displaying erudition when a simple comment will do. Finally, some operations which are extremely difficult to detect as part of one's repertoire are nonetheless to be eschewed as detected. An instance of this is the tendency to shape a client to fit the clinician's pre-existent theory rather than the reverse.

In chapter one I wrote of the difficulty of specifying ethics when the general principle is that at the least, one should provide no treatment that will worsen the patient's condition. One of the circumstances that I had in mind was that I have heard in the past few years the argument made that coitus with one's (attractive) female patients has been of some benefit to them. To me, this is patently absurd, but treatment strategies can be argued interminably. The singular advantage of Sullivan's dictum that personal satisfactions and especially esteem enhancing maneuvers are to be eschewed is that such travesties as coital-treatments are distinctly ruled out.

I would like to add a "not" operation of my own. The psychotherapist is not to downgrade intuition. Rather, covertly attempt to verify or disprove the intuition. Consider the case of the general practitioner who referred three draftees to Sullivan.

"That was amazing. Here were three people. We see two and both of them are the sorts of people that a psychiatrist should see. (The third had not waited for Sullivan's arrival.) This was interesting enough, so I went out and discovered that the good

old general practitioner was responsible for all of these references.

"Why in the world did you send these people to us?" I asked him.

He was embarrassed and replied "Why (sic) wasn't anything the matter with them?"

I said, "Well, before we go into that, tell me why you sent them to us?"

He said "As I was going over them, I got the impression there was something odd about them."

(Sullivan, 1940, p. 203)

This concludes the group of strategic operations.

The tactical operations which follow are of three main but not exclusive types. Some tactical operations are illustrations of an application of one or more strategic operations. Some are specifically designed to meet one or another common impasse in psychotherapy. Others are intended to be useful with a particular type of client.

F. Tactical Operations

Given the strategic operation of maintaining an optimal level of anxiety, the task with a terrified psychotic patient is to reduce anxiety. Sullivan believes that if you can hearten him or her to the task of observing what provokes this fear, the terrified person may realize that the threat was apparent rather than actual. If, however, you attempt to reassure him or her, you are almost certainly foredoomed to failure. (Sullivan, 1956)

A related situation is that in which you are working with a client who has an ongoing significant relationship attended by a degree of anxiety sufficient to encloud the understanding of what is occurring. Sullivan (1956) says, that in the particular case of a detached isolated woman married to a man who was abusing her, he would start at a point in the not

too distant past of the relationship and work slowly toward the present. The parallel with Wolpe (1958, 1964) and with Lazarus (1971, 1972), who have attempted to apply the originally experimental paradigm of graded hierarchies to clinical material, is striking.

Still a third related situation is one wherein the client's level of anxiety is rapidly rising, which is entirely equivalent to saying that the interpersonal field is disintegrating. (Sullivan, 1953) In this case, the only operation possible to the psychotherapist which may have some positive effect on the situation is a covert one. The clinician should observe closely his or her own attitude toward the client and hypothesize how this might be instrumental in bringing about the presently disintegrating situation. (Sullivan, 1954)

This is sometimes obvious as when the psychotherapist has, due to his own problems, taken a significant dislike to the client in question. It can, however, be as convoluted as the psychotherapist feeling a great warmth and compassion for the client while the client understands this as pity for a hopeless case.

One frequent dilemma for the psychotherapist is the client who wishes to be given advice on a problem when it is the client's construction of this problem which is the fundamental problem. Sullivan (1954) says this: "Why pick on me? You can ask anybody, anywhere, for advice and get it. Now why in the world waste your time with a psychiatrist by asking for advice?" (p. 212) If Sullivan left it at this, he would most probably be violating his strategic operation that the inter-

ventions of the psychotherapist should lead to a constructive action from the client's view. Fortunately, Sullivan (1954) goes on to say that he would then outline the general problem as he saw it, of which this specific request for advice was an instance, and advise treatment for that.

There are other objections, however, that are best articulated by imagining one's self in the situation. In the first place, if I were on the recipient end of such a statement, I would feel chagrined that I had not known what the psychiatrist's function was, befuddled as to what he was supposed to be doing, and too embarrassed to ask because I was chagrined that I hadn't already known. This may be my personal problem, but then personal problems are what you expect the client to have. In the second place, there is an implication in that answer that the psychiatrist does not give advice, when I believe that even the most conscientious analyst does, on occasion, give advice - and rightfully so. There are situations that call for advice giving.

This implication is most unfortunate as Sullivan was not against the giving of advice. For example, he says:

"In other words, since the psychiatrist is an expert in interpersonal relations, it is not at all strange that the patient comes to the physician expecting him to handle things so that the patient's purpose will be served: namely, that his assets and liabilities in living will be correctly appraised, and that his difficulties will be tracked down to meaningful and remediable elements in his past - or that he will be advised, for instance, to divorce his wife in case she is really his trouble instead of his past."

(Sullivan, 1954, Pp. 29-30)

I would modify Sullivan's approach and say something like the following. "I think that if I did give you this ad-

vice you are seeking, you would probably feel much better until you stopped to think that you were paying good money to get what practically anyone will give you for free, namely, their opinion. What I can do that is very worthwhile is to help you learn how such situations arise that leave you feeling that you need my advice."

A psychotherapist must often act under great time pressure. In this situation it is helpful for the clinician to have developed a capacity to behave in such a way as to minimize the cues as to his favorable or unfavorable response to the client's previous statement. (Sullivan, 1954) I suspect that the mechanism of action here may be implicit in the notions of attributional theory as developed by Jones et al (1972). The client becomes cautious of elaborating what might possibly be 'bad' answers.

There arise occasions in the practice of psychotherapy in which the psychotherapist wishes the client to engage in a specific technique. In Sullivan's time, the technique was mainly that of free association. Sullivan found that a description of the technique and an exhortation to perform said technique were not notably effective inducements to practice. He eventually discovered that if he could induce a few demonstrations of the technique working successfully, and then point to those successes, he was marvelously equipped for enlisting the client's aid in this particular practice. He also discovered that this original induction was most facilitated by treating the matter rather casually. (Sullivan, 1954)

Clients report daydreams - what Sullivan calls a willed fantasy. Sullivan (1953) highly recommends that the psychotherapist should carefully attempt to prise out those components of the daydream which are essentially planning for the future from those components which are not readily understood in this way. The point of this I think is that Sullivan had a considerable respect for the adaptive capacities of people and would be quite pleased to let embryonic plans alone to be developed in fantasy. It would be the remainder to which the psychotherapist might most profitably turn his attention.

As previously mentioned, tactical operations include a sub-class with reference to heuristic sub-groups of client type. The diagnostic system as presently used has been repeatedly shown to be of low reliability and validity. (Zubin, 1967, 1972) Nonetheless, it is a shared vocabulary even though the referents be loose, so I shall use it in what follows while attempting to specify average expectable behavior patterns. This is an attempt to implement some degree of diagnosis as strategic understanding. (Bachrach, 1974)

G. Diagnosis

Sullivan (1954) has defined the essence of the schizophrenic state to be the failure to restrict attention to those referential processes that can be consensually validated. It has been objected that this definition would mean that a person would be schizophrenic during orgasm because there are components to that experience that cannot be consensually validated. I do not think that Sullivan was speak-

ing of any such immutably private experience as orgasm when he used the phrase "referential processes". In fact he says that he wishes to avoid the immutably private. (Sullivan, 1953)

What I understand him to be referring to by his phrase, "referential processes that can be consensually validated", are phenomena such as he describes in his 1925 paper on peculiarity of thought in schizophrenia. For example, Mr. E.K. understands the phrase "I'd like to make five dollars today" to be an accusation that he was a homosexual who enjoyed the practice of fellatio. Mr. V.H. says "I'm afraid of getting into more minds" when the context indicates that he means in consensually validated language 'I'm afraid of being unduly influenced by you'. Mr. W.Q. gives "herditiary" as his association to the word table. Finally, what is the most clear example of this sort of spread of personal meaning is Mr. G.H.'s account of how license plate numbers carried secret information about the girl with whom he was infatuated.

In short, I think Sullivan to mean the unwitting substitution of personal meanings for the established ones of words and sentences. These personal meanings may be more or less permanently attached to words which have other consensual meanings. This may be accompanied by the coining of neologisms which the creator is unable or unwilling to define, or which may not have a stable meaning at all.

Where I think his definition is lacking is that in his emphasis on the essence of the schizophrenic state there

is a neglect of the difference between the person who becomes hospitalized and the one who does not. The person who becomes hospitalized may not indeed be experiencing anything that everyone has not at some point in his or her life experienced. The schizophrenic, however, experiences these highly personalized referential processes more frequently, perhaps more intensely. It is important to note that a person is only recognized/diagnosed as schizophrenic when they frequently give voice to these experiences. So I would define the schizophrenic for the purposes of this discussion as one who habitually fails to restrict his attention to consensually validated referential processes and who likewise cannot restrain himself from voicing these idiosyncratic references.

After working with schizophrenics, Sullivan (1929, 1940, 1954), Searles (1965), and to a lesser degree, Laing (1969) individually concluded that these persons suffer a high vulnerability to anxiety. Sullivan therefore devotes considerable attention to operations designed to reduce anxiety. He suggests that one way to do this is to make your statements to such a person very ordinary and commonplace, not surprising. (Sullivan, 1940) It has been my experience that should you do telephone crisis intervention this is likewise a good tactic to take with people who telephone because they are panic stricken at their personal experience of the effects of L.S.D.

With regard to that sub-group of persons who experience catatonic processes, Sullivan (1954) says this:

"I reduce my attempted communication to certain things which seem to me so very highly probable that the chance of their being irrelevant are small...if I go to a lot of trouble to avoid misunderstanding about what I am trying to communicate, it does have an effect even on these least communicative of people." (p. 207) For example, I recently began work with a young woman who was hospitalized because she had been chronically dysfunctional for the past four years. While not strictly speaking catatonic, this person did choose to remain mute for the first 20 sessions. During this time I restricted my comments to the following two themes. One: I couldn't know very much about her while she remained silent, but she looked like she was unhappy and confused, and I would assume she was unless she said otherwise. Two: It was her right to remain silent, but she would probably remain unhappy unless she began to talk. I delivered these comments in short sentences. e.g. "You look unhappy today."

In dealing with that group of people who may be considered as paranoid and by this I mean, that group of people who do seem to be truly and unduly suspicious of you and your motives, it may be difficult to obtain adequate information. Further and worse, the more that you become patient and understanding with these persons, the more highly they suspect your motives, particularly as patience grows thin. Sullivan (1954) says: "I am sure I have received a great deal of information from some paranoid people because they felt I was a thoroughly disagreeable person." (p. 232)

For example, one of my supervisors had a hospitalized

patient who adamantly refused to take medicine on the grounds that it was poison. He replied to this by grumpily pulling from his files the manufacturer's advertisement which includes a list of observed side effects while he muttered, "Here. Read it for yourself." On the following day, the patient began to take medicine.

I believe that the diagnostic group of hysteric is defined by the accommodations that Sullivan (1956) thought you had to make when participantly observing them. He believed that therapeutic progress could be made if one were to tone down the narrative accounts and listen very carefully for the gaps in these accounts as that is where important information has been deleted. (Sullivan, 1956)

As an example of this, there is a man hospitalized on my unit whom I have been seeing in group therapy. He delivers long rambling monologues on how his father is the most wonderful man in the world whom he has brought to financial ruin by his wicked actions. What transpired is that the father lent the son some money for rent which the son gambled away. What is missing in these narratives is that the father subsequently committed the son to the hospital.

Those people who are described as obsessional which is to say those who present a hypermeticulousness in thinking usually accompanied by impulsive and not infrequently ineffective action present another kind of problem. It is difficult to tell them anything directly. So, if you wish to deliver a particular piece of information such as an interpretation of their behavior, the most efficient way to accom-

plish this is to provide information from which the obsessional will presently draw a conclusion that is the information you originally wished to deliver. (Sullivan, 1940)

I once worked with a man who spent an enormous amount of time ruminating about the fact that he was losing his hair. I eventually noticed that these ruminations frustrated to the point of bafflement some people who from my point of view were behaving rather cruelly to my patient. But when I suggested that my patient might be angry with these people, he disavowed any such feeling. So I asked him if he felt they had been behaving fairly and my patient eventually concluded that they were unfair and he was furious.

Similarly, in dealing with people who show a pronounced peculiarity in their demeanor such that an inordinate amount of time is spent over a particular, usually common, human activity in the effort to perform it correctly, there is an easy way to obtain information. It is to comment on some estimable quality which is at least epiphenomenal to the peculiarity observed. (Sullivan, 1940) For example, if it was believed that several hours were being spent in dressing, one might comment on some resultant neatness of dress. By commenting on this neatness, the patient is not left with the feeling that his normatively unusual amount of effort is being critized. He is thus free to complain of the feeling of compulsion involved in this effort. The psychotherapist may then exclaim "You mean you feel that you have to do this? You don't enjoy doing it?" This allows the client to explain how he hates doing this, how he struggles valiantly against the

compulsion, but fails. In this way the client and the psychotherapist can become allies working together to end the compulsion.

Chapter 3

Method of this Study

In chapter two I introduced the idea of strategic and tactical divisions of operationalizations of participant observation. But if strategy and tactic were all that there was to psychotherapy, it would not be the fantastically difficult endeavor that it is. My overall hypothesis is that the way of doing psychotherapy that is participant observation may be fruitfully considered to be composed of four ongoing concurrent and overlapping processes: participant observation as techne, participant observation as attitudinal set, participant observation as strategy, participant observation as tactic. The specific hypothesis that was tested in this study was whether or not there exists a residuum to the participant observational attitudinal set that can be measured by having raters rate the interviews for intensity of presence of the various components of the attitudinal set.

A. Background for my hypothesis: The Techne

I should explain my use of the word "techne". Techne is a perfectly good English word though now almost archaic. It is roughly synonymous with process or method. I have deliberately used this older term rather than method to emphasize two points. First, I wished to avoid the simplistic and rigid connotations of method. Second, I wished to emphasize what I consider the absolute importance of setting yourself to do psychotherapy by placing this "set" as the fundamental techne or way of psychotherapy. To speak colloqui-

ally and (I hope) evocatively unless you put your heart into the session, relatively little psychotherapy will happen no matter how superficially skillful your strategies and tactics may be.

While I by no means picked this hypothesis out of a hat so to speak, my rationale is a little obscure as it primarily derives from my limited experience in doing psychotherapy. As best as I can verbalize it my reasons are as follows. On the one hand there are most definitely strategies and tactics as I have detailed above. But when do I apply what tactic? Furthermore, how do I say what I have to say? Any intervention that I might make is more or less timely, more or less appropriate, more or less graceful.

There are some general principles such as "any interpretation should be almost self-apparent before you deliver it to the patient". This is a statement that speaks of what is timeliness but the timely moment is something that I realize is here. Similarly I realize that one intervention (or no intervention) is more appropriate than another when both are possible. The wording, tone of voice, etc. that I use is something I realize to be graceful in this situation.

These realizations are not something I figure out in the sense that I talk to myself and say, 'aha, now is the moment'. They are certainly not the product of divine revelation as I am wrong nearly as often as I am right. Nor are they something that occur automatically for these moments of realization seem to be not only correlated with, but also covariant with the amount of effort that I make to

"set" myself as a psychotherapist. As I mentioned in chapter one the old woman-young woman illusion demonstrates that a rather great deal of information processing occurs without my having any awareness of it. It is, I think, an entirely reasonable assumption that these realizations are the result of information processing that occurs without awareness.

It is unfortunate that there are not pre-existent terms in English for I as referent and I as self-aware doer, self-aware thinker, self-aware feeler. The I as referent and the I as sense of I can be readily distinguished in the following way. Breathing occurs twenty four hours a day at its own rate and rhythm. The answer to the question "Who is breathing?" is "I am" in the sense of referent, but I am very rarely doing breathing in the sense of breathing deliberately or being very aware of breathing occurring. So I shall introduce a convention of using underlining to signify I as sense of I, thusly: I and without underlinings to signify I as referent, thusly: I, whenever it would be useful to have such a ready distinction. The same convention will be applied to the other forms of the first person pronoun.

I realize something in the sense that personal but unaware cognitive processes are doing the work. Realizations, however, always occur to me. When I set myself to do psychotherapy, I (I hypothesize) begin to process information and at certain points in the session, the results of this processing occur to me as realizations. Since I am no more infallible than I am, these realizations are not always correct.

Returning to the model of the young woman-old woman

illusion, I initially saw this rather steadily as a picture of a young woman. When I was told that the picture could also be seen as that of an old woman I did not believe it, but when I was told that the nose of the young woman was the wart on the nose of the old woman I saw the illusion shift. I take this as prima facie evidence that I learn from experience and that I have access to, at least, a part of the highly verbalized experience of me. Returning to the point, I hypothesize that I become better at doing the work of realizing as a product of my experience as to the accuracy of past realizations. Accuracy is established by the reliable method of empirical test.

The cognitive processes that eventuate in my experience of realizations are matters of deduction and inference which is to say that they are hypothetical. Being hypothetical I think that the question of whether such cognitive processes really exist is entirely beside the point. The debate over whether the platonic idea or the thing-in-itself is more real is largely irrelevant to psychology. The important questions I think are how are such hypotheticals used in the theory and what convincing demonstrations of the action of these hypotheticals can be arranged.

Such a broad-based treatise on the function of inferred cognitive processes within a theory of psychotherapy and the construction of rules of experimentation to demonstrate effect of these putative processes is well beyond the scope of a Ph.D. dissertation, but I would like to make two preliminary observations.

Firstly, there is a tendency among members of the psychotherapeutic community to use phrases like 'the unconscious thought' or 'he thinks unconsciously'. (See for example Schaefer, 1975) This is a convenient terminology even if it is paradoxical in terms of the ordinary language usage of the word 'think'. The problem with this terminology is that it is entirely too convenient. I have heard any number of conversations between psychotherapists in which the alleged unconscious thoughts of so and so's patient bore more than a slight resemblance to my sense of what it was that so and so wanted his patient to be really thinking.

In my own pedantic way, I divide mental events into four classes: apparent, actual, inferred, implicit. Apparent and actual are the two subdivisions within the class of mental events that the doer is aware of doing. Actual is that subclass where the person's behavior is in accord with their statement of the mental event. Consider the following hypothetical exchange: A: "Why did you take the stairs?" B: "I thought the elevator was broken." B's thought would be an actual one. Apparent is that subclass where the behavior is not in accord with the person's statement of the mental event and we have no reason to believe the person is deliberately lying. The thought of the 'loving' rapist in chapter one is an illustration of the apparent mental event.

Inferred and implicit are the two subdivisions of information processing that is not accompanied by awareness. Inferred mental events are those that are the most parsimonious explanations of otherwise discordant data. They are

what is typically meant by "thinks unconsciously" and can usually be described by a sentence which includes the phrase "acts as if". For example: "Despite his apparent belief in feminism he acts as if he believed women were helpless." Implicit mental events are a subclass of the inferred in which the weight of evidence becomes overwhelming. They are rather rare.

The only real justification for using four rather cumbersome terms where there are two more convenient ones (conscious and unconscious thought) is that it forces me as a therapist to remain closer to my evidence. A second justification for this use might be that when we use the word 'thought' it carries a freight of familiarity so that 'unconscious thought' becomes just a little variant on the familiar as 'gray rose' is to 'rose'. This language usage supports the assumption (for which there is no evidence) that inferred cognitive processes are very like those of which we have awareness and which we call by the name "thinking".

Secondly, one area of scientific endeavor in which mathematical models have repeatedly proven themselves to be of use is that of clarifying the initially imprecise specifications of hypotheticals. For example, differential calculus has been used to good effect in Newton's laws of gravitation and motion and Maxwell's theory of electromagnetism. The primary limitation to differential equations, however, has been that they describe phenomena where change is smooth and continuous. (Zeeman, 1976) Realizations and many other psychological phenomena are discontinuous. That is to say that

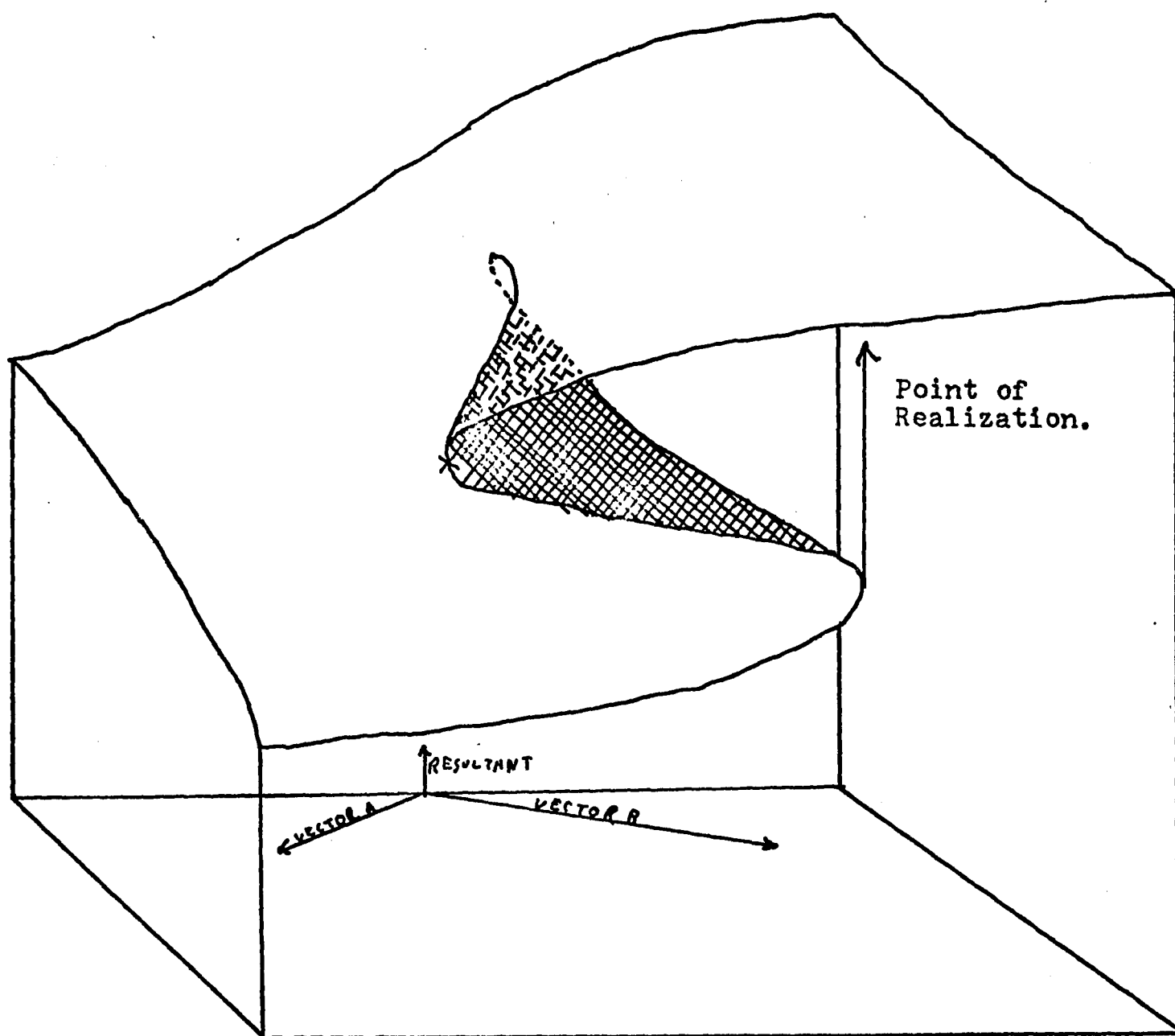
there is a sudden break between now you don't realize it and now you do.

Recently, however, Thom (1974, 1975, 1976) has generated a mathematics based on topology for use with discontinuous phenomena. He calls this "catastrophy theory". I personally feel that a better name would be sudden change theory for not all sudden changes are catastrophes, but just as we have become used to the barbarously named "transcendental equations" we may very well have to become used to "catastrophe theory".

Thom (1975) has shown that for processes that are controlled by no more than four factors there are no more than seven "catastrophes" or topological models that describe the moments of discontinuous change in four factor processes. To the best of my understanding "factor" is essentially a synonym for independent variable. I shall (hopefully) illuminate the term "catastrophe" by constructing an example of a two factor catastrophe model of the events that lead to a realization. The two factor catastrophe is called a "cusp" catastrophe because the behavior surface (defined below) forms a cusp shape.

Illustration #2 may be initially considered as a perspective drawing of a box with a double fold in the lid. The fold begins near the back edge of the lid as a crease and progressively widens and deepens in all directions until at the front edge it shows a pronounced S curve. S curves are, incidentally, composed of two cusps which are welded together at one point. It is from this fact that the name "cusp ca-

ILLUSTRATION #2.



All cross-hatched areas represent the region of least probable behaviors. The dashed cross-hatched area is a cutaway view of the underside of the top fold. See text for further explanation.

tastrophe" is derived. Notice also that this box does not have top edges of equal height. The left front top is lower than the left back top which in turn is lower than the right front top which is lower than the right back top.

Imagine an ant placed roughly $\frac{1}{2}$ cm. back from the right front top edge. The ant proceeds on a straight course toward a point $\frac{1}{2}$ cm. back from the left hand top edge. Everything proceeds smoothly until as he reaches the actual cusp of the top half of the S curve he falls off the edge. This is the catastrophe. If the field of gravity were reversed, and he proceeded from left to right, he would (from our perspective) fall "up" to the top of the lid.

Replace "lid of the box" with "two dimensional surface folded through a three dimensional space". Replace "bottom of the box" with "plane". A one to one correspondence between points on the plane and points of the two dimensional surface can now be made (as in ordinary geometry) except for the region of the fold. In the region of the fold a special convention is made. To each point on the plane below the fold there are considered to correspond two points on the two dimensional surface. These are the point on the top side of the fold and the point on the bottom side of the fold. The third point in the hatched middle area is ruled out of bounds as it were.

Lines can now be drawn on the bottom plane by plugging various values for a and b into the equation $\frac{1}{4}x^4 - ax - \frac{1}{2}bx^2$

where a and b are the independent variables.¹ The independent variables a and b may be considered vectors or factors.

To any line on the bottom plane there corresponds a line on the two dimensional surface except in the region of the fold where a special convention applies. The fold region convention states that the point chosen is the one that is on the surface along which you have been traveling until you cross a cusp whereupon an instantaneous translation to the other surface of the fold occurs. Replace the "ant" with a point moving along the surface and you will have a good visual image for what happens. The two dimensional surface is called a behavior surface because each point on it corresponds to a behavior, and the places where the "catastrophes" occur correspond to sudden changes in behavior.

Bisect the two dimensional surfaces with a cut made horizontally through it at a level midway through the hatched area (where the X is in the illustration). Call everything above this cut, the top side, and everything below it, the bottom side. Let the top side correspond to "thinking" that is to say cognitive processes characterized by awareness, and the bottom side to inferred cognitive processes.

1. This model is, parenthetically, useful in the development of Sullivan's concept of the vector of anxiety as being in opposition to vectors of needs. Let " B " be any vector of need and " A " be the vector of oppositional anxiety. The phenomena that low levels of anxiety can actually facilitate performance can then be reconciled with Sullivan's dictum that anxiety is opposed to satisfaction of need in the following way. Set $A = by^n + c$ where y is the anxiety and b , n , and c are constants. If the constants are appropriately chosen, when y is positive but of low value, A will have a negative value and hence a facilitative effect on B . At higher values of y , A will pass zero, and entering the region of positive values will have a hindering effect on B .

Let a and b correspond to any two factors that appear to be necessary and sufficient conditions for a realization to occur. For the sake of this example, call a the novelty of the stimuli and b the number of informational units given. Assume that a is initially high and b is initially low and a decreases quite slowly while b increases at a more rapid rate. By plugging the appropriate values into the equation a line will be generated across the plane. The corresponding line on the two dimensional behavior surface will move across the bottom side of inferred cognitive process until a sudden translation occurs to the top side of thinking. This moment of translation is the realization.

One of the many reasons why it is entirely premature to attempt to perform experimental work on the techne of psychotherapy is that we have no reasons to suppose that we know what are the two necessary and sufficient factors for realizations of timeliness, appropriacy, and grace or even that the necessary and sufficient conditions number two. But if the evidence accumulates so as to point to four or less factors being causal then Thom's catastrophe theory will be the mathematical model of choice.

B. My Specific Hypothesis: Attitudinal Set

A portion of the techne of psychotherapy is the specific use of a particular attitudinal set to further the process of psychotherapy. I say "use", but I believe that the attitudinal set in question is not so much one that is a deliberate pose or mechanism as it is something that the psychotherapist has to begin with as he or she begins this career,

and which is developed through the process of working as a psychotherapist. It is this particular attitudinal set that I attempted to measure by having raters make numerical judgments on the degree of presence of the various components of the set. Before I discuss the procedures that I used I shall make some comments on the nature of attitudinal sets and what I mean by the components of an attitudinal set.

I think there is a sense of "doing" this attitudinal set. By doing the attitudinal set, I am referring to the rather commonly observed phenomena that one can be having a rather distressing day and yet when the time comes to go and do a session, certain preoccupations, concerns, and worries drop away to be replaced by a more "balanced", "stable". and distinctly professional feel. This shift is simultaneously an effort of will and something that just happens on the way to meet the client.

An attitudinal set, as I conceive of it, is something that while definitely mental is not a verbal operation. To say I feel great or lousy or concerned or indifferent or whatever is to point to that which is originally unspeakable with words. By originally unspeakable I do not mean anything remotely resembling transcendental or mystical, but rather that attitudes are as unspeakable as colors. We say "the grass is green", but if we actually look there are thousands and thousands of individual colors with discriminable differences amongst them that seem, to my untutored eye at least, to vary along dimensions that I do not even always have named. Nonetheless for each of them, it is accurate to say:

"the grass is green". We are still "within" what Sullivan (1953, p. 104) called "the envelope of insignificant particular differences".

So the attitudinal set of the psychotherapist is one attitude partially happening, and partially adopted that must be described with many words. The six descriptive adjectives that are the most primary to this attitude are: attentive, open-minded, sensitive, responsive, considerate, compassionate.

"Why six and why these six?" is a legitimate question. I would emphasize that this is an analysis of what is actually unitary. Other people might "slice the pie" of psychotherapy attitude differently. I almost included honesty as another major component attitude and almost merged sensitivity-responsiveness into a single component attitude. In the final analysis (so to speak) I chose these six because they seemed to me, in fact, to be the most primary components. Before I articulate what I mean by these rather common adjectives, I should eliminate any confusion that may arise as to the nature of attitudes in a participant observational theory. Attitudes can be considered as "within" - that is to say private, enduring, and almost changeless affective tones. With such a conception, it is difficult to see how attitudes could be rightfully considered under the rubric of participant observation. There is, however, an alternate conception in which the potential attitude is uniquely actualized by the situation in which it exists.

Put quite simply it is not possible to be sensitive

unless there is something or someone to which or whom one is being sensitive. Further, if one is being sensitive to a person, this sensitivity is different depending upon whether the person is a man or woman as we ourselves are either men or women.

By attentive I mean the capacity of regarding with considerable care the various performances of the other. Some roughly synonymous words that might help you to get the feel of how I am using the word 'attentive' are: mindful, heedful, observant, vigilant, and alert.

When I say open-minded I mean unprejudiced: the attitude of being willing to hear and consider. Being willing to hear and consider, a person with this attitude is free from pretense in the sense of not being a know-it-all. Such a person is the exact opposite of a poseur. I wish to especially emphasize the accessible and receptive aspects of open-mindedness in contra-distinction to the free voicing of one's thoughts, attitudes, beliefs, etc.

By sensitivity I mean the capacity to detect actual (as opposed to apparent but illusory) changes in a situation while these changes are still rather minute or subtle. The sort of changes that are most likely to and most important to be detected are changes in the feeling tone of a situation.

As I am using the word, I mean 'responsive' to be the ready inclination to react in an overt, though not necessarily large scale, way to the suggestions or impressions one has gained from the environment. The ideal responsive act is apt, quick, ready, and right. As aptness is an integral com-

ponent of responsiveness, those responses which are quick and flagrantly overt, but in no way apt, are not at all responsive.

By the attitude of consideration I mean the capacity of being thoughtful or heedful of the comfort of others. The skilled psychotherapist practices two distinct kinds of consideration. First, he or she shows what amount to basic social skills, more or less what we ordinarily mean when we use the word 'considerate'. Second, there is a distinctly professional kind of being considerate; what you might call the limit of feeling for the other that you can have and still be fundamentally based in the notion that psychotherapy just happens to be a peculiarly difficult, though lucrative, way of earning one's living.

Compassion is an attitude of profound feeling for and understanding of human suffering. It is further typified, in the modal case, by a concomitant desire to alleviate this suffering. Compassion differs from pity in that there is little, if any, sense that the compassionate person is in a more favorable position than that of the one for whom he or she has compassion. It differs from sympathy in the clear recognition of the self-created nature of much of human suffering. It differs from empathy in that there is not only an intuitive appreciation of the other's state of mind, but also an understanding of that state.

Such a listing of attitudes reads as if the experienced psychotherapist were a cross between an avatar and a paragon with perhaps a soupcon of saint. I certainly am not laboring under any such delusion, but I do believe that these

attitudes, possessed in human measure by human beings, are present. If they are present, then they are almost certainly present in the clearest form 'in' some of the senior psychotherapists. By this I am not claiming that age brings wisdom, though I do believe that that can happen. Rather experience teaches. It does not teach inevitably. We can easily form ways of living that become self-perpetuating. My hypothesis is that among those people who have become degreed and certificated psychotherapists, those, who have not fallen into one or another self-perpetuating delusion, will in their last years of work show most clearly the attitudinal set that furthers the work of psychotherapy.

To summarize: the overall hypothesis of this study is that participant observation consists of four ongoing and concurrent processes, techne, attitude, strategy, tactic. By techne I mean the process of repeatedly deciding to participate in this situation with the intent of doing psychotherapy. By attitude I mean the feeling-tone that partially accompanies the process of techne and which partially is deliberately adopted to further the doing of psychotherapy. Strategies are the general procedures (largely heuristic) that can be verbalized on doing psychotherapy. Tactics are specific procedures that can be verbalized on doing psychotherapy in one or another frequently encountered situation. Without techne, there are no realizations of timeliness, gracefulness, aptness. Without attitude there is insufficient information for realization to occur or procedure to be applied. Without procedure there is sacrifice of that which

can be generalized from one client to the next.

The specific hypothesis of this study is that psychotherapy attitude exists but that its development in any given psychotherapist is neither inexorable nor inevitable. I am further taking an optimistic hypothesis that our training, and dedication, and experience have done some good and that there will be an overall greater than chance rating across all therapists when all facets of psychotherapy-attitude are grouped together. The procedure by which I generated a data-base and then measured psychotherapy-attitude will be discussed in the next section.

Before describing procedure I would like to clarify what I consider to be the relationship between training and experience and, ipso facto, clarify the domain of the study. It is certainly easy to gain a superficial familiarity with the writings of the more profound theoreticians in this field. One can make equations and translations between their terms on the basis of this familiarity such as participant observation is like transference and counter-transference. These translations are quite accurate as far as they go. It is also true that one's feeling for the meaning of any terminology within the school of one's choice changes profoundly during prolonged, careful, intensive study. In this sense, I know that I do not know the meaning of the words 'transference' and 'counter-transference' in anything like the way that I know the meaning of the phrase 'participant observation'. I believe that if the actual meaning of the phrases 'participant observation' and 'trans-

ference and counter-transference' could be mapped on a Venn diagram, the overlap would be between 80% and 90%. This is belief and not knowledge.

Our training in a school dictates to some degree what sort of experience we shall undergo. It follows that there is quite likely to be some divergence in the actual experience of someone who has intensively studied Sullivan and someone who has intensively studied Freud. My impression is that there are significant differences in one's experience depending upon the population with whom one chooses to work, and this difference is then reflected in one's theorizing.

For example, one of my patients had to be isolated for assault. I did a session in the isolation room with her. She was crawling across the floor, delusional, agitated, and probably hallucinating. She screamed at me in mingled rage and agony that I was just like her father. This was transference but my experience of transference is different from that of the person who works with the well functioning office patient in psychoanalysis.

Accordingly, the training and experience of one who has studied Sullivan and worked predominantly with profoundly psychotic patients are somewhat different from that of the person who has not. I do not believe these differences are large enough to be significant, but I do not wish to claim generality for whatever my results are. My emphasis on the uniqueness of the Sullivanian position is not a claim for totally different much less a claim for better. In short, I believe that, on the average, these Sullivanian therapists will

show greater than chance psychotherapy attitude, that this is probably not the unique result of training in Sullivan's theories, but that generalization to all psychotherapists should not be made because of the possible effects of the subtle differences in training and experience across the schools.

C. Procedures and their Rationale

Obviously, I could not discover the presence of psychotherapy-attitude by the simple expedient of asking therapists if they were possessed of such an attitude. On the one hand who would not want to claim to be attentive, open-minded, sensitive, etc? On the other hand, many who might actually be possessed of such an attitude might not be articulate about it, or might have a theory which compelled them to deny anything that even remotely resembled the presence of a healing personality. What I was called upon to do was to create a situation in which they would be allowed to demonstrate such an attitude without being called upon to do so, or having the situation artifactually create psychotherapy-attitude.

My solution to this problem was to interview psychotherapists on their developing understanding of what participant observation was. By developing understanding, I meant what they originally thought Sullivan to mean (more or less intellectually) by the term, how they learned that to which the term actually referred in their training by Sullivan, how their understanding changed, if it did, in the course of their practice, whether they thought what they did was

somehow uniquely Sullivanian or entailed the use of Interpersonal Theory, and finally what they thought of as being important in the development of a psychotherapist.

These interviews are of considerable value whether or not my hypothesis of techne, attitude, strategy, and tactic is supported. This is for two reasons. Firstly, it has been claimed that studying with Sullivan, the person, led to an understanding of his theory and method rather different from that typically gained by reading his works. The idea I get from these rather vague rumors is that the 'sense of the man' is largely lost in the literature.

After spending some almost two years studying his work rather carefully, I have come to the conclusion that if Sullivan is almost unreadable, it is not because he is imprecise, but because he is precise to the point of being mathematic. It is not because he uses too much neologistic jargon (though he does have a few words which he uses in a distinctly unusual sense) but rather because he does not use accustomed jargon where English will do. If his writing contains any actual faults, they are that he is so terse as to be telegraphic, and that he does not make any reference to the rejected jargon terms.

For example, he would use the words "chronic consultant". At first, I wondered what he meant by that. The words themselves seemed to mean that he would see someone else on a regular basis (chronic) to talk about their patients (consultant). I wondered with no little annoyance why he didn't use the term "supervisor" like everyone else,

when I finally figured out that the words meant exactly what they said. Then I began to compare the two phrasings.

"Supervisor" has a definite implication of hierarchical status. According to Sullivan's theory such a concept of hierarchical status offers a great opportunity for anxiety. "What will the boss think?" "Suppose I don't get it right?" Such anxiety practically guarantees that the supervisee will minimally present things in their best light, if not actually eliminate "undesirable" portions of the case material. This makes the task (that of conversing about the situation to the end that everyone, including patient/client, supervisee, and supervisor, experience some ultimate benefit) more difficult. The solution is to describe the situation accurately in such a way so as to disavow hierarchical notions hence: "chronic consultant".

Secondly, I am interviewing senior students of Sullivan, which gives the interviews a double historic value. These are the last people still living who had direct contact with Sullivan, and if they are not interviewed now, they may soon be uninterviewable.¹ Also being senior students, they have had the most experience in the Sullivanian method in particular and with doing psychotherapy in general. This renders them, with the exception of areas of personal warp, experts whose opinion will be of value.

I obtained an initial list of people who had been

1. This has turned out to be tragically true. Mary White Hinckley was unable to be interviewed for reasons of declining health. If I had been only three months ahead of the schedule that I actually was on, she would most probably have been interviewable.

supervised by Sullivan and who then continued to practice psychotherapy and/or psychoanalysis through Dr. Herbert Nechin. I then obtained additional names as I went from whomsoever as I might. I also wrote the director of Chestnut Lodge in an attempt to establish some contacts in the Washington D.C. area. In all I finally obtained roughly 16 names of people who had been at least rumored to have experienced Sullivan as a chronic consultant.

The way that I attempted to obtain an interview with these individuals was as follows: First, I would send a letter in which I outlined who had referred them to me, asked them if they were willing to be interviewed on the topic of participant observation, and explained who I was to be seeking such an interview. See appendix B for a copy of this form letter. Along with this letter I enclosed an abstract of my dissertation proposal to more or less establish my intellectual bona fides. See appendix C for a copy of this abstract. Secondly, I followed the letter with a telephone call. In some cases this was sufficient to be either told 'yes' or 'no' in no uncertain terms. In other cases, the initial telephone call opened the way for a more or less lengthy set of calls or letters in which I tried to participantly observe as much as I could, and then deduce what might be the motives for a not complete refusal. I would then attempt to nullify such fears as I might have deduced and try again. With one interviewee, this procedure continued for a good six or seven telephone calls.

In still other cases I sensed an immediate rapport,

but the person involved was so busy that scheduling became a major problem. In these cases it was mostly a matter of time and dogged determination. The record here was seven months between initial letter and finally doing the interview.

The interview in itself was planned to cover eight major topics. The initial questions for the eight topics are as follows:

1. What do you think Sullivan meant by participant observation?
2. How did he teach you to refine yourself as an instrument of participant observation?
3. Have you applied participant observation in your clinical practice?
4. Have you amended or changed this principle as a result of your clinical experience?
5. Have you utilized either the method or the conception of participant observation in your teaching?
6. To what extent do you think that participant observation can stand by itself as a concept independent of the remainder of the interpersonal theory of psychiatry?
7. Do you think this way of doing psychotherapy is fundamentally different from that of competent psychotherapists espousing other theories?
8. Out of your experience as a psychotherapist, what is the single most central recommendation that you would have for a beginning psychotherapist?

Under each topic heading I would ask such follow-up questions

as seemed to be appropriate.

The interviews were recorded with a Sony TC-55 cassette tape recorder. I used an omnidirectional microphone equipped with Sony's variant on Automatic Volume Control circuitry. A.V.C. is a circuit which functions so as to ensure a relatively even recording volume despite fluctuations in voice volume. Roughly, the A.V.C. works like a thermostat monitoring the absolute strength of the incoming signal at that stage of the signal throughpath immediately after the initial translation from mechanical to electrical signal. It adjusts the gain accordingly so that the recording circuit per se 'faces' a relatively constant signal.

When the recording circuitry faces a relatively constant signal, the meters may be used with greater sensitivity so as to ensure that you do not try to have the tape record a louder signal than it is constructed to do. This latter is called 'running out of headroom', and the net result is a bad distortion of the voice upon playback. When using A.V.C. I had to be especially careful to ensure that the motor of the tape recorder ran so quietly that it would not activate the A.V.C.

Between the A.V.C. and the recording circuit, I used a secondary circuit that artificially boosted the gain of those portions of the signal that fell within the range of the human voice. (roughly 60 Hz to 1.5 KHz, (Cotter, 1976)) This is because much of the hum, hiss and rumble that can be heard on tapes is at a frequency above or below that of the human voice.

In transcribing the tapes, each cassette was listened to by at least two people. I then made a final comparison between the transcript and the original tape and corrected the transcript. Pauses and stutters, I simply deleted from the transcript. "ThThTh The reason why" is transcribed as "The reason why". Repetitions of connective that indicate the individual is still thinking were shortened to a simple statement of the connective except where the repetition seemed to profoundly affect the meaning of the sentence. Thus "... meant by participant observation and and and and and also that one could simply not ..." becomes "... meant by participant observation and also that one could simply not ..." Finally, I have replaced internal references to interviewee's names with the appropriate code number.

The interviews were rated for the presence of psychotherapy attitude by two raters acting independently and without knowledge of the hypotheses involved. The rating procedure was as follows. First, I prepared a code book to teach the raters what I had in mind by the various attitudes and to provide illustrations of these attitudes. The code book itself consisted of some seven sections, a section of general instructions, and one section for each of the attitudes involved.

Each of the attitude sections was constructed according to the following plan. First, I defined the attitude in question using the definitions that I gave above. Then I constructed illustrations of the attitude as they might be seen in the interview. Each illustration was based on what I consider-

ed to be an actual instance of the attitude in an interview.

I would take this instance, attempt to define its essential structure, and then create a hypothetical illustration with the same structure. The primary difficulty that I experienced in this task was not the creation of an illustration that sounded different enough so as to be unrecognizable as a translation of the original. What actually happened was that more often than not I would discover that when I had created such a 'hypothetical illustration', it sounded 'all too much like another instance of an entirely different interview.

Using Schafer's (1954) recommendation I then created a five point scale of intensity of presence of the attitude with 5 indicating a high degree of presence, 3 a moderate degree, and 1 a low degree. I then sorted my hypothetical illustrations of the attitude, picking out particularly good instances of high, moderate, and low degree of presence of the attitude in question. The result of this was that I had a teaching manual that not only defined what I meant by say 'sensitivity', but also gave illustrations of high sensitivity, moderate sensitivity, and low sensitivity. Or at least I thought I had. I gave the prototype of the rater's code book to two preraters. They assured me that much of what I had written was completely unreadable and gave me many valuable suggestions as to how I might rewrite sections in more communicative English.

The second problem that I faced was to divide the interviews into rateable units. I thought that to have the

raters attempt to make a rating for each and every grammatical unit such as a sentence or even a paragraph was contraindicated for three reasons. First, I did not think that any given grammatical unit would correspond to the length of one instance of an attitude. In some cases two sentences would also be two instances, while in others two sentences would be a piece of an instance. Secondly, it seemed to me that there were large sections of each interview where there was simply not an instance of the attitude in question and forced ratings would only 'create' artifactual instances of the attitude. Thirdly, I thought that the task of rating every sentence would prove to be so onerous as to destroy the interest of the raters.

I also ruled out the possibility of having the raters attempt to rate an entire interview at a stretch. I thought that the sheer bulk of the material, as some of the interviews run better than forty pages, would prove to be confusing, if not overwhelming. So I divided the interview into 'parts', each interview having from eight to ten parts. Parts 1 through 8 corresponded, simplistically enough, to the eight major topics that I covered in the interviews. If the interviewee began to speak spontaneously before I asked any questions, I cordoned that off as Part P for prologue. Similarly, if he or she continued to speak after the conclusion of the formal interview that became Part E for epilogue. I asked the raters to rate whole parts at a time and to rate all the parts of an interview on one attitude before rating any part on another attitude.

My third problem was to provide a definition of an "instance" of an attitude that would prove more enlightening than confusing to the raters. The problem of defining one instance of an attitude is structurally identical to that of defining one response to the Rorschach. I solved the problem similarly by defining the instance abstractly. An instance is one idea, topic, or exchange in the conversation. I further explained that most, though not all, instances would fall into one of three categories. My categories were the exhortation to practice of the attitude, the revealing reminiscence, and the me-you interaction. Exhortations to practice I subdivided into direct and indirect using indirect as a generic for both implied and inferred exhortations.

By exhortation to practice I mean more or less exactly what the words say. I felt that the direct exhortation deserved a high rating as it was a statement of the values of the therapist even if the person was not actively demonstrating the attitude at that moment. The indirect exhortation is one in which the interviewee does not specifically state that one should do "X", but from which the practice of "X" constitutes a necessary inference or is strongly implied. Here is a hypothetical illustration of an indirect exhortation to open-mindedness.

Learning is really a double edged sword; on the one hand, it's absolutely necessary, absolutely indispensable. If you don't learn the theories, you may very well just flounder around. But on the other hand, it can just junk up your head with being a Freudian or a Sullivanian or a what not.

The revealing reminiscence is the case in which the interviewee, while speaking, mentions something of his experiences in supervision or with patients that unwittingly reveals his or her attitude. For example, this illustration of a high (5) level of compassion is in the form of the revealing reminiscence.

Once I had been working with this woman for a year -- she was being maintained on an out-patient basis -- she and her daughter were having this malevolent relationship that got spun up out of the mother's fear of disciplining the daughter for being bad, because then she would be bad. The mother was terribly, terribly afraid of being thought to be bad by the grandmother. Any way, one day we were going round this dilemma for the umpteenth time and she said "But she'll think I'm a BAD mother." And I said "So what?" Well, I'd thought I'd blown it, but Sullivan thought otherwise.

Me-you interaction is my term for those times during which the interviewee demonstrates the attitude in question by his or her attitude toward me. I would consider the following me-you interaction to show a high (5) level of sensitivity.

J.B. It seems that for Sullivan, participant observation was both given and trained. Let me clarify that.

X.Y. Uh, I think I know what you mean. It might be more simply put that while people are always participant observers, they can get better at it. (etc.)

Obviously, I did not do the interviews to hear myself talk. The interviewee, sensitive to my fundamental wishes, responds appropriately.

My fourth problem was to minimize the possibility of the Halo effect. The Halo effect in this study would consist of the interviewee's being given a high rating on attitude "Y" because they had been given a high rating on attitude "X". To some degree the Halo effect is theoretically less worrisome in this study than in others because my assumption is that psy-

chotherapy-attitude is largely unitary. Some of the attitudes are predicated upon each other. For example, an interviewee is not able to be highly responsive unless he or she has been sensitive enough to have the information upon which the responsiveness pivots. Such sensitivity is usually found in people who are attentive.

The attitudes can, however, be differentiated. It is possible for a person to be moderately responsive while showing a rather low degree of sensitivity. More common is the person who is 'naturally' sensitive to the feelings of others and does not seem to have to make the effort of attentiveness to be quite specifically aware of the other's state of mind. So I did my best to minimize the Halo effect in the following four ways.

First, I delivered myself of a direct exhortation to guard against the Halo effect. Secondly, I requested that the rater rate an entire interview on one attitude before rating any part of that interview on another attitude. My hope here was that there would be some forgetfulness as to exactly what he or she rated as how indicative of what attitude. My raters assure me that this is exactly what happened. Thirdly, I decided to forego the collection of some data that would have been fascinating, namely, to have the raters mark with a pen what they considered to be one instance of each attitude. By foregoing this data, I assisted their forgetfulness. Fourthly, the raters were rating the transcripts. This means as I developed at some length during chapter one that they did not have available to them all the vocal and gestural modi-

fiers of verbally given meaning. Therefore, they were not able to rate all the instances of attitudes that there were. To give just one example, consider the following dialogue.

J.B. One last question.

#4. Beg your pardon.

J.B. One last question, which is, out of your experience, what do you have - what do you think of as a single most central recommendation for a beginning psychotherapist?

The tone of voice used in "Beg your pardon" would indicate whether the interviewee is being quite considerate or quite inconsiderate. In the transcript it is unrateable while on the tape it is obvious. The unrateability of portions of the transcript should counterbalance in some measure whatever Halo effect remained after my first three precautions.

D. The Statistical Analyses

My fifth problem was to devise an appropriate statistic to assess the reliability of my raters ratings. I eventually settled upon the following. The probability of the two raters making the same rating by chance on any individual rating is one in five, of coming within one full point of each other three in five. The probability of random concurrence on the mean rating cannot be greater than the probability of random concurrence on any individual ratings. Should the overall concordance, where concordance is defined as being within a range of plus or minus 1, exceed .60, the degree to which concordance exceeds .60 cannot be assigned to the category of random concordance which is equivalent to saying that to that degree the raters judgments are reliable.

It can be argued that the test of observed concord-

ance of the means vs. predicted random concordance of the means does not actually constitute a proof as no degree of concordance is theoretically impossible. e.g. while it is highly unlikely to role box-cars 6 times in a row, it is not impossible. Accordingly, I supplemented the test of concordance with a calculation of the Pearson or product-moment correlation coefficient.

The product-moment correlation coefficient was initially designed to assess the correlation between pairs of Z scores. Z scores, as the reader will recall, are computed from the standard deviation scores which involve the taking of the mean. It was only later that the raw score formula for the Pearson test was derived for computational ease. (Spence et al, 1968) To the best of my knowledge there are no theoretical limitations on the application of the product-moment correlation test to pairs of mean scores.

Unfortunately, the test of significance of the product-moment correlation involves the making of the assumption (among several others) that the distribution of X and Y scores be normal. The X and Y scores in this case are, if my hypothesis is true, not distributed normally but are bunched toward the upper end of the distribution. In short, while the Pearson can always be calculated, it can be tested for significance if, and only if, the interviewees show a wide range of variation on their intensity of presence of attitude scores.

Finally, the Pearson and its corresponding significance test can be calculated with no restrictions whatsoever

on the correlation of numbers of instances rated. In summary this means that I can answer the following questions. Is there a significant correlation between numbers of items rated? Is there a reasonably greater than random correlation between the ratings given?

When the reliability of ratings is established, then a simple grand mean can be taken as a test of validity. The degree to which the grand mean is higher than would be achieved by chance is an indication of the presence of psychotherapy attitude. The more that the grand mean approaches chance, the less likely is it that psychotherapy-attitude actually exists. Ordinarily one would then compute a t-ratio between the means to evaluate significance of difference between the means. Unfortunately, there is no way to compute this statistic when one of the means is the hypothetical random mean because there is no way to compute the standard error of a random distribution and such a statistic would have to be calculated as a preliminary to the calculation of t.

Chapter 4

Abstracts of the Interviews along with the Author's
Personal Experiences of Them

Some readers may well find the interviews themselves to be interesting reading and they are printed in their entirety under the heading: Appendix A: The Data Base. I recognize that other readers may not have either the inclination or the leisure to plough through the entire data base particularly as the transcripts are lacking in the tonal and gestural modifiers that communicated so much in the original interviews. I have, therefore, attempted to abstract from the data base a general sense of the answers I received to my eight question-topics.

A. Abstracts

- (1): What do you think Sullivan meant by participant observation?

There was universal agreement among the interviewees that Sullivan meant to emphasize with his term 'participant observation' that one could not get away from the intrinsically participatory nature of one's being in the situation. Some interviewees focused more on how one, as a therapist, was always effected by the actions of the patient. Others focused more on how one inevitably acted on the patient in ways that were influential.

Those interviewees who commented on the observational half of 'participant observation' tended to emphasize its use as a way of being participant. One said that it meant that the analyst watched more closely than a non-therapist for

shifts in the conversation that were occasioned by anxiety; the others said that it meant to be aware of your participations and the other's participations with a view to deducing how the other fellow understood your actions.

(2): How did he (Sullivan) teach you to refine yourself as an instrument of participant observation?

All agreed that Sullivan's main teaching method was supervision, and that during his supervisory sessions he did not lecture. The one interviewee who had been in analysis with Sullivan commented that he had learned a great deal of participant observation by participating in this fashion with Sullivan. Those who specifically spoke of how Sullivan supervised were agreed that he would set aside two consecutive 50 minute therapy hours. Sullivan would then listen in silence to whatever presentation the supervisee had to make interrupting only if he did not hear a word. After the supervisee had finished presenting, Sullivan would begin.

One interviewee said that Sullivan would trace the origins of the anxiety. The others were more graphic and described what one called Sullivan's technique of 'birddogging'. 'Birddogging' was Sullivan's habit of asking for an illustration of any generalization that the supervisee offered. One of his favorite phrases in this regard was "as illustrated by what?" Sullivan would do this with a view to increasing the supervisee's curiosity as to what the patient was actually like as a person.

The other facet of Sullivan's supervision was that he was really quite sharp in his attempt to counter what he

took to be unhelpful distortions on the part of the supervisee. One interviewee commented that Sullivan had told him that he wasn't sure if he (the supervisee) was asleep or disinterested. Another said that Sullivan told her that she ran the risk of being disrespectfully intelligent. All the interviewees agreed that although Sullivan could be very sharp in his approach, it was not done with any intent to humiliate. One interviewee felt that Sullivan was uncannily accurate as to the (primarily) parataxic distortions (or counter-transference) of the supervisee because he was not only amazingly intuitive to the not-said but also had an astounding memory. Another interviewee commented laconically that Sullivan's amazing intuition was the result of years of dedicated work making detailed case notes.

(3): Have you applied participant observation in your clinical practice?

One interviewee said quite simply "No". He had not been comfortable with Sullivan or his style. Now, toward the end of his life, this man felt that he was once again moving toward a more Sullivan-like approach. Another felt that the question was wrong in that participant observation being inherent could not be applied. The others all said that they had most definitely used participant observation in their practice. One said that it was not a question of whether or not to participate, but how to participate most constructively. It was a question for the other interviewees of being aware of one's participation and the other's participation. One interviewee added that you had to keep a certain

level of tension in the work, not to allow the anxiety to increase too much or become too little. This same interviewee also said that you must not have too great a financial stake in maintaining any one patient (particularly if she had Sullivan as a supervisor for this patient as Sullivan was forever calling a spade, a spade).

(4): Have you amended or changed this principle as a result of your clinical experience?

Only one of the interviewees actually spoke of making an amendment or change and this was not in the principle per se. She said that as she had gone on in her work, she had become very interested in female development. Sullivan had not been particularly interested in this area so she had had to do most of the work of theory building by herself.

Most of the interviewees spoke of developing an individual style more or less based on a gradually growing conviction that such and such was peculiarly central to the practice of psychotherapy. For one interviewee, it was getting the patient to say what he meant. For another, it was working to counteract the despair of the patient while learning to relax more during the therapy hour. Another said that she simply got better at participant observation even though it was inherent.

One interviewee, however, only spoke of how he had shifted in his career from focusing on being more of a participant to being more of an observer. He understood these shifts as being by and large occasioned by anxiety. He felt that he moved into the participatory role out of the anxious

sense that the patient would not like him, would not respond to him as a human being, or out of his own loneliness. Then when something the patient did was frightening or irritating, he would attempt to become more of an 'objective' observer moving into a position which, carried to its reductio ad absurdum, would be 'I'm only in it for the science'.

(5): Have you utilized either the method or conception of participant observation in your teaching?

One interviewee simply said "No". Another said "Yes" without elaborating. The others said that they had taught and that they had utilized participant observation in their teaching. One said that participant observation was the way in which he taught. Another said that she emphasized Sullivan very much in her introductory courses because she found that his emphasis on being humane and teaching the student how to look for things was quite helpful. The last said that he used what was essentially a demonstrator.¹ He would take detailed notes on a session or series of sessions with a particular patient and then use this as a basis for whatever he wished to emphasize in the lecture or seminar.

In general I was somewhat disappointed with the results of this question. Neither I nor any of my interviewees were really able to come to grips with the issue of how one teaches such a simple yet subtle matter as being an observant participant. My personal sense of the difficulty in this is that participant observation cannot be taught in the same way

1. 'Demonstrator' is my term not his. I was struck by how his method was very much like the way that I had been taught composition - by demonstrators rather than by rules.

that the conjugation of third declension verbs can be. Participant observation can be demonstrated; it can be learned. But the demonstrator cannot force the student to become observant of self-and-others participation in the psychotherapy. The demonstrator can only work with the student's own willingness to develop his or her capacity for participant observation.¹.

(6): To what extent do you think that participant observation can stand by itself as a concept independent of the remainder of the interpersonal theory of psychiatry?

The interviewees were again divided in their answers to this question. Four thought that it probably could stand by itself and the remaining one thought that since participant observation wasn't really a concept but a part of reality, it would be inherent in anyone's theory no matter what they might call it. Of the interviewees who thought of participant observation as a concept, one said that he thought that participant observation was independent of the remainder of the interpersonal theory because it was a much broader concept in science generally. One commented that participant observation could obviously stand by itself as other writers notably Heinz Hartmann had used the concept without giving any credit to Sullivan. Another thought that while participant observation could stand by itself it was better to have the entire theory or at any rate an entire theory to guide one's clinical practice.

(7): Do you think this way of doing psychotherapy is fun-
1. Hence my emphasis on participant observation as techne.

damentally different from that of competent psychotherapists espousing other theories?

One interviewee replied immediately and confidently to the question that, of course, all competent therapists did the same thing whether or not it was called participant observation. The remaining four said "I don't know". Three of those said that probably all competent therapists do more or less the same things with their patients. Most of the interviewees said that we really knew very little as to how other therapists went about their practice. Several said that there might be a considerable discrepancy between the explanations that one gave of one's practice and the practice itself. One interviewee commented that if somebody were actually Sullivanian in theory and practice and another person were actually Freudian in theory and practice, the Sullivanian would tend to be a more direct and active participant in the analysis.

(8): Out of your experience as a psychotherapist, what is the single most central recommendation that you would have for a beginning psychotherapist?

Two interviewees mentioned that they felt that psychotherapists had to have sufficient experience in their own lives, of having taken a caring role toward another person during their development. Without this prior experience, the role of psychotherapist would never be understandable. Though the interviewees differed as to whether anyone could be developed into a good psychotherapist, they were in almost universal agreement that the therapist is not to assume that he

or she knows what the patient is talking about!

In order to do this, one interviewee said, you had to cultivate your awareness of the experience of both participants in the meeting. Specific recommendations were, first and foremost, to enter into one's own psychotherapy as sincerely as possible, secondly, to read and study, thirdly, to get a great deal of supervision. It is highly interesting to note that although the analysts and supervisors of the interviewees read like a 'Who's Who' of the American psychotherapy world, there was a consensus that supervision to be beneficial didn't always have to be with the most senior or famous person.

B. The Author's Experience As Participant

My personal experience as a participant in the interviews was that I learned from each of them. The person I am was most profoundly effected by my participation in interviews #3 and #5. This is not to be confused with a claim that #3 and #5 are "better" than #s 1, 2 and 4 but only that the me that is the sum of my development was most ready to hear what #3 and #5 had to say.

As a rather direct result of interview #3 I have become much more interested in the historical whys and wherefores that may be causal to the present behaviors of my patients and clients. This is in rather direct contradistinction to my previous conviction that since present behavior must be considered as the resultant of prior experience there is no especial need to focus on the developmental history of the present patterns of problem behavior. The problem behavior, I

thought, was largely maintained by its consequences and could be altered by changing the reinforcement contingencies more or less without consideration of the historical antecedents.

I am now inclined to ascribe a smaller portion of the causal variance of any given behavior to its contiguous primary reinforcers and a greater portion to the person's understanding of the primary reinforcers. This understanding cannot be fathomed by a participant observer without some close reference to the developmental history of the behavior patterns. To take a mundane example, sitting and typing a report will be accompanied after some time by painful sensations in the striated musculature. These painful sensations are a primary punishing reinforcer. As such they should lead to the termination of the behavior pattern - sitting and typing - but in fact they do not always do so. This is because the painful sensations can be understood as signals of finishing the report perhaps with additional surplus meanings such as 'being good'.

As a result of interview #5, I learned that the motivation of personal suffering that drives us to become psychotherapists does not have to be denied. It does not have to be somehow magically exorcised by some impossibly effective psychotherapy. It has only to be clearly recognized so that it won't hinder us in our work. The same interview taught me that the way in which dimly recognized suffering - particularly anxiety - can hinder the work is by facilitating a twist in the therapist's understanding so that he attempts to be purely par-

ticipant or purely observer. This formulation will be considerably developed in chapter five under the heading of attachment and detachment, so I shall restrict myself, in this chapter, to one example of each error. When I begin to feel like "a good guy" with one of my patients or clients I now recognize that as the anxiety driven mistake of attempting to be purely participant. Similarly, when I begin to feel like "the dedicated research scientist" I recognize that as the anxiety driven mistake of attempting to be purely observer.

I would like to close this chapter by sharing with the reader excerpts from interviews #3 and #5 that struck me as a participant in them as being moments of a most rare and unusual quality. The moments of most unusual quality might be entirely different for another reader depending on that reader's background.

The first is from Interview #3:

"For Sullivan was very, very good at sharpening the intuitions of his students because he got the student to listen and look at all kinds of minor things, to look at the clothing, to look at the gestures, to look at the posture, how the person sat, how they laid on the couch, when they were restless, when they weren't, their tone of voice, a million nuances, even the first telephone call, and how they approached asking for an hour, every minutia, and he could spend a whole hour with a student on simply what the student had missed either in one phrase or in one phone call, and by means of keeping at all the little things that might have been there, he developed in the student --- it's like learning an extra

dimension of hearing and seeing, smelling - almost, getting the sense of something and by means of bugging the student to keep looking and asking and looking and so forth and getting them more and more and more aware of all kinds of things he trained them to be much more intuitive."

The second is from Interview #5:

"---in talking with analysts, and I don't talk with many of them in terms of detailed theory, but when we talk about patients with each other --- trying to make some sense out of what's happening --- and are not defending some theoretical approach, then it seems to me we talk fairly comfortably, just in the terms we're discussing, and there the participant observation theme --- get away from that term and get away from transference counter-transference --- you are talking of how in God's name can two people stay together and talk with increasing clarity about some fairly personal matters without anxiety getting to such proportions that communication is obliterated or grossly reduced."

Chapter 5

Analysis of Data and Discussion of Participant Observation

A. Analysis of Data

As the reader will recall the interviews were to be approached in two different ways. Firstly, they were to be read as documents simply for what the interviewees had to say. This was out of a sense of the interviews being of historical worth. Secondly, the interviews were to serve as a data base which was to be analyzed for the presence of psychotherapy attitude. Three statistics were to be computed, the first two of which were essentially reliability measures and the last a validity measure.

The first statistic was the percentage of concordance where an instance of concordance was defined as any case in which the difference between mean ratings was less than or equal to one. It was shown that random factors could not account for any percentage of concordance above .60 and such values should be considered as indicative of reliable ratings. Secondly, product moment correlation coefficients would also be computed. Thirdly, a grand mean would be computed and the degree to which the grand mean was greater than that attributable to chance (i.e. 2.50) would be taken as an indication of the presence of psychotherapy-attitude.

The statistic of percentage of concordance of ratings indicates that the raters can agree on the presence of the attitudes in some cases, but not in all. (See Table #1) The product moment correlation coefficients are uniformly and

TABLE # 1.

Interviewee:		#1		#2		#3		#4		#5	
Rater:		G.A.	J.S.	G.A.	J.S.	G.A.	J.S.	G.A.	J.S.	G.A.	J.S.
Instances of Sensitivity:		7	6	18	12	28	24	6	16	14	10
Mean Rating of Sensitivity:		2.86	3.50	4.28	2.92	4.22	3.92	3.16	3.00	4.14	3.60
Instances of Openmindedness:		9	11	9	9	25	25	14	8	16	20
Mean Rating of Openmindedness:		3.44	4.00	4.67	1.78	4.44	4.04	3.36	3.88	4.31	3.55
Instances of Attentiveness:		7	24	7	8	21	34	17	18	18	20
Mean Rating of Attentiveness:		3.86	4.17	4.00	2.50	4.43	3.74	2.94	3.56	3.39	3.40
Instances of Responsiveness:		8	8	8	11	31	28	22	21	16	23
Mean Rating of Responsiveness:		2.75	4.50	4.12	2.73	4.26	4.46	2.50	3.57	3.63	4.04
Instances of Consideration:		8	3	17	16	21	20	22	12	20	20
Mean Rating of Consideration:		2.38	3.67	4.41	2.56	4.71	4.00	2.51	3.25	4.35	3.65
Instances of Compassion:		5	5	8	9	33	23	6	6	16	7
Mean Rating of Compassion:		1.80	3.40	4.75	3.33	4.64	3.83	3.00	4.00	4.00	4.00
"r" of Instance:		<u>.037</u>		<u>.812*</u>		<u>-.194</u>		<u>.477</u>		<u>.494</u>	
"r" of Ratings:		<u>.571</u>		<u>.067</u>		<u>-.833</u>		<u>.500</u>		<u>.260</u>	
Percentage Cocordance (+1) :		<u>.500</u>		<u>.167</u>		<u>1.000</u>		<u>.833</u>		<u>1.000</u>	

and disappointingly low. (See Table #1) This general failure to achieve reliable results indicates that one or more of three possibilities is true. One: the basic notion that there is an attitude that psychotherapists learn that is facilitative of their work is mistaken. Two: the notion is fundamentally correct, but there are limitations in the design that prevented me from demonstrating it. Three: the notion is correct and the basic design is feasible, but the statistic was less well chosen than it might have been.

It seems unlikely to me that the entire notion of psychotherapy-attitude is wrong. For one thing the concordance for #3 and #5 is 1.00 and that for #4 a quite respectable .833. When you compute a grand mean for all raters on all variables, the average score is 3.63. The fact that the actual mean is better than a full point higher than the hypothetical random mean indicates that either there actually is a psychotherapy-attitude, or else that the raters were predisposed to rate highly. There may have been some predisposition to rate highly as it is quite difficult to downrate even a complete stranger on such desirable traits as compassion and sensitivity. But the average scores range from 1.78 to 4.71 which indicates a willingness to give both low and high ratings. I would infer from these facts that there is some evidence which supports the existence of psychotherapy-attitude despite the relatively low indications of reliability between raters.

There is also the sense of personal conviction on the part of both the raters and myself that we were dealing

with human beings who were, by and large, compassionate, considerate, attentive and the like. My own sense of conviction may be partially dismissed as being wedded to one's theory. But my conviction may be only partially dismissed as I did have the direct face to face contact of doing the interview and could see how the analysts presented themselves.

My raters sense of conviction is even more interesting as they said things such as "I liked (name) immensely, and I'm sure he is sensitive, compassionate etc. etc., yet somehow the meagerness of his scores doesn't seem to justify that conviction". Both raters had the experience of gaining conviction that so and so was or was not possessed of a certain attitude, yet not being able to point to anything in the transcripts that was generating the conviction.

With the benefit of 20-20 hindsight, I can see numerous ways in which the study could be improved. Firstly, I would redo the code book. I would take the three categories of attentive, sensitive, and responsive, and lump them together into a single category of overt responsiveness. I would lump open-mindedness, consideration, and compassion together under the heading of warmth-compassion. With only two categories to rate, I could expand the code book considerably on both of them. I could then approach the problem that the responsive and compassionate attitudes are likely to be shown in almost minutely subtle actions by giving repeated examples of such. I would also expand the code book to include a workbook section.

The workbook would be one half of the training of

the raters. After studying the code book, the raters would then work the examples in the workbook. They could then rate some material that would be like the material to be finally rated. If I collected new data, the present series of transcripts could be used as a demonstrator series. With this method I could probably increase the inter-judge reliability considerably, though such a prolonged training period would necessitate that I obtain a source of funds to pay the raters.

Rating would be facilitated if I was able to provide a cassette or video tape of the material in addition to the transcript. One rater, in particular, commented on how such auditory cues would have been very helpful, particularly with #2 and #4. It is interesting to note that the interview with #2 had the lowest concordance rating of any of the five. To be able to provide even a cassette of the interviews that would be helpful, the master tape would have to be of considerably higher quality. This could be done with the use of tie tack microphones switched through a patch board or alternatively with the new omni-directional variable level microphones. The latter while excellent for this purpose (due to their unobtrusive nature) are extraordinarily expensive. Even with a high quality master tape, DBX or related circuitry would have to be introduced to prevent degradation of the copy tapes. Similar but more extensive (and expensive) equipment would be needed to provide decent quality video tapes of the material.

The rating task itself should be broken down into two phases, possibly with two different groups of raters.

The first task would be to simply have each rater mark on the transcript each instance of the attitude in question. If reliability can be established as to exactly what constitutes an instance of compassion or responsiveness, then the question of how much responsiveness or compassion can be addressed.

Finally, part of the problem may be that the interview situation with myself simply is not sufficient as a stimulus for psychotherapy-attitude. None of the analysts were "on duty" so to speak when they were being interviewed by me. All that can be reasonably expected is that a residual or background level of psychotherapy-attitude would be present in the interviews. Working with video tapes of actual sessions despite the immense difficulty in obtaining such material would be far more to the point.

Lastly, I have some question as to the use of the product moment correlation coefficient as the statistic of choice in future studies. Suppose that the selection procedures for establishing who shall be a psychotherapist are actually pretty good, i.e. that the training programs are choosing, by and large, individuals with a fairly high psychotherapy-attitude. If this is the case we are dealing with a distribution that is more truncated than I had supposed. Furthermore, it is biased in the positive direction. Kimble, Garnezy, and Zigler (1974) show that when the product moment is calculated for a sample from the top quartile of the distribution, it is almost inevitably lowered to the point of insignificance as an artifact of the statistic itself. Predicted vs. achieved concordance may prove to be the statis-

tical measure of choice.

B 1. Theoretical Discussion of Participant Observation with Clinical Illustrations

With regard to the question of whether the practice of psychotherapy is guided by personality theory or not, the analysts interviewed seemed to view that as not an either-or situation. They seem to see it as one in which the theory influences the data discovered, but the data collected influence the theory. Interviewee #5 put it most succinctly when he said "One of the better ways to preserve the pristine pure nature of the theory is to avoid work with patients". They all seem agreed that participant observation is not an aspect of personality theory, but a broader description of what you do. Interviewees #1 and #4 vociferously argued against participant observation as being a method. The question then becomes if it is not a method, then what is participant observation.

While I was preparing this thesis Leston Havens released his book Participant Observation. There is very little in the language or conceptualization of participant observation to quarrel with other than Haven's ascribing to Sullivan counter-projective statements. Sullivan, to the best of my knowledge, did not use the term 'projection' but conceptualized the events that most analysts and therapists think of as 'projection' as 'distortion'. My surmise as to why Sullivan favored the term 'distortion' is that nothing is actually being projected from the body during 'projection' rather a distortion is occurring during the preliminary cognitive process-

ing of stimulus input. It follows that Sullivan might not view with delight the classification of his efforts to ameliorate the distortions of his patients as 'counter-projective remarks'.

It seems to me, however, that Havens misses the essence of the meaning of participant observation, namely, its reference to the interconnectedness of events. I get the sense, which may well be wrong, from this book that Havens is relatively unaffected by his patients or else unaware of the degree to which he is effected. My own sense of participant observation is that the psychotherapist is inevitably participant, influenced and influencing, and that the therapist must, by the process of continually redeciding to do psychotherapy, become aware of this process of mutual influence to the end that he or she be useful in elucidating the client or patient's problems in living. I shall offer some examples from my clinical work of this way of doing psychotherapy and then develop the idea further.

The first patient is a white Catholic female who was 18 years old and single at the time of this psychotherapy. This was her fifth hospitalization in the last four years during which time she had been chronically dysfunctional. Periods of mute withdrawnness alternated with agitated states accompanied by elated mood. When the patient began to move out of the withdrawn state she not infrequently became suicidal and had a history of ideation, gesture, and attempt, the most serious being by ingesting approximately 2400 mg. of thioridazine. During agitated and elated states she presented a con-

siderable management problem. There had been lengthy trials of chlorpromazene, perphenazine, thioridazine, and trifluoperazene among the phenothiazines. The patient had also received trials of haloperidol, imipramine, and lithium carbonate. Some initial improvement was noted on each drug but no great or lasting improvement. During the psychotherapy with me she was on molindone hydrochloride 300 mg. h.s.

Session after session, day after day, this patient remained mute. After some 20 or so sessions she was willing to walk with me to my office. The day of the next session I chanced to be ill. When I returned the following day the patient was once again mute, isolated, withdrawn. As the season changed from autumn to full winter I began to feel more and more helpless and despairing with this patient. I tried a variety of tactics to induce her to begin talking, but gradually I lapsed into longer and longer periods of silence myself. My despair over my inability to reach this, my first really psychotic patient, became quite profound and I began to question whether my career choice had been a product of hubris.

Then I realized that my despair was the product of our mutual participation, and I became more observant of my own despair. I gradually formed the hypothesis that though my patient was mute she had continually demonstrated to me the net result of her four years of being psychotherapized - despair. I began to work vigorously - needling, nagging, being sarcastic with this person. She became assaultive toward me. When even this did not work, she began to talk - she hated

psychotherapy, she hated me. Eventually she began to speak of her despair - of wanting to die. When the three month limit at our hospital was reached, she voluntarily signed herself into one of the few remaining long term facilities. Spontaneously she offered to shake hands good-bye.¹

The course of psychotherapy with this patient illustrates fairly well a concept that I mentioned briefly in the first chapter, namely, that while the variables in a theory of psychotherapeutics are highly coupled - they are not necessarily of equal effect on one another. My experience of despair was highly coupled to the patient's experience of despair. Nevertheless, the intensity of my feeling, I believe, in no way approached the intensity of hers. Similarly, my experience of despair was largely situation specific. I wondered about my career choice when I wasn't with this patient, but I really only felt that sense of hubris and despair when I was with the patient. I would describe my therapeutic error of being insufficiently observant as the mistake of attachment (explained below).

The second patient is a Protestant mulatto female who was 22 years old and single at the time of this psychotherapy. This was her third hospitalization. She showed marked loosening of associations with no recognition that others could not understand her and a devastated attention span. The first two hospitalizations (which were sequential) were initiated by a suicide attempt in which the patient had

1. I have followed this patient's progress in her sixth hospital. It pleases me inordinately that she has been almost as difficult for the next therapist as she was for me.

first taken diazepam and discovering that it was of insufficient quantity to kill herself, had then attempted to drown herself, but could not keep herself submerged. She then slashed her wrists and stomach and fainted from blood loss. During all hospitalizations she had been extraordinarily resistant to the idea of taking medicine and had earned a reputation as being "one of the most assaultive patients on the unit in years".

I, myself, never felt that this patient was particularly assaultive and would routinely take her off the unit to walk across the grounds and have a session in my office. My reasoning was as follows. The patient's mother had developed fibroids during her second trimester carrying the patient. The mother was medicated with diethylstilbestrol to prevent spontaneous abortion. The patient, as did so many of the female children, developed cervical cancer, and this was treated with the surgical interventions of hysterectomy and oophorotomy. The patient displayed amnesia for this event.¹ Reading the progress notes of her previous hospitalization carefully I noticed that all instances of assaultiveness occurred within thirty minutes of receiving medicine. I hypothesized an inferred belief of the patient's to the effect that medicine = poison. Since I did not give her medicine nor were my sessions contiguous to her taking medicine, I did not think myself or my furnishings to be in any particular danger.

1. I have not settled to my own satisfaction whether the patient's 'amnesia' is her truthful account of no memory or prevarication around a topic too distressing to discuss.

Nevertheless as one session followed another and nursing staff, whose intuition and experience I respect tremendously, continued to mention their own forebodings about this patient's "unpredictable, savage assault" I resolved to be more and more observant. I decided to watch for anything that might be a prodromal of assault and return my patient to the unit if any such should appear.

This culminated in my receiving a telephone call one day that my patient after receiving her weekly injection of trifluoperazine decanoate, had assaulted two patients, and it had taken six attendants to remove her to the isolation room, where she was now so agitated that an injection of sodium amytal was being considered. I did not want her to have to receive another injection or have her reputation as "the terror of the D.A.U." to be furthered. So I held a session with her then and there in the isolation room. She greeted me with "You know why!". During the course of this meeting I realized that I had been so busy being observant of this patient for signs of assaultiveness that I had not participated with her in any way that would give this person an ally in her effort to trust others sufficiently to take another medicine. The way that I had participated had been as another objective watcher. I would describe my therapeutic error of being too remote in my participation as the mistake of detachment (explained below).

The third patient, a Catholic Caucasian male, was 23 years old and single at the time of this psychotherapy. This was his first hospitalization. He was transferred to

our unit for reasons that were obscure shortly after being hospitalized. He, like the first patient, was mute. Just as I began to think "Oh, no! Not another one!" I realized that what I was feeling was not despair but a curious comingling of fear and hope. I tentatively assumed that these feelings might be somehow a direct response to those of my patient, and recalled that I had observed him to walk with me to this on-unit session room in a manner that seemed willing enough. I hypothesized that my patient also might be feeling some fear - perhaps constrained from talking - and yet also hope that I might somehow be of help.

I commented to this patient that if there were some difficulty about talking, perhaps he would nod his head yes or no. The patient tentatively nodded his head yes. I began to ask questions that could be answered yes or no, and whenever my patient was immobile assumed that there was something about this question for this person that made it incapable of being answered yes or no. In this way we gradually established that my patient had lived for almost nine months in mortal terror of an anonymous 'they' who were listening to his conversations, who repeated fragments of these conversations back to him, who had put rabies in his coffee, had tapped his telephone, and had implanted electronic listening devices in his teeth. (These latter he had attempted to remove with a pliers.) Even how 'they' very probably were waiting outside the hospital for him to emerge so that he might be murdered.

In this particular case I found the strategies and

tactics that Sullivan enumerates as being useful in dealing with paranoid schizophrenics to be enormously helpful. But I could only apply these more methodic procedures after I had worked with my initial sense of the mutual influence. I had, more by luck than aught else, managed to hold on to both aspects of being the participant observer - what I call remaining unattached. I shall explain what I mean by "unattached", after I discuss what I believe to be the two fundamental mistakes that the psychotherapist can make. These are the mistakes of attachment and detachment.

By attachment I mean the unwitting living out of a role in a situation. I use the word "attachment" out of some feeling that the person doing the unwitting living has some dimly felt, but none the less profound, emotional investment in the role. "Attachment" has both the nuance of stuck (by virtue of the unwittingness) and of emotional investment.

Before I can properly give some further examples of attachment, I need to explain my tripartite division of learning into conditioning, insight, and realization. By "conditioning" I mean any more or less permanent change in activity that looks like it must be a consequence of the original activity having called forth pain or pleasure e.g. the hand having touched the flame does not grab fire again. This use of conditioning is somewhat more loose than that of the learning theorists.

The aspect of conditioning that I wish to emphasize is the unspeakable nature of such learning. No one is saying "Oh, there's the fire again. It burned me last time. Better

not try to grab it.", there is simply conditioning. I say "unspeakable" rather than "nonverbal" as nonverbal is not sufficiently suggestive of the power of conditioning. Though this unspeakability facilitates attachment, it is functionally necessary. If we had to talk our way through all our activities, we would die of thirst trying to get a glass of water.

I am using "insight" much more loosely than the psychoanalysts to refer to the ability to learn by articulating causes and effects. Insight creates a logical past and a logical future in which because of that then, there is this now, and if we do this now, there will be that then. Insight may be accompanied with varying degrees of emotional feeling. The degree of emotionality depends to a large degree upon the personal importance of the "this" and "that".

Realization is the term I introduced in chapter 3 to describe the sudden knowing that now is the moment (timeliness), this is what to do (appropriacy), and this is how to do it (gracefulness). More generally, to realize is to suddenly perceive the situation as it is now in a fundamentally different way. Realization differs from construction and understanding in that the new perception is 'obviously' more real to the perceiver than his or her prior perception. Typically though not necessarily, the situation as it is now is not perceived as being in any way different from the situation as it was then, it's just that I never saw it this way before.

Where conditioning is unspeakable, and insight is quintessentially verbal, realization is, to coin a term, transverbal. One can usually verbalize a realization, but to con-

fuse verbalization with realization is to confuse a photograph of "X" for "X". Given this caveat, here are some examples of the verbalizations that accompany realizations. "You can see it two ways." (refers to young/old woman illustration) "I love you." "I hate you." "It unscrews counterclockwise." "I am an alcoholic." "All beings are enlightened." "It's a leaf." (refers to previously formless percept of green something or other) "I'm not crazy!!" Realizing like verbalizing (insightizing?) and conditioning may be accompanied by varying amounts of emotion.¹

The three modes of learning have overlapping ranges of effect on the person involved. While all three modes may vary from the trivial to the profound in their effect, insight is potentially more profound and far reaching in its effects than is conditioning while realizing is potentially the most profound form of learning. These overlapping ranges can result in painful situations. For example, a person may have insight into the relationship of cigarette smoking and lung cancer yet be unable to quit because the reinforcement of smoking is too great.

This long digression has been necessary to provide background for some tentative hypotheses about the causes of attachment. Essentially, I am assuming that the unwitting living out of roles comes about because the persons involved have learned their respective roles through conditioning.

1. I rather strongly suspect that what I mean by realization and the distinction I make between it and insight may prove to be of use in clarifying the somewhat vague concept of 'emotional insight'. I plan to discuss this issue at some length in a future paper.

Individuals may 'shape each other' into complementary roles without a single direct statement ever being made. It can take considerable analytic and synthetic reasoning to reach some measure of insight as to what is ongoing. Alternatively any participant, who simply, but alertly, begins to observe the ongoing situation, may realize what is happening.

There are many attachments possible for the psychotherapist. As they are all "unwitting living" they may all be considered as mistakes of "mere participation". Some of these attachments are more or less chronically inflicted upon whomsoever is unfortunate enough to become the client or patient. Such chronic attachments are unresolved problems in the therapist's living. Others are acute, which is to say that the therapist learns by conditioning to play the complementary role for the client. These acute attachments can be as disastrous as the most chronic if the therapist is not alert enough to realize what he is doing.

For example, I recently found myself on the verge of saying something that seemed therapeutic enough. Then I realized that actually I was filled with the desire to humiliate my client with scathing sarcasm, mildly disguised as interpretation. Why? As I listened to what he was saying, he certainly seemed to be working in the therapy. Further, the topic of conversation was not something that would ordinarily arouse such anxiety in me that I would try to regain my sense of security. Finally, sarcasm isn't even one of my typical security operations. In supervision, I realized that I had felt sneered at. This was communicated, my visual memory

tells me, through body posture. Such sneering was part of the way that my client attempted to ward off the scapegoating to which he had been repeatedly subjected.

The poignant truth is that the method by which my client attempted to obviate any potential insult practically guaranteed that he would be insulted. Being insulted, he made more strenuous efforts to prevent future insult, the net effect of which was only to bring about humiliations and scapegoating. As his efforts to stop or at least vitiate these unpredictable humiliations became habitual and postural, he slowly created the nightmare world he so devoutly wished to escape. This process when continued and intense becomes a self-perpetuating delusion.

Before an attachment can be reversed, there has to have been a prior insight or realization that it is occurring. Both insight and realization depend upon observation. Knowledge of an attachment may be sufficient to undo it, or the conditioning may be so strong that a formal program of counter conditioning is needed.

Where attachment is the mistake of mere participation, detachment is the mistake of attempting to be merely observant. More formally, detachment is living as if one were not in a situation when one is. As such it is a crippling of our creative capacity to imagine or pretend in that the detached person is not clearly aware of and hence not in control of the imagining. Detachment seems to have its genesis in situations where one has been both terrified and entrapped, for example, being suddenly and severely punished

by a parent who had hitherto been behaving quite nicely.

The closest thing to escape from such a terrifying situation is by devoutly pretending that one is not there. Under these circumstances, the reinforcement may be so powerful that even such a complicated activity as imagining may lose its selective voluntary character and become a conditioned response. In this way, detachment can become habitual. Guntrip (1969) has movingly described the experience of such people.

Detachment can be further complicated in the following way. Consider the situation in which a person is badly frightened by the experience of being in love. Detachment occurs. If the person nevertheless wants to be in love while experiencing detachment in the situation with the loved one, he or she may turn to the cultural heritage for guidance. He or she will then do those things that the lover is 'supposed' to do. To the casual observer such a person is the ideal lover (obviously), to the acute observer there is an as-if quality to the actions. They become performances.

Detachment and as-ifness can be extraordinarily troublesome to the psychotherapist. By the very nature of his job the psychotherapist is exposed to those social situations which are most likely to be frightening. They are, after all, the ones most likely to constitute problems in living. Detachment readily occurs. What is worse is that the detachment may be justified by recourse to ill-understood theory. Such a person may glibly speak of 'not endangering the transference' and know very little of the original meaning and sub-

sequent development of the concept of transference much less be able to recognize transference when he sees it.

In my own case, when detachment occurs it is complicated by as-ifness. Frightened and frightened of being frightened I become detached. Eventually I recognize my own detachment and try to remember what I might have read that might apply here. So I imitate and do my best to act as if I were a psychotherapist. The difference between learning what one can from books on psychotherapy and using book-learning to bolster the as-if activity may seem abstruse when discussed. It is all too painfully obvious when I listen to tape-recordings of my sessions.

Where attachment is being insufficiently observant of how one participates, detachment is being insufficiently observant of the fact that one participates. To be unattached may be defined negatively as falling into neither attachment nor detachment. It may also be positively defined. The essence of participant observational psychotherapy is to remain unattached by which I mean to simultaneously recognize one's inevitably participant status in these dyadic situations while remaining committed to observing as much as possible of these situations as they develop.

Participation is of two kinds: overt and covert. By overt I mean every thing that might possibly be recorded by video taping of a session. By covert I mean that which we learn we must communicate to an observant other rather than that which we continually demonstrate to such a one. Speaking loosely, covert refers to my experience.

Experience is so habitually thought of as both private and mine that it is remarkably easy to forget that my experience is my experience of the situation. It is to place some emphasis upon this simple fact that my experience is called covert participation. For example, I recently was listening to a client speak about her father's compulsive gambling. While she spoke I saw an image of a movie poster that said "For \$10,000 they break your arms, for \$20,000 they break your legs". To dismiss that fantasy/image as 'mine' would be to throw away opportunity.

I asked my client if she was perhaps trying to say that her father was a broken man. She said yes, that was exactly it, and then spoke a great deal on her previously unarticulated feelings about this. Without my having seen the movie poster, it couldn't have occurred as a memory so, in a way, the experience is 'mine'. But the fact that the memory occurred exactly then in that situation made this experience a covert participation.

To review for a moment, participant observation as a way of doing psychotherapy may be considered as consisting of four overlapping, concurrent processes, techne, attitude, strategy, and tactic. When the four processes of participant observation are applied correctly, the therapist is an effective participant observer which I have described as being unattached. To be unattached is to be neither attached nor detached both of which mistakes are the result of being insufficiently observant. This means that to be unattached is or is the result of being alert. It seems reasonable to conclude,

therefore, that if the psychotherapist can increase his or her alertness, his or her aptitude for doing psychotherapy will ultimately be increased.

B 2. Preliminary Communication on Contemplative Practice (Zazen)

During the past five years I have engaged myself in a practice, unavailable to Sullivan, which develops alertness.¹ This practice is zazen. Zazen develops alertness in no mediate, magical, or mystical way because zazen is simply a term for the practice of being alertly focused upon some activity. At the same time, zazen specifically refers to the practice of sitting contemplation either upon breathing or posture. Before I discuss the effects of zazen, I should clear up some prevalent misconceptions about it.

Zazen is almost exclusively known in American as the major contemplative practice of the devotee of the religion of Zen Buddhism. The fact of the matter though is that the Zen Buddhists themselves recognize that zazen can be practice from several different understandings for a variety of purposes. (Kapleau, 1965) Practice for the purpose of developing one's capacity for participant observational psychotherapy would fall into the traditional category of Bompu (ordinary) Zen.

Zazen is frequently grouped with T.M. or other forms of meditative practice in the minds of people who have a peripheral interest in such matters. Several distinctions must

1. There is a tradition among serious Zen students not to speak of this experience for the first 10 years of practice. This tradition is neither arbitrary nor exclusionary. I am making such a preliminary communication solely because I shall have no other opportunity to do so within this institution.

be made in order to reduce confusion. First: zazen is not strictly speaking a meditation. The goal is not to focus one's concentration on a mantra (sound-syllable) or yantra (fantasy-image) to the exclusion of all else. It is, as I have said, to remain alert, focused upon one activity, not repressing other stimuli, but not allowing free association to occur either.

Second: zazen is not primarily a relaxation. As both excessive relaxation and excessive tension interfere with alertness, the experienced student assiduously avoids them both. There is just enough tension maintained in the striated musculature to keep an erect and balanced sitting posture. The reader unfamiliar with zazen practice may generate an accurate visual image of the posture being discussed by recalling the posture of a trained typist. Though the Zen student usually sits on a small round cushion, the posture from the hips up is that of the typist.

Third: considerable emphasis is placed upon the maintenance of this posture. This is not true of many of the popularized forms of meditation that are currently in vogue. One reason for this emphasis on posture is that it is believed by Zen students that alertness is most easily maintained in this postural state. The traditional explanation is that the posture affects the blood circulation in such a way as to facilitate alertness. I do not know if this explanation is true, but it is certainly true that maintenance of the posture covaries with maintenance of alertness.

Extended discussions of how to practice zazen along

with precautions, and likely effects, have already been made in such books as The Three Pillars of Zen by Philip Kapleau. For the purpose of this discussion, it is only necessary to mention that the activity typically focused upon during the formal sitting practice of zazen is breathing.¹ The practitioner does not force any rhythm or rate, he just carefully observes this breathing.

The first effect to be noticed is that breathing while undeniably essential is one of the world's dullest spectator sports. To occupy one's self for periods of time ranging from 30 to 60 minutes with nothing other than the careful observing of one's breathing is to make the careful observing of the dullest client appear easy in contrast. (I am aware that "dull" is a product of the perceiver, but when I am doing the perceiving, the dullness resides 'in' the perceived.)

The second effect that I have noticed is the gradual abolition of the belief in an abiding or true self. Such terms as "true self" and "ego" are notoriously difficult to define in any satisfactory or useful way. I am using the term "abiding or true self" to refer to the idea that this sense of me has some underlying and defining characteristics that began at some time in the past, continue, and will extend for some time into the future. These defining characteristics of me are not, however, used in the way that most defining properties are. They do not define or uniquely determine my behaviors.

1. There is a variety of zazen, known as Shikan Taza, in which the emphasis is not placed upon breathing.

The actual use of these allegedly underlying characteristics, it appears to me, is to divide all ways of behaving and presenting one's self into two classes, those that are in accord with the 'true self' and those that are not. For example, the purchase of an article of clothing may be urged because "it brings out the real you". A pleasant feeling may be described as "I feel more like myself today". An invitation to some activity may be refused with the explanation "That's not me".

There is an accompanying idea that ways of behaving which are in accord with the 'abiding self' are both more proper and more pleasant than ways which are not. A person who is extremely concerned with behaving properly or who notes that his or her own life is not exactly overflowing with pleasant experiences may begin a protracted search for their true self. As long as such a search is confined to trying various modes of behaving, the logical absurdity of searching for that which is defined as pre-existently there need bother no one.

What causes grievous suffering, I think, is the decision that such and such is an underlying characteristic. The person then either lives that way or does not. Either case generates unending trouble. If the person succeeds in living consonantly he or she runs into the fact that no characteristic, no matter how estimable, is inevitably beneficial in every situation. For example, telling the truth may be put forward as representative of or consonant with the true self. As I mentioned in chapter one, telling a highly anxious person that you expect them to become frankly psychotic within

the month may be truthful. It may even be accurate but it is rarely helpful.

Extreme suffering is the frequent result of living consonantly with a characteristic, purported to be of the true self, that is less than estimable. By "less than estimable" I mean one that is usually followed by unfortunate consequences. For example, a person, feeling helpless and unable to do, may dismiss the matter by saying "I'm just like that. (ineffectual) That's all". When he or she does not try, others see a person not trying to rectify an unpleasant situation and conclude that the person must be helpless and treat him or her as if he or she were helpless. This cycle when repeated in the context of a deteriorating situation rapidly becomes a self-perpetuating delusion.

When the person does not succeed in living consonantly, there is a discrepancy between what the person believes him or herself to be and the way he or she acts. When the belief is comforting and the discrepancy not noticed, the effect may be no more disastrous than the obviation of any potential for acting from time to time in accord with the belief. Where the belief is not comforting and the discrepancy not noticed, it is a truly poignant situation. The great Zen master who never practiced zazen is an example of the former case, and the mother who actually does quite well by her children yet feels insufficient is an example of the latter.

Where the discrepancy is noted, there is potential for change. The person may try to live out the characteristic, feeling elated when successful, depressed when not. The

person may with sorrow or relief drop the characteristic from the (never completely articulated) list of attributes of the true self. Rarely, the person may begin to question the whole notion of a true or abiding self.

The initial questioning is not infrequently dropped because the idea of no abiding self can be annoying, irritating, angering, frightening, and even terrifying. This is because no abiding self can be equated with a loss of self and particularly with experiences of depersonalization. The mildest form of depersonalization is one in which the body gradually takes on the status of an object. It may be petted, pampered, fussed over, prized, but at base the body becomes a possession that I own.

In its more traditional sense, depersonalization is that experience in which some part or even all of the body comes to lose the immediate sense of being me. An arm may suddenly be seen as just as much a part of the furniture as the chair upon which it rests. This experience may be viewed with equanimity as an interesting psychological event, or it may be viewed with a mounting degree of anxiety. This anxiety may merge into actual panic if the person begins to think "My God! What's happening to me? I'm losing myself". Panic seems to accelerate depersonalization so that the final result may be the literally horrifying experience that I am being eaten alive.

Fortunately, experiences of terrifying loss are not the only alternative to belief in an abiding self. As the Zen student continues to practice, extending the practice

to more and more daily activities, he or she begins to notice the little discrepancies between ideas of the self and what is actually being done. Slowly, over the course of years of practice, the student comes to respond, not on the basis of habitual and preconceived notions, especially of who I am, but simply on the basis of the situation as perceived. To give a non-clinical example I used to have extensive food preferences. I liked this and didn't like that. Gradually I began to appreciate the taste of more foods simply for what they were. Now that whole period of food preferences seems like it was so much extra work.

This ability to see what is and respond to that is of inestimable value to the psychotherapist. I believe that the quote from Sullivan (given in the frontispiece) on psychiatric expertness as participant observation shows that he prized this ability greatly. Sullivan repeatedly emphasized that you must be an expert observer. Shunryu Suzuki, a great Zen master, emphasized the mind of a beginner, the exact opposite of an expert. It would seem that zazen and psychotherapy must be fundamentally irreconcilable.

But expertness consists of the ability to observe. In order to do this, the psychotherapist must not only have a great deal of learned technique, of strategy and tactic, and a sense of what is average and expectable. He or she must also be ready to see the uniqueness of this particular person who has come at this particular time. This cannot happen if the psychotherapist is asleep or knows in advance all about this person. This awake, aware, nonpreconceiving attitude is

the mind of a beginner. True psychotherapeutic expertness consists of the ability to maintain or regain beginner's mind.

APPENDIX A

The Data Base

Interview With #1

J.B. --- with Dr. Sullivan what their impressions were because I'm told, in my first interview I was told most strongly, that he spoke very differently from the way that he wrote. So to begin, what do you think Sullivan actually meant by participant observation?

1. Well, I think he meant that in distinction to the idea that an analyst is simply, or a scientist for that matter, is simply observing, you know, what goes on in front of him, or observing his patient, that the analyst is not only observing, but that he is also - I don't want to say changed - effected by his patient and by the situation, and that he is in the very process of the therapy that he is involved too. He is not simply a see-er or a seer either one. That's one part of it, and the other part is that, of course, he is also someone who is participating in the therapy as an active participant, but I think the difference is that at the same time he's not only observing the patient, but observing himself and being changed and effected by the relationship. I never thought of it as a method in itself. I thought of it as a component part of a method, or an essential way of approaching therapy. Colby, you know Ken Colby, he took issue with this term, participant observation, and called it - he said it should be called, and what Sullivan really was talking about was

participant communication. Well, I'm not sure I quite agree with him. I don't see -- he wanted it -- you see, he wanted to emphasize the communication part of it. Well, I'm sure Sullivan didn't have in mind leaving that out. I think that's implicit in the 'participant' word, but what he did want to emphasize, I think, was the same thing in that. You know you would explain it in anthropology that the anthropologist must realize that he isn't just an unmoved observer of what he's observing, that he's effected by what he is observing, and he is a very important part of the process of what goes on.

J.B. My understanding of how he came to that concept was at the time that he came up with the term, he was sort of arguing strongly against the concept of the analyst as the blank wall or blank screen.

1. As simply a mirror

J.B. Yes.

1. Oh, yes, definitely. I'm sure of that.

J.B. How did he teach you? He talks about, in his books, refining one's self as an instrument of participant observation. How did he teach the beginning therapist to go about this?

1. Well, now, he, of course, he did lecture us, and we did have courses in which he lectured, and we had courses in which cases were presented to him, and he would then talk about the cases and the role of the analyst in the case, and then thirdly, another way he taught was through per-

sonal supervision. I had all three experiences with him. I had the personal supervision for over a couple of years about once a month.

J.B. Is there anything in particular that stands out as an illustration or an incident of his teaching method - nothing too personal, but something that still after these years stands out?

1. Well, yes, the way he would supervise. He'd let us -- he always left an hour and a half for supervision. And well, that was because, you know, we were a month apart. It wasn't weekly supervision as is the custom, and so there was really quite a lot of material to report, and he would wait til you were all through. I don't remember his ever interrupting me except if he didn't hear me or didn't understand a word I used, or something like that, but I don't remember his interrupting. Then when you got through, he would grunt or sigh or do something like that, and then start in. And the thing I remember that happened more often than once was that he really didn't get a very clear picture from me of what was going on in the therapy or with my patient, and he, I remember his saying at one time, that he didn't -- he wasn't sure whether I was simply asleep or uninterested as he felt that I, you know, wasn't really paying attention to what the patient was communicating to me. Now those are not Sullivan's words, but this was his - the kind of thing he would get across. He certainly, constantly emphasized the business of not taking for

granted you knew what the patient was talking about, of not assuming anything, about getting at what -- you know he thought it was terribly important that there be real communication that goes on, and he felt a lot of times, of course, that the patient was - is very difficult, his very neurosis, or whatever you want to call it, was something that had effected his communication and made it as uncommunicative as it often was, and it was the doctor's job to get it to be communicative and to realize that he wasn't being communicated to and not to assume that he knew what the patient was talking about or meant. Those were some of the things that constantly ----- . Then, about this thing of refining one's self as an instrument of participant observation, I think by that he meant not repeating the same thing with the patient. Not being - he would put it in terms of knowing what one wanted to - what effect one wanted to have on the patient and to communicate as tersely as possible something that would have that effect. So it was in terms of refining how you said things to the patient in order to produce the effect that you thought was necessary, or doing something. If he felt a patient, you see, was getting too anxious about something, he would feel that the therapist should intervene by saying, "Well, I think we can let that go right now, but I would like to know - you know you talked about your Aunt Lucy and what about her?" In other words a change of subject

like that, that would get the person off the anxiety - too anxiety producing a topic.

J.B. After your training with Sullivan did you then go on and apply this in your clinical practice? 'This', the participant observation.

1. I would ----in answer to that, I would say -- you see there was ----. As you know, analysts vary terribly in their personal styles and ways of doing things. My own personal analyst there at the time was, well a friend and a learner from Sullivan himself and so on, was Louis Hill. That man there. (Points to picture.) And he had a way of saying things and doing things with patients that I naturally modeled myself after much more than I did ---. I found myself not really able to be Sullivan, and I don't today. I'm not ----. I can't do the thing that Sullivan did or be ---- communicate in his style of language, as he reports himself in his various books of what he says to patients and so there ---- and there were some other influences in my teaching. So I think for quite a while I was trying to find some way of my own, you know, with a lot of influences and not particularly consciously utilizing Sullivan. I would say that the older I get the more Sullivan gets to me and the more I think I do. People tell me when I teach, or when I tell them about cases or use cases as a way of teaching that I do sound like Sullivan, that I do act like Sullivan, so, and I feel too, well you see I --. It wasn't until really after, well way after his death,

that I found myself writing about Sullivan and going over his stuff again, and it really getting more of a grip with me than it did at the time.

J.B. And to get back to the point you were just talking about, how you found your own style. How did you go about amending and changing, I know that's an impossible question to answer in a few words, but to the best of your ability, how did you amend or change that idea of participant observation as you went along in your own practice?

1. Yes, well, I was never conscious of, you know. I was never conscious of saying to myself, 'Now I'm going to be a participant observer', or that 'I'm going to indulge in participant observation when I'm with a patient'. I don't think that's what you mean either. I think it was a question mainly of being myself and trusting to my own ways of dealing with a patient and realizing more and more what Sullivan reiterated again and again - that one needed, in order to intervene with a patient, to get him to get somewhere close to saying what he really meant to say, you know. And well, one thing I remember was about seven years after I graduated from analytic school I was sitting with a patient, whom I didn't know beans what to do with. He was talking and so on and so forth, and I wondered. I was trying to think to myself, 'Now what would an analyst do with this?' And suddenly I thought to myself, 'Well, for God's sake, I'm an analyst. I've been one for sev-

en years. Why don't I think about what I would do with him?' Well, you know, and I said, 'I don't have to be an analyst for this patient. I can ---.' Well, this was a kind of --- I remember it as a kind of revelation to me that got me out of any rigid application of any of the analytic ideas or theories or practices that I'd been taught. That I could, you know, use myself as a tool of the analysis in the way I thought best, whether you call it analysis or not, and that was a great --- it removed a great many shackles from me which have continued to drop off, so that I wonder if anybody really, who saw what I did here with patients, any analyst would ever think of me as an analyst any more.

J.B. Have you done any teaching since then -- along with your practice?

1. I've always taught. I never stopped. I taught first, you know, as a younger person. It's the people like social workers that tend to use you, and I taught them, and I taught in psychological departments in schools, and I taught teachers, and I taught ministers and physicians and, but after about five years, you know, being an analyst you can get on a faculty of an institute, and I've always been on a faculty of an institute, and taught analysts too.

J.B. Have you used Sullivan and in particular the idea of participant observation much in your teaching?

1. As such no.

J.B. A topic you sort of mentioned transiently in the begin-

ning was to what extent do you think participant observation sort of stands by itself as an idea, and to what extent do you think that in order to really use that concept you sort of have to use it in concert with the rest of Sullivan's interpersonal theory?

- # 1. I always thought of it as a much broader idea in science that the scientific observer is never outside of what he observes and always --- I knew a lot, you know, about scientific development in general, and I always thought that, well, of course, one of the places where it came up first was in terms of physics and the, you know, --

J.B. Heisenberg.

- # 1. Yes, and - but I always had the feeling that Sullivan was responsible for making it very real in psychiatry and in the social sciences generally in terms of his interest in research and teaching researchers in human behavior this fact.

J.B. Do you think that Sullivan's way or any way of doing psychotherapy, which emphasizes participant observation, is in some way fundamentally different from the way that competent therapists, who espoused another theory, would go about doing psychotherapy?

- # 1. I find that hard to answer. You see we really know --- so little. We really have a chance so little of the time to know how other competent therapists actually go about therapy. It's a general - I think it's a general fact that the -- that no matter what training one has, no matter what theory one espouses, the older and more experi-

enced one is the more one is likely to do the same things with patients, and the younger one is and the more one happens to be influenced by one's recent teaching, the more difference there seems to be in the way one goes about things. So one answer to your question would be that probably any experienced competent therapist would, maybe not be conscious of using or operating with participant observation, but would be doing so no matter what his theory was.

J.B. This is sort of an omnibus question in some ways. Out of your own experience what is the single most central recommendation that you would have for a beginning psychotherapist?

1. Don't assume you know what the patient is talking about.

J.B. Isn't that sort of very close to participant observation in some ways?

1. I would think so. Yes. (Pause during which I thank the Interviewee, who then begins to talk.) This is the most frequent, you know, when a therapist is not responding appropriately, or is not understanding appropriately, is missing something. I think this is the most frequent error, that he assumes he knows, you know, what the patient has in mind when he says something, without getting the patient to tell him what he has in mind.

J.B. One of the things that most struck me in another interview was that one of the psychoanalysts said that in the course of her own supervision, what struck her about Sul-

livan was he was always asking, "As illustrated by what?" Do you think this gets at the whole thing of not assuming that you know what the person is saying, what they mean?

- # 1. Yes. It gets at that, and it gets at another thing, and that is the tendency of patients to talk in generalities, which, you know, you never know exactly what the referent point of the generality is, what the patient is really thinking of in terms of what you can see and hear and feel and observe, and this is in a sense, you know, something that the behavioral therapists really work with, and I think are bringing back to our attention, and in a way I don't find them at all far out from therapy except in so far as they deny that there is anything else to people in behavior, but when they don't have to do that, and some of them don't, I feel that they bring in a very important thing that has been lost sight of in terms of analysts getting lost in their theory, and talking in their own generalities without reference points along with the patient and -- what was I going to say there? Well, I've lost track of it.

J.B. From the - there is some idea. I know some of my professors feel this way, and I feel this way myself that Sullivan seems to sort of have a unique compatibility with the best of the behavior therapists. Do you think this is so?

- # 1. Yes, especially in the sense that it is the operational aspect of his theory.

Addendum

J.B. O.K. Addendum.

- # 1. So I was saying that in regard to participant observation, one of the things that we, I think a number of us stress, people like Tauber and others has been the use of feelings in elucidating what was going on between the patient and the doctor, such as, if one's feeling bored, and the patient says something about it. Well, I remember Sullivan, himself, would say to a patient, "Well, are you saying anything that is really interesting or meaningful here?", and - but I was thinking of a little bit different kind of thing, as maybe a patient --- you feel anxious, or maybe you feel - you find a patient is making you feel very resentful, and then to look for what the patient is doing, what is there beneath what he is saying and obviously saying and so on, and the patient usually doesn't have any idea of this, and one can -- this is kind of a crude example -- but one can, you know, say to a patient, "You know you're making -- you're -- I'm feeling really quite resentful of you right now. What do you think it is? What do you think is happening here? Do you think you're having some part of it in this?" And the patient may come through or may not in terms of realizing that yes, he really would like to get the doctor mad and was trying to do so. That sort of thing, the constructive use of feelings in the analyst to elucidate what goes on in therapy, is what I'm talking about.

Interview With #2

2. I didn't think it's that complicated to begin with. However, it seems that there may be some necessity for whenever one gets away from a situation ---- You want to tape this stuff?

J.B. Yes, if that's o.k. I just wanted to make sure that -- because you are speaking softly that the recording levels are o.k.

2. Oh, I see. I didn't think it was that complicated. The idea of participant observation.

J.B. Yes. What did you think Sullivan meant by participant observation?

2. Well, I think, you see historically he came into the field at a time when they had this sort of a blank screen idea, you know?

J.B. Yes.

2. And that still is a feeling that sort of, from what I hear, seems to permeate at least the theory and so forth. Orthodox Freudian therapists, the therapist, who is sort of a blank screen, in a way is not really effecting the situation, but having come in at this point I guess having his whole notion of interpersonal theory of the ties that are connecting people in more ways, he felt that it was rather preposterous -- that would be my notion. So he tried to define that the analyst was participating just like all people. Any time two people come together they participate in something. They go into action. Their whole personalities in a

sense go into action vis-a-vis each other, you see, and what goes into action are their needs - their human needs and their security system. Are you familiar with the notion of the security system - security operation? And this goes on as soon as they make contact, and if one observes, as he became quite sensitive to observing the shifts in the communication set, he began to differentiate where certain needs, that might be expressed, suddenly ran up against something, which to him ultimately meant anxiety, and something else occurred so there was the actual break in the flow of communications and that that was when he felt the security system went into operation. What I'm simply telling you then is sort of extending, as you may already know, mainly his theory of what happens in interpersonal relations, and therefore that the therapist was always a participant, you see, and yet he would have to observe what would go on. I suppose in most of our relationships, at least in those days, people had relationships. I don't know how many people observed in any psychiatric sense the flow of communication, you know. And if you were to do this with your friends, I mean either you'd have great intellectual conversations, or they would find you rather tedious, you know, but if one comes into therapy, I suppose there is a mutual bargain made - a mutual arrangement to understand one's self and the meaning of one's interpersonal relationships so you go ahead. So that's all it seems to me he had in mind when he talked about

participant observation. O.K?

J.B. In the books he talks about teaching people how to refine themselves as an instrument of participant observation. Now I understand you said you were supervised by Sullivan, himself. How did he teach you?

2. Well, how does one say that? The way, I guess, the way he taught was basically to hear the information that you got ----- that you had kind of, you know, worked up. You had seen your patient a number of times. You brought the material to him. He would listen and then he would tell you what he felt had been going on between you and the patient, or between the patient and the patient's world that excluded you. In other words, you get a history from a patient. The history in and of itself tells you something about what he has experienced in life, and how he has reacted to that experience, you see. I suppose you've had an example. If you get a patient and you sense they are very rigid for instance, that means to you that somewhere along the line they developed this rigidity because there is something rather risky about flexibility. So actually the way he -- I think the way he taught was simply to try to make sense of the presentation in terms of tracing the anxiety which would be a kind of a reflected appraisal, he never used that word, you see, of the life experiences and see how they operated in the long run of the person's history before they came to you. How they repeated themselves with the hour. The emotion of the

anxiety and the way he dealt with anxiety, the way the patient dealt with anxiety, the way the stream of communication could shift. That was his method. That's what he would primarily concern himself with.

J.B. Did he emphasize very much paying attention to and even cultivating your own feeling -- reactions as part of this refining yourself?

2. I think that would be implied, you see. He didn't certainly go in for it the way we hear about it today. It has practically become a fetish in a sense, and, but he implied that one certainly would need to have had such experiences of one's self, you know, to be analyzed, in other words.

J.B. Another thing, from different interviewees, I'm not sure, I have the sense Sullivan may have used different styles of supervision. One person told me quite explicitly that he would wait until he had heard all the information and then he would start to go through it with you. Another person mentioned that he would frequently say "As illustrated by what?" I'm curious if your experience was that he would wait, or if he would interrupt.

2. No, he would not interrupt. He would listen to the whole presentation and when I would be finished ---- I'd see him for double sessions, you know, not an hour session, but two sessions so it would probably be ---- two 50 minutes is what? an hour and a half, an hour 40 minutes. He allotted I think two hours. We might even

have a little break in between, you know.

J.B. Another person said that -- in fact it was interviewee # 3 -- said that he emphasized very much straight talk.

2. Oh, yes, no jargon, no jargon. You were to talk to people the way people were accustomed to -- to listen to people who they hoped they would understand.

J.B. After your training with Sullivan do you think that you applied participant observation in your own clinical practice?

2. Well, yes, there is no question about it. What it did was relieve me from the burden of feeling I had to be anything except who I was. You sit there thinking you're, in the old times, sort of some kind of a god or all of these things. I feel that's kind of a burden to carry and this way, well ---- you see there is another factor I guess that must be applied. There is some kind of ----- maybe this question will be one you ask me later --- there is a certain kind of feeling that you get from Sullivan, namely, that he is very much interested in you as a person and in your growth and in your development, you see, and that's something that you feel as (garbled) to do. And the reports have been that people who work with him as patients had that feeling, and that means he is participating in a certain fashion, you see. This is an element. He is participating as the kind of a person he is, namely, a constructive person in terms of interpersonal theory. If something is shown by you that may even need a lit-

the applause, he might very well applaud it, you see. God knows if you haven't had any applause in your life when you say something, maybe you should get a little applause if you never had it, I think he would feel. I mean he wouldn't stand on his head or get ridiculous about it, but you would get a signal from him that this was something that you could be proud of in a sense basically. So there were these. You see this would be part of his participating in a certain sense as a real person. I wrote a paper by the way. I don't know if you've read it, have you?

J.B. I don't think I've read it.

2. It appears in ---- in which I try to explain something about my feeling of what therapy is all about, and I think I cover a lot of this. It appears in a volume called "Interpretation". It was a volume by Emanuel, no not Emanuel, Leon --- Hanley. Emanuel Hanley. Yes, that's right. He's the editor. If you asked me when it was published, I'd be damned if I know.

J.B. But the title was "Interpretation"?

2. "Interpretation". It's a volume that was put out by Norton, I think. It's probably around. It has many papers in it, but I have one paper in that thing. I don't know where, I really don't. Once I write a paper I'm more or less through with it. I don't remember what chapter, but it's, I think, Chapter 28 or 29 or something. You might find that of interest as I tried to say what I felt. Now Empire State College, --- did

you ever hear of that college? -- it's some kind of a community college, -- recently published a course on Sullivan. They wrote a manual, and they asked the publisher and myself whether we would allow them to put this paper in and we -- I said I was quite willing. So if you can get a hold of that monograph -- I think it's a \$1.85 -- I think it's the Empire State College -- you will have a rather rich source of stuff on Sullivan that you don't ordinarily have because the woman who edited this is a woman named Jane Dahlberg. Well, you want to ask me some more questions and you only have -----.

J.B. When you went on in your practice did you then start to amend or change, or how did your actual application of participant observation change as your experience grew?

2. Well, I guess I relaxed more, you see. I guess in a funny way, you know, people have certain personalities and personalities can be sort of healing personalities or relating personalities or understanding personalities, or they can be derogatory persons or different, and this is something that is always operating within the framework of a therapeutic situation. I suppose after you have enough experience, well, you feel in some sense lots of your people, the people you work with, seem to have come out having grown considerably, maybe raising your own children. You begin to get in touch with certain qualities that seem to have an ef-

fect on people that you weren't quite aware of in your own living because maybe the people who raised you weren't exactly in touch with the virtues of some of these things so as you get more in touch with some of the things that happened as a result of your contact with people, I guess you tend to relax and use it more. You know you could put it this way: if a person really could have a friend, could find a friend, in a funny way, this is a theoretical concept, you see, they probably -- they might not need a therapist. We can argue that. It's one of those things because we speak linearly, and we mean three dimensional things, but in essence a therapist is not a friend for many reasons. Let me give you a definition that Sullivan I believe he once said that the process of therapy, as he saw it, was two people coming together to understand -- to see if they can understand each other so to speak, and one of those people would probably have more problems than the other people, and he hoped that the person with the fewer problems would be the therapist. Now you see you might find that. I don't think I've said it as well as he said it. It just didn't come out. You know I haven't said this for such a long time, but he sort of defined that as therapy. He felt that, in a certain sense, that ultimately the therapist's main problem probably was to counteract the despair of the other person, the patient. Well, listen I'm talking too much. When I get started on this, I can free associate.

J.B. Have you done any teaching?

2. Oh, yes, yes I've done a lot of teaching.

J.B. Have you utilized participant observation as a concept in your own teaching?

2. The principle of what?

J.B. Participant observation in your own teaching.

2. Yes. You know, curiously enough, it's very interesting to me that you have seized upon it, you know, as something to try to understand. To me it's sort of obvious. That's what's interesting to me because I think so much of history is this way, you know. It was so obvious. You see I started out in this field as a Freudian, only because that was all that was around, you know. If you wanted to become a psychoanalyst you had to tie into the Freudian's social circle, as you know. That's where you got your training. But I remember the funny feeling I had, it didn't make much sense to me. I was paying good money for analysis and all of that so when you pay that good money in order not to feel foolish -----Is it ---?

J.B. Yes. I just wanted to check. (I check the recording levels.)

2. In order not to feel foolish, you begin to rationalize and try to convince yourself that it makes sense, but I always had that sneaking suspicion, which I really couldn't really verbalize until some years later, when suddenly I found what did make sense, that really corresponded to feelings that I had and ---. For instance,

I think my first analyst --- I think he slept all the time. I don't think he had the slightest interest in me as a growing person. I was a customer, you know.

J.B. Yes.

2. And I remember my dreams, because I was talking to him didn't help, I started to dream to him. Now that's a little theoretical notion. And my dreams were so explicit. He just --- he was a screen or something. He never said a word. If he had said three words to me, or six words, or ten words, you know, to give me a little hint he was there with me or something like that, it would have been an entirely different experience for me. He would not participate. I don't even know if he was observing. I assume he was observing, but I doubt it. Then I had my second analysis with Clara Thompson, and she was much more participating and, of course, that was such a totally different experience to me. So there I had it from my own experience, but what I mean to say when we teach we sort of assume that you are having a relationship with another person, and just having relationship means you are participating. In other words, if I sit behind my desk and you're sitting in another chair below me, we are having a relationship in which you are experiencing yourself as a subservient person, so I'm participating to collaborate in that by virtue of sitting behind my sign of authority, you know, and that cannot be avoided. All I am trying to emphasize is that my feeling that what seemed to be obvious to us, another

generation comes along, and I find it rather interesting, and begins to wonder what could he possibly have meant, you know.

J.B. I think in some ways it was the whole fact that participant observation did seem to be so obvious that got me interested in it because the more I thought: 'Well, yes, it's obvious, but what is it?'

2. I'm not trying to minimize what you're doing. I mean it interests - I hope the whole program - interests me because I realize ----- a generation away from where the thing began it begins to take on so many new relevances in terms of the thinking that a man with your background brings to it, which it may not have had at that particular time.

J.B. Participant observation is sort of embedded in the context of the interpersonal theory of psychiatry, although it seems to have developed in some ways as a concept either in direct response to the Freudians, or somehow out of either Sapir and the Chicago school, or even Sullivan's reading of physics. Do you think participant observation can stand by itself as a concept independent of the rest of the theory, or if a therapist starts thinking in terms of participant observation he really should also start thinking in terms of the rest of the interpersonal theory?

2. The rest of the what?

J.B. The rest of the interpersonal theory of psychiatry.

2. Well, I'm sure it would be very useful for him to think

in those terms only because if one is operating, one operates much more effectively if you have some idea, you know, where you've been, where you're going, where you are at the moment. There are some things that are kind of intuitive, that are also helpful to people. Now that's a friend, you see, could be an intuitive person and could be helpful, on the other hand no matter how intuitive he is, he might be mistaken unless he knew something, he could be helpful but very -- rather limited, more limited certainly in certain situations, limited by virtue of the fact that he would get anxious and probably not be equipped to either deal with his own anxiety, understand what he does when he gets anxious, you know. This is one of the things that I guess happens if you get anxious very often, you start rejecting the person that's made you anxious. Such things could happen in therapy, you know. A situation with an analyst, so in other words, you're giving him your problem. You're making him responsible for your anxiety, you're repeating the life history of each person, who when they make the people, who are supposed to handle them, love them, grow them, or whatever you want to call it, the significant figures, they make them anxious. Now I guess you can't expect that friends can deal with their anxiety in the same way that one would hope a therapist could, so maybe friendships could break up or get very difficult or very sticky, whereas, in a curious way, the therapist might on reflection, seeking

help of his own, hope to straighten out some of these things. You see we really can't ask friends to change too much, you know. You attempt to take your friends as they come, and in a funny way, there is an implicit statement that you can expect something a little more, perhaps, since that's the agreement you're making. So it's very peculiar in a funny way. It's an artificial situation by virtue of this crazy agreement that you sort of make, you know.

J.B. Do you think that this way of doing psychotherapy is fundamentally different from that of a competent psychotherapist who is espousing another theory, or do you think, for example, Freudians talking about transference and counter transference that they are really talking basically about the same phenomenon but using a different jargon?

2. You are absolutely right. I think that it's really a personality thing. Some people feel this, that theory gets translated, that words and what it does is maybe make it difficult for them to talk to each other, but I haven't any question in mind that a sensitive thoughtful therapist of almost any persuasion is utilizing the only thing that happens when people get together, namely, interpersonal relations. No question about it. It could have been possible, I believe, that if I had selected a therapist from whatever ----- that first one - that had more sense that - there must have been others around, you see, that I would have felt something from him, you

know. So I absolutely agree with you. I do not believe, in fact I think it complicates theory. It complicates our lives because they now have to ---- unless they can acknowledge this, that they are not going to be able to say what they really experience, you know. I can tell you that I feel that if I get somebody who has needed a father in life that by virtue of the kind of person I am, just the whole general approach to the nurturance of this person as I listen to him, as I behave with him, in some ways he's getting a little fathering, you see, you know. That doesn't mean I'm all over him and I come ---- oh, you're going to be my son, but by virtue of a general quality of my personality it's going to happen and that's going to be important to him. Other things are going to happen in the course of therapy that I'll have to deal with, you know, but if he can't leave ultimately saying this fellow was really interested in my development and listening to me and so forth, I don't think anything very much could have happened to him except he'll be getting more cynical and more bitter than he was when he came.

J.B. Sort of an omnibus question and the last formal question. Out of your experience as a psychotherapist, what is the single most central recommendation that you have for a beginning psychotherapist?

2. What kind of a question did you say this was?

J.B. Sort of an omnibus question.

2. Omnibus.

J.B. Yes.

2. That's a terrible question. You take who comes along ----- I guess it would be a capacity to grow, you know. I would hope that there would be a kind of enough experience in the so-called preadolescent - adolescent. I would hope. I mean I would think it would be almost urgent, I mean a necessity that there would have been experience in that area. Well, I think that once that's stated, you're familiar with the theory aren't you, enough to know that this preadolescent intimacy experience. Otherwise, I would think that a capacity to grow would be my ----- . Now, that, of course, would mean to me kind of a lack of preoccupation with matters that have to do with status and prestige, you see. I suppose I would have to acknowledge that everybody has a certain amount of it 'til it becomes a kind of a ----- . We have to live in this world and we do need some, but the kind of overweening preoccupation, you know. I think that would be a matter that in my book that sort of eliminates their usefulness. Of course, that's another way of saying what I said before, the quality of the adolescent or preadolescent experiences is. That matters of prestige and status play no part, you know.

J.B. I would think that one thing that ties a lot of what you just said together is the ability to tolerate some degree of anxiety.

2. Well, I suppose. You know I don't know whether that's

any better than anything I said or worse. It just didn't occur to me to think in those terms, though perhaps that would be a very useful thing in helping people to grow -- if they could tolerate anxiety. Well.

J.B. I certainly think that one of the parts of the capacity to grow is that in order to not just have information sort of pass peripherally through your awareness, but just sort of let it come through that part of focused attention. I think in order for that to happen you have to like tolerate the fact that not all information is going to shore up your security system.

2. Yes, well, you know the interesting thing about this is I mean ---- it's not exactly what I had in mind of thinking, maybe because that's more jargon in a certain sense, you know, than my sense. You get a feeling if someone has a capacity to grow and that includes many things. It includes the ability to learn by little hints. Do you know what I mean?

J.B. Yes.

2. Undoubtedly, it has to include the capacity to have anxiety. It also has to include quite a considerable experience, that to be living in this preadolescent experience, you see. These things have a way, if you look at them, they all kind of feed back on each other and other different ways of almost seeing how complex the whole human situation might be at any particular moment, you see. I suppose if one were going to just ---- when you asked that question, what one thing, that makes it

very difficult. It's the kind of question one shouldn't answer except as a challenge --- let's see what do I think. After that you can't have a discussion about it because ---- I don't know that anybody necessarily has to be committed to statements that are like one, you know. You know they used to ask Sullivan --- Sullivan was once asked what did he think was the outstanding human quality, and I think he said that he thought the outstanding human quality was their gullibility. What do you make of that? It doesn't matter. I don't think he would have to commit himself. He wouldn't want to have a fight with you about it. So he's not gullible. At that moment that was his sort of feeling about that's an outstanding human quality, you know.

J.B. O.K.

2. So, all right.

J.B. Yes.

2. Fine. I hope it's been of some use to you.

J.B. I think it has.

Interview with #3

- J.B. -----questions in a semi-structured interview fashion. The first couple are really sort of warm-up questions. I'm sure Sullivan, in the teaching that he did, must have used the term 'participant observation' from time to time. What do you think he meant when he used that term?
- # 3. Well, I don't remember his using it very much in supervision because he believed tremendously in simple straight talk, and I think he talked to a supervisee like he expected the supervisee to talk to the patient, which is very different from the using a lot of analytic jargon. For instance, if the patient or the student were talking about the Oedipus situation, he would stop the student and say "What do you mean by that?" "What does your patient mean by that?" and make the student spell it out. So that I don't remember his using the words 'participant observation'. What he really did was to illustrate it by means of the way he supervised. He made it quite clear that it was very important that you knew how you got across to that patient, and what that patient thought of you. How he experienced you, and to be very, very acutely aware of any clues, and if you didn't have any clues, at some point it was important to say "You know you've been sitting here with me in the same room for so many hours, and you never said a single thing about how I strike you. What kind of a person you think I am. I keep wondering what's going on in your head."

You know that would be the kind of plain simple language in which he would try to get the patient to respond to the therapist.

J.B. Yes.

3. Instead of taking for granted.

J.B. In his writings he talks about people refining themselves as instruments of participant observation, by this I assume he must be talking, I guess, about supervision, or what he would call being a chronic consultant more than anything else. You said that in the supervisory sessions he would sort of illustrate it more than discuss it or talk about it. How do you think he actually taught you to use this process of participant observation?

3. Well, several ways. One is I think he would ask questions of the supervisee to perk up the curiosity of the supervisee as to what he was missing, what he was hearing, what he was not noticing, so that he would do something that he called bird-dogging. He would say "You say that woman hated her mother, can you give me a good example of how she showed it? Do you know when it started? What kept the rage going? What was her role in it? You know by the time a hate relationship between two people gets going it begins to have a history, and it takes two people to participate in it, you know. The mother did something. The child did something. It escalated. Do you have a history of how that grew? If you don't, then go back and get it." And he would ask

enough questions that no student could ever answer all of them. You know if you were on the ball, you could answer a certain number, but he could always do you one better, which, of course, serves a purpose of showing you the number of things you didn't think about, the things you took for granted. The ways you let a pregnant moment go by without saying "What do you mean by that?", or one of his phrases was 'as illustrated by what?'. And you should come up with an illustration. Well, of course, you might be doing the same thing with the patient, and say to the patient "As illustrated by what?", and then you'd get a clear cut picture, hopefully, if the patient was on track. It would also flush out the kind of person who was doing intellectual talking, but when he was really asked to give an example, either the student or the patient, we didn't have one, and it was sometimes if you bird-dogged a person far enough down a road, they would end up saying "Well, you know you've got me confused. I don't really know what my mother meant by this particular thing. It never occurred to me to ask. I just assumed that this and that was happening. I assumed she felt this or that." and then sometimes the student would be in a position to say "By the way you told me something the opposite about your mother several months ago. How do you make those two things fit?" Now you see Sullivan could also do that with a student. He would say "Look you told me -----." He had a remarkable memory, so he often remembered what the student had told

him when the student had forgotten it. That was a kind of eerie feeling, his ability to pick up details like that, and let us say point out how one detail contradicted another because, of course, that's the way you sharpen the mind of the person that you are talking to ---- is by pointing out the contradictions, or the fact that there is a big gap between this stage, age 5, when mother nursed you in bed and this stage, age 10, when she was anything but nourishing. What transpired between those two points in time? What was the evolution of the interpersonal relationship between that parent and that child. Now the second message --- I talked about the bird-dogging as looking for information and getting details and data with a constantly skeptical inquiry as to what something really meant, and what really happened first, and what the sequence was. The second thing was he was really amazingly intuitive as to what was not said by anybody, and he could pick up on the student's emotional reactions to the patient, and he could say something about, "It seems to me you have a certain kind of condescension toward that young man. Do you realize how he is suffering?" He picked me up on something very astute, which actually when I look back shouldn't have been much of a surprise. It was the way he did it without much data. He said "You know I think you run the risk of being disrespectfully intelligent." Now he says "There is nothing wrong with being bright. In fact to do this work you've got to be pretty bright

and pretty sharp and pretty intuitive, but you certainly don't need to, in any way, show that off to your patient. For you to show him that you remember his dreams, if you do it low key is o.k., because that shows him you are with him, but if you, in any way, make him feel that you knew that a long time ago, or that you were way ahead of him, and, of course, maybe you are way ahead of him. You can see a lot about him that he hasn't seen yet, but you show it to him a little bit at a time, and time it so he can digest it. If you overwhelm him with how much you know about him, you put him down, and he's probably been put down by many people before in his life, and he certainly doesn't need it from you. So be as intelligent as you want, but don't use it in such a fashion that it makes a distance between you and the patient, use it to understand him."

J.B. One thing that struck -- I got a sense from reading his books that part of this process of refining the student had to do with the fact that people miss the obvious a lot, and that he was always trying to pick up on missing obvious elements. I can give some illustrations of that if you like.

3. The first illustration I thought of was the business of hating the parent which you know has gotten to be so common place that the analyst always assumes, of course, you hate your parents or you wouldn't be here, and I guess if you had really good parenting, you wouldn't be in an analyst's office, but a word like 'hate' is such

a catch-all, just like 'love' could be such a catch-all, just like a rubric like the Oedipus complex can be such a catch-all, and he was very careful to get each one of those as carefully defined for the particular events of that patient's life so that it became highly individualized, personalized.

J.B. After your training with him, did you go on and apply this participant observation in your own work. Sort of a silly question in some ways, but I think in other ways -----.

3. I think it influenced me enormously. I have often felt that I use him more in my treatment of people than maybe anybody else. The other main supervisor I had was Eric Fromm, and he had a much more Freudian frame of reference although he was also a political scientist so he was perfectly aware of all kinds of social forces, but he was more intellectual and not nearly as intuitive, but I think he gave me access to the ways of investigating how I came across, and what kind of a person I was, and how much of myself to reveal, and gave me good reasons for how much to reveal. For instance, to get to some details, you reveal who you are by anything you do, anything you wear, everything that's around you, any magazine. You can't be a blank wall. It's impossible. If you try it, what you usually look like is some kind of a stick. A stiff pedantic person. Sometimes a patient, lying on a couch not looking at you, gets this feeling of a God-like person, who's omnis-

cient, knows everything, and that certainly doesn't add to their self-esteem, and self-esteem to him was a tremendously important thing. He was always watching the self-esteem level of the patient, so that to take a God-like, "I'm not in this, I'm just listening to data, and I will give you answers or diagnoses or prescriptions," or else "I will leave you alone with your troubles, you work them out, I'm just back here watching you work and struggle, and I'm not with you," which is, I think, what can be the unspoken message of the orthodox analyst. He tried to get the young analyst to see this as a two way thing that material was being fed in all the time by all kinds of things. I'm thinking, for instance, about reading material. I've forgotten how it came up. I think ---- back in those days --- this was the early forties -- New York was very different from what it is now. There were many more liberal groups. The American Labor Party was very active. The Daily Worker was a much more acceptable thing for people to have, and for a while I either bought an occasional copy of the Daily Worker, or else --- I know I did not, you know, belong to the Communist Party. They were too authoritarian for me, but I was intrigued with some of their ideas. I think one of my patients saw a Daily Worker or something of that kind on my table and had a rather violent reaction, and his comment was that he had a feeling that although, you know, the way I dressed and lived was my business providing it wasn't pro-

vocative, sexually exciting or inappropriate.

J.B. The 'he' here being Sullivan.

3. Yes, that he felt that something like your politics was so much a matter of individual preference. It would be like your religious convictions. If you had them, you had better keep them out of the other person's way because that again is a matter of highly individual choice, and it is highly charged. Now you had a right to your convictions, but you don't make them conspicuous, just like you don't propagandize for anything. Fromm was a little different in a sense that he felt that one did in a sense have a mission to accomplish to help people become more constructive and less destructive, and he had a little more of the missionary spirit, a little bit more of a Messiah type, but with very vague outlines about what was constructive and destructive. He never had any doctrine, but Sullivan was much more neutral than that in a way, because he thought that the biggest --- the most important instrument that you were using was your own faculties for observing and connecting and working through historical fact and present day behavior, and your intuitive ability to pick up emotional responses and to try to draw them out because the patient was so often afraid of them, and the borderline person he felt had extremely strong feelings even though they might be very remote and withdrawn, but the remoteness covered up extreme malevolence because of how they'd been hurt, and that they were afraid to touch

that, and they had to know you a long time and trust you not to be moralistic or frightened --- one was as bad as the other. They needed to know that you could stand to hear some of their really very hostile thoughts or some of their enormous dependency needs or some of their deep homosexual fears. And you had to kind of intuit where those danger points lay by means of the history you took, the dreams they had, the unspoken between the line things, and then whether you pursued it further or not at that point depended upon whether you thought the ego structure or the self-system, as he was apt to say, was strong enough to take it. For instance, one example was the young schizoid boy, who was on the verge of a homosexual panic, Sullivan would not dive into the background of his homosexuality while he was in that panicky state, instead he would say "Well, it sounds like you have a lot of homosexual fears. We'll get around to those later. Let's go study something about how you grew up, what kind of a person are you in other respects other than how you fantasy using your sexual organs or how you had used them." And he would get the person interested in the whole individual, and then when he built up some background, for instance, if he found in getting more material how absolutely overwhelming and undermining and infantilizing the mother had been, he might then stick in a provocative sentence like "Well, with a mother like that no wonder you don't want a woman to trap you. Men are safer, aren't they?"

or "Men are more familiar, aren't they?" And not that he would brush away homosexuality as being that simple, but that's the way he would start to decrease the level of fear so that it wouldn't be such a shock, and the border line person wouldn't go into another panic about "My God, what you're really saying is I'm a hopeless homosexual so why am I coming."

J.B. He would literally say something like, "Let's go study something else."

3. Yes. Now that's border line patients, which was quite in contrast, for instance to the way he could be quite sharp with the typical obsessive compulsive defenses. If they were strong enough, given the fact they may cover over deep oral primitive needs, but they could be very tough - as you know a real obsessive compulsive can distract you with intellectualizations and lose the point altogether, which is really unconsciously his goal is to get you away from what made him anxious, and there he was merciless in a sense in trying to get the person back, stopping him in mid-stream, not letting him free associate away hour after hour after hour and waste time. But saying "Look I get a feeling this may have some importance," and he could act quite humble. He would say "You know maybe I'm missing what you really are getting at", and give the person a chance to say, "What I really mean is this", but if the patient didn't then say "What I really mean is this", he would say "Look you know we've worked together a long time, and

I know how you can divert to get away, tell me, I have a feeling something made you very anxious before you started on that diversion, can you go back to that point and see", and with obsessives he would work and work and work until he got the obsessive to know that he was diverting and to catch the diversion within a couple of minutes, maybe within a few seconds, so that he got a hold of the anxiety that occurred first, and then they could talk about what made him so anxious. So in talking about his treatment methods, you have to consider how sick the person was, how well defended he was, because this take it easy and move away from the center of anxiety was because he thought that might be the better. The amount of anxiety it would arouse to face that issue would be disruptive, and he not only was respecting the self-esteem system and a drop, a sudden drop in self-esteem, but he also knew anxiety could really make a border line person so confused that nothing that went on the rest of that hour would be useful for anything, and the patient wouldn't remember it, and it would just drop into a back hole. But that's different from the obsessive, whereby they could frequently waste hours and when you finally could nail them on something and make them see their anxiety and break through their armour, they might not like it at the moment, but they would finally begin to get the feeling that they couldn't get away with all that intellectualization, and they had better damm well get

down to the point if they expected any change.

J.B. My sense from the reading was very much that he tried to keep the person's level of anxiety in sort of a workable, manageable range.

3. Yes.

J.B. With a reduction or increasing, depending on where the person was at that point in time.

3. Yes, that's perfectly right and people like Earl Wittenberg, who have written his techniques, he's got a very good chapter in Rowan's book on Sullivan's treatment of obsessive compulsive, in which he talks about keeping the right level of tension up, let things not get too soft and palsy and reassuring and --- like motherly, kind confidante, that kind of thing, but that you keep up enough tension so that nobody gets bored, and so that something new, hopefully, comes out of every hour even if only a small thing, you know, no miracles. And he sometimes would recommend that you try to put your finger on the most important thing that was said in a given hour, sometime before the end of the hour, to give the person a chance to respond to it, but that it often gave them something to think about as he left, and he would get a feeling of ah-yeah - that was something to take home with me. But he particularly said with very confused schizoid people you didn't do that because it might overload them with something that they would begin to get more and more and more anxious about before they could get back to the next hour. So there again one

prescription does not fit all patients.

J.B. After the time that you spent in training with Sullivan, you then went on for a number of years. Did you start to amend or change the things that you had learned as being participant observation during the course of your practice?

3. Yes, I'm sure one must because you really have to find your own style, and I took to him, like most students did, our sickest patients, and the techniques he gave me worked best with the sickest patients. I can remember his helping me with a very depressed rather withdrawn young girl, who'd been given a year off from Vassar because she also had asthma, but she had been treated by a therapist up there, who she had the greatest contempt for, so that she'd been burnt once. Actually this guy has a bad reputation so I assume she was partly right, but she was a very silent individual, and he helped me learn how to break through her silence. It wasn't just withholding. It was a deeper phenomenon than that, and he gave me some techniques of getting her to talk. Sometimes kind of free associating as to what she might be thinking and asking her to correct me if I was wrong, sometimes giving her a choice of three possibilities and with that, you know, she might break out and say "For God's sake, it's not that. It's this." I've never really had a patient since that was as withholding or as silent as that, so that some of those techniques I use more in supervision. You know the

young students often get the sickest patients. You see what's happened to my practice as I've gone on. You see I've decided with working with him and working with Freida Fromm-Reichmann that the psychotherapy of the border line or the schizophrenic patient was something that took such time and energy and devotion and readiness to answer a call for help at different hours that it was not compatible with a family life, a home office, and raising children, and I also found myself much more interested in character problems and interested in teaching so my practice has been much more character problems. I get lots of obsessives and lots of them in medicine and psychiatry. I've also gotten very interested in the psychology of women and the female development. Now that's something I've had to do all off on my own because he wrote very little about female development or female sexuality. It was not a topic that particularly interested him. And some of the women I now get, for instance, to make a contrast between 1975 and 1945. I get some pretty competent professional women who have a lot of conflict about their professional lives and their sexual lives and their marriages and some of them have extra martial affairs, in the past many of them were frigid. I would say that I take a more directive role in eliciting material. I don't have to be as careful about their level of self-esteem. Now it's still participant observation in the sense that I'm very well aware that I stand for certain

things to them, and if it's not clear I try to get them to let me know what I mean to them or what they think with what I'm doing.

J.B. Could you go into that a little bit more?

3. Well, you see to many of these women I represent a successful woman who has had a family and also kept up a busy practice of psychiatry and psychoanalysis. I've written papers. I've written nine papers now on women. I'm trying to write a book, and I'm having a hell of a time, but I have enough of a reputation that a lot of women come to me seeing that I've done the double job, and to them I'm some kind of a model. Now sometimes they get very jealous. One of the analytic students that I had a great deal of trouble with was a woman who also had three children. They weren't quite the ages of mine, but she was only about ten years younger than I. She'd missed a whole period of her life where she was living in another country, and her husband was doing all the supporting and all of the work, and she was raising the children, and she dropped out completely. Then when she went back, she was let's say 15 years or 20 years behind where I was at that age, and one of the problems in the treatment was that she, I think, was extremely jealous of me and unwilling to face it or to talk about it because if we could have talked about it and ----- I tried to help her with it and tried to give her some data about my life, which is the kind of thing ---- I don't think Sullivan would give data about

himself much to patients. He was a very kind of private man. Now a person who is working in an institute with a bunch of students and whose family life is to some degree known is a much more known quantity, and the kind of rumors and talk that goes on about training analysts needs to be dealt with more openly so I think maybe ---- one of the things that he said to me was that he felt in his terms of not over exposing your patient to too much private material. He didn't have ----- . He had a lot of private thinking, but he didn't have much private life. He felt that the young married person, who was raising children had a lot of private life that really didn't need to upset the patient. For instance, he was, I think, against the idea that children would be walking through the waiting room or spouses, wives. Particularly let's say the young male therapist with an attractive female as a wife. The exposure to baby carriages and the wives could make the patients very jealous, and that seemed to be a kind of unnecessary cruelty. When we first moved in here the back elevator ran all the time and the children and the baby carriages and the bicycles did not have to come through this front hall. By the time they automated the elevators and turned the back elevator off, the kids were old enough to have their own keys and come in and out by and large, and there wasn't much problem. But I think he would have been against a kind of laying it all out open, telling your dreams to your pa-

tients, meeting them socially, getting involved with them on all kinds of different other levels. You know a lot of that is fashionable nowadays, and I think it's been way over done, and I'm sure he would have felt that you overloaded the patient, particularly in the early stages of analysis when they still really didn't want to know all that much about you. They really were there to find out about themselves, and he would have ways of turning down questions that he thought ----- questions the patients might address to him when he really thought the data was not going to help them, and he would say that. He would say "I really don't think the data about my sexual activities or my private life is going to be of any use to you. I can only see it as a burden, and I think it is a distraction from your studying your own. Now whatever fantasies you have about me, let's hear them because I think that will tell us something about you, but I really don't intend to give you, certainly not at this point, a full explanation to that question", but he had a way of saying it that didn't put the patient down. It didn't say what a patient of mine recently dreamed. They dreamed that ----- a fellow asked me about my sexual life, which they are scared to death to do, and I simply said "It's none of your business." Now that's a kind of a put down, a snotty response, which he would never give. He would have said something more like I just said to you, which is "I don't think that's helpful." "I don't think you need to know about that. I

can't see any point in sharing it with you, you know, maybe later", or "let's get back to what your problem with this is." Now you were asking had I ---- I got a long way off from your question, had I changed my ways of working. I think to whatever extent I work with much better integrated people, who are sometimes doing a fine job of teaching, lecturing, even young analysts, who are doing a good job of analysing. One gets to a point where one can be much freer and much more direct in trying to get at their problems, and you don't have to be as cautious as you do with a sicker person, but you're still practicing participant observation, which is, of course, another way of talking about transference and counter-transference, the tremendous awareness of the kind of extra meanings that the analyst can have to his patient, but also the patient can have all kinds of extra meanings to the analyst. Which brings me to another thing he was very succinct about, which was the importance of not having a stake in the patient, and he would often say to his student "Look if you have too much stake in that patient in keeping him because they are paying you well, and you would suffer economically if you lost him, I think you had better not bring him to me because the way I like to work is to call a spade a spade. If a patient is trying to get away with hiding something or not facing something and I think they are able to face it, I want to face it with them. I don't want to just make them com-

fortable and make them like me or have them like you."

To the student: "You shouldn't need to have your patients like you. You should get your satisfactions out of the whole challenge of the problem solving, of trying to figure out a human being, and how they got this way and how to get them out of certain dilemmas, and that's a very long term satisfaction. You know occasionally you have an hour you really feel good about, but you have a lot of others that you don't feel so good about. You don't know whether you're making any headway. So if you have a stake in being loved by your patients and having nobody ever drop out of treatment, then you are in trouble."

J.B. I think that somehow the whole population, not just the ones that would come to you in particular, but the whole population of patients has changed to some degree from the time that Sullivan was practicing. That's partially because cultural stresses have changed. Do you think this should lead to any real change in participant observation or change away from this?

3. Well, there's a lot of pressure now for briefer modes of treatment, and I think one of the difficulties with trying to really do a job on once a week is that you really don't have time to catch those nuances. Now once a week therapy can either be the easiest kind of thing to do because you don't have very high goals, and you're trying kind of to help a person limp along and make a better social adjustment, and you don't probe into depth ma-

terial. That's appropriate for certain kinds of people, and it's amazing how much one can get done, but if you really want to do much character change on once a week, you'd better have good training, so that there's a dichotomy there between the fact that residents, for instance, just beginning to learn how to treat often are more comfortable seeing patients either just once a week, or seeing them for just 15 minutes at a time. Now sometimes patients are so goosey that that's all you could do with them.

J.B. Goosey?

3. Goosey. They are so afraid of being invaded and ----.

J.B. Jumpy. Edgy.

3. Yes. Afraid of being goosed.

J.B. Oh, goosey.

3. Intruded on really. Goosey. But that's a good way to start, but I think he would have said to start with 15 minutes, if that's all they could take because they were so afraid of intimacy. To see them quite frequently so that at least they got a sense of predictable re-occurring contact, and you would happen to see them on a particular day when they would blurt out something that would really get you started, but he was very much against re-assuring treatment whereby you tell people they are really o.k. and they shouldn't worry, that kind of thing. It's really very easy to do and counselors and untrained social workers and people who have never really been supervised or ana-

lyzed themselves can do that kind of thing. That's one end of the scale where seeing people for once a week can be a kind of mild help and doesn't do much damage unless you happen to have too sick of a person that you get in once a week where that just isn't enough and the lapses are too much for them. At the other end of the scale, if you really expect to get a good deal done in once a week, you really need a lot of training because it's much harder on the therapist. You see the young therapist feels it's easier because they don't have to go into such depth, and they don't have to go into transference and counter-transference. You know they don't have to know the interaction. They are more giving advice, whereas on the other end of the scale the really trained person, who is aware of all the possible things that might be going on that are not being spoken about, he's got to be really very skilled to know which one of those things that haven't been mentioned should be picked up. He has to have a list of priorities and decide which thing to deal with first, knowing that there are a whole bunch of things he's missing. The untrained person over here didn't even know what he was missing.

- J.B. Have you utilized participant observation in your own teaching, either the method itself or the concept of it?
- # 3. Yes, well I used to teach the first clinical seminar to the first year students, and I used the book, "The Ini-

tial Interview"¹. in which he really talks about how you get oriented with a patient. You know the simple questions of telling what sent you here. What do you see as your major problem? Tell me something about how you grew up so I can tell how you got to be this kind of person. What did you expect from treatment? You know those stages of psychiatric interview, and then he would go back after he got some kind of an over-view, and it may take, you know, an hour or two. It might take five or ten hours. Then he would go back if he made a contract with the patient then to go on and study the problem, and he was quite explicit about that. "Well, I think you have a problem that will ---- that could respond, not that will, that could respond to my way of treating, and I see your problem as this. Now I think I could work with you on that. Is that what you would like to do?" And then you'd set up hours and times, fees, etc., and proceed to get more detail. Now that whole way of getting going and launching analytic treatment to me always seemed the clearest and best description that I know of. Particularly the way I got it from him first hand, not so much the way --- it's more long-winded in the book. So I use that book for that class, and I talk more about Sullivan than any other one person although I would

1. The interviewee is probably referring to The Psychiatric Interview. "The Initial Interview" is a chapter title in Freida Fromm-Reichmann's book Principles of Intensive Psychotherapy.

stop and compare the way Sullivan would attack a patient compared to the way an orthodox Freudian would. The orthodox Freudian would frequently, you know the patient would come in and sit down and he would say "Well", or he would say nothing, and the patient was simply expected to pick up the ball and carry it, and at some point the analyst might say something, but sometimes they restricted themselves to a few sentences here and there, or a comment at the end of the hour. Sometimes they were sadistic enough to say nothing, and Sullivan labeled that "say-distic". He felt the least you could do would be invite a patient into your office, indicate where they might sit since they are absolute strangers, and then proceed to help them get going, and it wasn't that he put any words into their mouths, you know, or made any predictions or diagnoses or jumped the gun on them, but that he simply sat down and showed them by the way he worked what he thought ---- well, first of all he got them to tell him by the way he asked what was bothering them, and then by the way he handled that material, and the questions he asked he began to teach them what is relevant material to the understanding of the origins of a problem. Now I used that book and his method for that beginning class. The other book I used was Saul's book on The Technique of Psychoanalytic Treatment. It was originally a rather small book. It recently came out apparently about three times the size. I never bought the new one be-

cause I heard it had been terribly padded with all kinds of case material and illustrations, and the thing that was nice about the early one was that it was quite succinct, and it was good straight talk, and it was half way between Sullivanian talk and Freudian talk because he, Leon Saul S-A-U-L from Philadelphia, he had worked with Sullivan, had some training with him, and he also was a member of the American Psychoanalytic, which Sullivan never wanted to be. He fought their jargon and their politics from the very beginning.

J.B. One thing you mentioned that I think is not particular ----- I don't think I've ever seen it in any reading -- is teaching -- you said something about teaching the patient to pick up what is most important.

3. Teaching him what's relevant. How to look for the relevant things. You know some people have said analytic patients rarely fall into your lap. You know occasionally they do. I think Anna O. was an example maybe of somebody who just came in and spilled, and oh, I've forgotten the name of the early patient of Freud's who nursed her father and who in her work with Freud had almost total recall for what happened on Dec. 9th of the year before when she was nursing her father. She would remember it a year later. You know that's a ready-made patient practically. She went right through all the trauma of that year with great accuracy so that Freud could follow it. That's a rare thing. What's been said is analytic patients don't happen, they're made which

means that most people, the best you can hope, is that they can at least tell you what's bugging them, but they're really helpless to know how to pursue it usually. If they're well-read, they may have a lot of formulations that are more or less true, but they don't know what to do with them. It's intellectual insight, and it's not digested. It's not connected up with the deep feelings, and you really have to teach them how to use the concepts or the ideas they have, document them properly with accurate memories and connect the accurate memories up with what they do today. You have to get them aware of how they get across to other people, what effect they have on the people they live with, the people they work with, and you see the astuteness that you, as the analyst, develop about what effect you have on people, not only your analysand, but what effect you have on your supervisor, what effect you have on your peers. Supposedly you're pretty trained in picking that up in yourself, so you have to train the patient to pick up the clues, to notice, and some, particularly many remote or rather schizoid people, are absolute. They're so wrapped up in their own problems. Today you call it narcissistic. They are so narcissistic that they just don't notice what other people -- how they re-act. They don't know when they hurt anybody's feelings. They don't know when they have been arrogant, or they don't know when their withdrawal has been read as arrogance, and they're so afraid of the other person

they never ask. So that's what I mean by teaching a person what's relevant. It's not only relevant past experiences, but also relevant clues from present day living, and then to connect the past and the present in some way that's emotionally alive.

J.B. Participant observation for this generation of people who are studying exists as a concept that's embedded in the interpersonal theory. Do you think that the concept can stand by itself, or do you think that it really should be that if you adopt one, you should really pick up most, if not all, of the interpersonal theory along with it?

3. That's hard to give a simple answer to. If I had to I would say "Yes, it could be dealt with by itself", and I'm thinking of the more classical Freudian analyst, who deals with transference all the time, and he uses different words and he approaches it differently, let's say, than a Sullivanian trained person, but he really is doing more or less the same thing if he's good and if he's human. He is studying the effect of each person on the other person, and he is also aware of the fact that there could be many other people more or less in the room too, you know the mother, the father, the grandfather. You know it's not just what the patient is saying. There are all kinds of forces going on. Now that's a common enough idea now. There are lots of people who work with that who would not want to be associated with the interpersonal school because they have

so many misconceptions or preconceptions, and they feel that it does not deal with the intrapsychic, so they think of interpersonal as opposed to intrapsychic, and it turns them off. So that the Freudian I think has a real misconception of the interpersonal school as overlooking intrapsychic forces, which Sullivan, God knows, never did. Now maybe some of his students did, maybe some of our students are guilty of not looking two-sided enough. Certainly the transactionalists, who I think developed from the interpersonal school, have gotten to that. You know The Games People Play, Eric Berne type thing, gives passing recognition to intrapsychic processes and to the unconscious and to early family influences, but it is just brushed aside much too quickly. And from the encounter groups, for instance, that I've known, who use that kind of game theory, of which there are many different varieties, it is much more just what happens here and now and that's all. Sullivan never did that. He really went back and got the specific history of everybody.

J.B. And he did it I think with an idea that that was a way that was favorable of bringing about change.

3. Yes. He thought you really got change if you hooked it all up. That just getting a good description of the current interaction was not enough, but you couldn't overlook it either, but I think many classical analysts are doing something about the ---- what's your phrase?

J.B. Which one? On this question itself?

3. Yes.

J.B. To what extent do you think participant observation --

3. Participant observation. That's the one. Participant observation is so close to what many practitioners do in analyzing transference. There are some differences.

J.B. Yes.

3. One basic difference, for instance, is that in regard particularly to ----- well the classical person goes in two bad directions, I think. They will force transference interpretations on neurotic patients when there is very little evidence for them, and they will do it in much too a kind of pedantic a way that belongs to the theory and does not come from the situation itself. That's one extreme. The other extreme is that they say psychotics have no transference, are incapable of it. They are too narcissistic. Both of those extremes I think are wrong. Sullivan when he was working with ---.

J.B. The schizophrenic population?

3. With the schizophrenic population was very, very careful about making what he called you-me interpretations until there was a solid basis of some kind of understanding about the use of words and some trust on the schizoid person's part, because he felt that their need for distance was such that you didn't ever jump into the you-me. And you were rather careful about how much you participated overtly, and how many personal comments you made so that you stayed much more aloof because there's one thing that most schizophrenics or border

line people need is a certain distance, so he respected that distance, but he felt that actually the amount of tremendous rage and feelings that they had was enormous rather than not there at all. You know they were narcissistically preoccupied because of their shaky equilibrium, but it was because they had too much to hold back and not too little, which is the opposite of the classical approach.

- J.B. With the tremendous input of the encounter group people, there really has been a very strong emphasis on staying with the here and now interactions. I wonder if you could speak for a few minutes on the necessity, as you see it, of going into the historical roots, and maybe even how that is, as you see it, a necessary condition for a change to bring -- to come about.
- # 3. Well, I can give you an example of a woman who had been not only in, I think it was called Roscow, if you have ever heard of it. It is an encounter group, and I don't know enough about it to know how qualified the leaders were, but it had at least as good a reputation as most of those. It was not one of those that we all know are crack pots, so that as far as I know it was reputable and didn't have any gross sexual acting out or anything else. I had as a patient for a while a woman who had not only been in this training, but who was actually doing some of it herself, and what struck me about her was that number one - she had a lot of cliches, about just as many jargonistic cliches of their kind as

the Freudian has of his kind. I'm trying to think of what some of them were. This was several years ago. She talked about 'the script', somewhat like -- kind of like 'the given', the script that was written for you as you grew up and which you then re-enact. So there was that kind of concept, but since they dealt so much with the here and now, although she could describe to some degree, let's say her major problem really was survivor anxiety. Her entire family except ----- her parents were the only members of a large European family that survived the holocaust of the Nazi persecution, and she was their only child so the burden of surviving was on her, and she knew that in a way. She could say it, but she had never said it in any detail, the character structure of either parent, and one of the big things that I was able to do for her. She was between marriages. She was living with a man, whom she might marry, and she was finishing off with a man, who had been a very withdrawn character, with whom she had lived several years, but she really, for instance, did not know enough about the kind of person her father was, and why he had so much survivor anxiety himself, and what it was he programmed into her. She could say "I was programmed", you know. That's part of the lingo too, but she didn't know enough about his idiosyncrasies, and she began to get all kinds of specific memories about what her father did, how her mother responded, and the numbers of illustrations as to how

this process of programming, if you want to use that word, or how that really developed, and why it was so sticky, and why it didn't loosen up with the encounter groups because it was really --- they were two pretty disturbed parents, and that she'd never really figured out. She had just assumed the problem was, you know, the multiple deaths and the depression, but she had none of the details for it. I think her mother was primarily depressed and over-protective and anxious, and her father was primarily remote, but just being refugees with dead relatives didn't explain it all. I've seen enough, and she did not have any of these specifics, and she was hung up in choosing the right kind of man to live with because she had not figured out her father, and her choice of her first husband had to do with her father. You know the father who is unknown, distant. So often the girl of such a father will marry an also distant man who is hard to know. That's what had happened with her, and she had not made that connection either. So the problem was to get that clear, who her father was, and how her husband was somewhat like him. To see that she didn't make a second marriage of the same variety.

J.B. One of my supervisors is actually writing a book right now. He feels that the way that the essentially traumatic events in childhood get perpetuated is that the person starts to act in accord with their experience, and they sort of like shape the responses of the envi-

ronment in such a way that sort of like feeds into their notion.

3. You mean like a self-fulfilling prophecy?

J.B. A self-fulfilling prophecy that sort of changes and then keeps going.

3. And, of course, that was what Freud labeled a repetition compulsion, which is a very bad term for it because it sounds like it's an automatic fact that it's like a conditioned reflex. I think he was using that kind of paradigm which is not a good explanation, and it makes it hard to do therapy on it.

J.B. So if it wouldn't be ---- tell me if this is like paraphrasing you too badly that the use of the historical is in some sense like unwinds -- the self-fulfilling prophecy.

3. Yes. I often use the word, it's like unraveling something to constantly get the antecedent of that, and Sullivan would do that by phrases like "when did that first start?" "what happened before that happened?" "what was the background for that particular response?", well, you see that's the unwinding.

J.B. You sort of answered this question already in answering the question before, but maybe you would like to go into it some more. Do you think that this way of doing psychotherapy is fundamentally different from that of competent psychotherapists espousing other theories? I noticed that you talked about the fact that Sullivan, in fact, did not overlook the intrapsychic, but that

there were some differences with the classical Freudian analysts, which were that you didn't force transference interpretations as much, but that you did tend to believe and eventually look for me-you interpretations with the people who were experiencing psychotic phenomena. So do you think this is fundamentally different?

- # 3. There is such a wide range and such tremendous overlaps it is really very hard to answer that because most Freudian people when they write a paper will put it in Freudian language and give adequate recognition to the past writings of Freud, etc., and they frequently in their practices are much more different from let's say any classical model that they were given in training. They are very different. Some of them are terribly human, and you wouldn't really know by the way they worked that they had not been influenced by Sullivan in any direct fashion. You see another thing that has happened is that the ego psychologists have really picked up a great many of Sullivan's ideas about the self, and the ego and the self are not exactly the same things, and they are not explained by the theoreticians in the same way, which as I was reading the other day, Sullivan's idea of the self as being composed completely of reflected appraisals of other people, whereas the ego psychologists began to get an idea of an autonomic ego. There is a battle there, I guess, that two theoreticians could engage in, but

actually to me it's not terribly important in the way you approach a person for treatment because if you --- it's almost as though Sullivan felt the people had no self until they interacted with other people. He says that, but he also had so much sense of each person's uniqueness because everybody, I'm sure he granted temperamental and constitutional differences and so forth, and then, of course, each person has an unique situation, even unique compared to the other siblings in that family, so that even the reflected appraisals as they formulate a sense of themselves, which is very close to the concept of ego, each person has their own, although there are all kinds of common problems so that as you work with the person's sense of who he is, lots of people do that in very similar fashions, no matter what their background. Now, sometimes the background makes a lot of difference. The people are too stuck in a particular formulation that they can't improvise, but I think really one of the tests of a good therapist is what he is able to improvise according to the particular person they are working with. You know you need a program, you need theory, you need a concept of development, but then you need to get to a point when you don't have to rely on any of those things, and you can be much more spontaneous and improvise as you go.

J.B. Final - one impossible question, which is this: Out of your experience as a psychotherapist what is the single most central recommendation that you would have for a

beginning psychotherapist?

- # 3. I think that everybody needs to be well enough read about psychodynamics, including a variety of different people writing about them. Everybody should read --- not all of Freud --- but some of Freud to get some real respect for him before they throw him out, or before they begin to make changes cause it's just too basic and too much has sprung forth from it. Then one needs to read some other people who are different, and, of course, the people recommended to be read will differ according to the school. You know "The Object Relations Theory" of Fairburn and "The Ego Psychologist" are now in vogue for Columbia and also coming into vogue even to the New York Psychoanalytic. So some basic structure of reading to get a person oriented is one basic thing. You have to kind of put yourself into it and try to believe it, or at least see what the man meant. Put yourself in sufficiently that you digest it instead of some of our students, for instance, will read Freud as though it were a tremendous waste of time because it is so dated, and they never get that sense of his greatness. And, for instance, Fromm has always said that you must never forego reading Freud. You've got to fall in love with him first, and then you begin to revise him. So that's one piece of advice. I really think one's personal analysis being as thorough going and as deep and as genuine and as real as possible rather than going through motions be-

cause it's part of training. That is really the core of becoming a therapist. My comments about supervision or advice about that is a little bit like the reading. You need a variety of supervisors, and you need to get a real sense of how a given supervisor works, how he wants you to work, try out some of his ideas, don't sabotage him by trying him out in a foolish way to prove he's wrong, but give him a chance to teach you something. Now, if he's no good, discard him. That sometimes happens, or two people just don't match, and they can't work together. That can happen with an analyst and a patient too, but, of course, supervision being more of a teaching situation. I've seen people decide after four hours that they really did not just want to work with this person. That's all you need. Is that much of a clue. Then I think the student's job would be with supervision, having gotten some variety, starting with just one person and getting that before he adds another so he won't be confused and usually stopping with the first before he takes on the third, and it's usual to have three supervisors, at least. Some people have more, but then the advice to the student when they've learned how to launch an analysis and get going in it and have had more than one supervisor, their big job is one of integrating what they're learning, taking from the supervisors as well as from the books the things that seem most important to them, combining what they pick up with their

knowledge of who they are and welding together a kind of psychoanalytic identity, or one's identity as a working analyst. And each person, in a sense, is somewhat different in terms of how they work. The students that have the most trouble are either the ones who fight being taught because they're so afraid they'll get thrown off, or the students who try to imitate or mimic everything they're told without thinking about it, because I think to be a good therapist or analyst you have to integrate it for yourself. Now some students have said that they never really integrate well until after they are through and certainly when you are on your own with no supervisor and no analyst, you're free then to begin to make your own decisions without the feeling of somebody watching you. Other students have said that they came in knowing what they were doing from whatever, you know, clinic or residency program they were in, where they felt they were pretty good, and then they have to unlearn certain things and learn a lot more, and they go through a period of feeling that they don't know anything, and that may be the second year, or sometimes it's even the third, so they hit a low spot, and then they have to build up from that by beginning to have more trust in their own ability to select and to throw out and to go searching for a missing piece to make it fit together, but I think one of the --- I've pointed out two bad attitudes toward training, one is the balky rebellious one, who's con-

stantly going off on their own before they know enough to go on their own. The other is the too passive, compliant student, who doesn't make enough effort to develop his own therapeutic identity. You know he's always thinking of himself as though he were the student of so and so. Now a lot of Freudians have done that. Freud was such a compelling, charismatic person that lots of people just kind of carried him with them all the time, and those are the people who held back progress because they haven't been willing to go ahead and up-date their thinking as life has changed. There are fewer of them around now, obviously, since he's been dead ---- I don't know how many years but, oh, 37, it's been about 40 years.

(Pause in tape) (Speaking of another analyst)

Transferential distortions are quite different. I'm sure that he would not have as moderate a view as I have. I am much more interested in making connections between things, instead of making divisions, whereas he likes to make much more clear cut divisions. I'm sure if you interviewed him, you'd get more pointed answers. I'm always tracing the historical development of somebody's ideas, and how this person influenced that, and how in a sense they more or less are saying partly the same thing from a different point of view, and he does not think that way. He thinks of things as this being a more discreet development of Freud, which has a dead end here, and Sullivan as being a very totally differ-

ent kind of person and, in a sense, never the twain shall meet. Now I'm always trying to integrate and make them meet.

J.B. Yes.

3. I think the thing that - I don't know whether you asked the question or not, or if this is relevant or not -- but Sullivan really was the first psychiatrist to introduce social field theory into this arena. Many of the things that he discovered about the development of the self were being worked on simultaneously practically by Fairburn and Winnecott in England, and we had some cross-fertilization with them in a sense that Guntrip, for instance, came over here and gave us lectures at one point. We also had Winnecott come to us at one point and Ronald Laing, whom you've heard of, and what was interesting was that Laing, for instance, was just amazed at the parallels between some of the discoveries of Sullivan and some of the things from the object relations theory which was parallel. They didn't know about each other. Now, of course, a real Sullivanian would hate the idea -- the word object relations, and Sullivan would blow his lid. People are not objects. They're human. So he would have a whole different language, but you know the difference, in terms of the patient, is often not nearly as great as the discussion about words.

(Pause in tape) (Resumes discussing Fromm and Sullivan)

J.B. O.K.

3. I've confused some of the things they said particularly where they overlap, but one or both of them said that basically you don't pick up transference material too fast unless it's getting in the way. If you have somebody who is being very negativistic and saying "Yes, but" and not really hearing what you said and so forth. Then you have to get to work on it soon because nothing will happen in treatment if you don't. But if there is just a kind of over admiration or some awe as though you were a bit of an authority figure, or some fondness for you as a parental person, which is not making the patient too compliant or too rebellious, you let it go for a while until it's time to pick it up.

J.B. So far I've done some interviews with some other people and # 1 said that he thought participant observation is much more --- it came from the sort of the physics end and from the Chicago school end, and he thought it was a rather simple concept, and it came in sort of as opposed to the notion of the blank screen. # 2, whom I just finished interviewing, and I've sort of put # 2's phraseology in # 1's mouth. # 2 was even more adamant about that. He thought it was very simple really, that when you consider the point in time it is really the fact that you just couldn't observe, you weren't isolated from the situation. And they both sort of developed roughly the same ideas that you did, especially the sense of like watching yourself and your own feelings as being one of the primary tools -- the use of the concept

of intuition, not a concept actually. You just talked about people being intuitive, and I think that's very important in terms of the development of the psychotherapist. What do you think intuition is, if you can try to put that into words, and is it simply a gift? can it be developed? how is it developed?

- # 3. Well, it certainly is nice if it is developed early in life, and it is developed - maybe some of the capacity may be partly inborn because people's sensitivities to sound, for instance, and the human voice vary considerably just to give one inborn component, but I think the most important factor in developing it is to be raised in a family where people are interested in talking about their feelings and who help a child label his feelings and who give him consensual validation for his observations. You know his feeling: Mommy's mad. If Mommy says "I'm not mad. Who said I was mad?" He gets two messages. You know the verbal is one. That's the typical double bind mother, you know, who denies her real feelings and throws the child off, and children frequently, in that kind of situation where they sense hostility, but it is denied, to oversimplify it, they grow up very mixed up and they frequently cop out. They don't listen any more because what they hear doesn't register, and they can either withdraw and not listen which is a kind of unawareness, selective inattention was the word he used for this, but it can also be a whole learning experience as to what

goes on inside people and between people both. It's just --- it's not learned, and those people -- and they frequently can be quite sick people - this is really part of the basis of the autism of the schizophrenic is that he never got the right words connected with the right feelings, and he never got to see the world straight, and he has to completely relearn by means of a psychotherapy process. Now when it comes to intuition in therapists, you hope that you have somebody who --- as a matter of fact you screen for whether a person has had a really very restricted narrow ambiguous crooked background and is kind of blind, or whether they have the capacity for being intuitive. Then you and he --- for Sullivan was very, very good at sharpening the intuitions of his students because he got them to listen and look at all kinds of minor things, to look at the clothing, to look at the gestures, to look at the posture, how the person sat, how they laid on the couch, when they were restless, when they weren't, their tone of voice, a million nuances, even the first telephone call, and how they approached asking for an hour, every minutia, and he could spend a whole hour with a student on simply what the student had missed either in one phrase or in one phone call, and by means of keeping at all the little things that might have been there, he developed in the student --- it's like learning an extra dimension of hearing and seeing, smelling - almost, getting the sense of some-

thing, and by means of bugging the student to keep looking and asking and looking and so forth and getting them more and more and more aware of all kinds of things he trained them to be much more intuitive. Now the training of that -- the goal is for the person to just naturally begin to be sufficiently open with his eyes and his ears and so forth that he takes in much more than he ever was able to before, and he doesn't have to specifically go looking for it all the time. He's always ready and alert for some clue, that something else is going on that he's missing.

J.B. So -----

3. That's the way you train.

J.B. So -----

3. They're now using tape recorders, you know, to do this and one-way screens, which Sullivan didn't have available, but it can be quite useful because with a one-way screen you can really see a student interview a patient, and then there are lots of observers behind the screen, all pick up different kinds of clues, and you get a very good idea about how intuitive people are, and how much they're on the ball, and how much they're showing off or blind or barking up some particular alley of their own. Now the tape recorder is not quite as good, but even there you get the tone of voice of the -- both the patient and the therapist, and you would often --- it's not just content that the therapist may have forgotten, but it's all these innuendoes that you can pick

up. So that's a very good training device.

J.B. So intuition in your sense then is some sort of being able to pick up the feeling what --- or the meanings for certain things to people.

3. Yes, well to pick up the things that are not clearly being verbalized. If something is clearly described, it doesn't take much intuition. You can get a pretty rational explanation and have a sense it really has nothing to do with what's going on, so that the fact that you are getting a rational description that seems clear does not necessarily mean that it is clear so that you have to keep a certain kind of skepticism. And one of the things that Sullivan talked about was --- particularly in the early phases of treatment when you didn't know a patient very well --- to keep in your mind all kinds of alternatives as to what he might mean by a given communication. What was either not said, or how much this was a cover-up for something else. Keeping all kinds of alternatives and all kinds of open doors, and you start out with as many open doors as you can, and then you kind of zero in and focus down on the most essential points.

Interview with # 4

4. For one thing the way my head works, generally , not all the time, but very often, is that I don't operationalize so that I give with direct experience, both my own and the patient's because the operationalizing produces something artificial like 'Now I have a method'.

J.B. I think I would like to get back to that because practically every interview I think I've had, they talked to some degree about that. # 3 emphasized how much intuition was used. # 2 emphasized that he thought it was really some quality of personality, the healing personality. But for the sake of the analysis of my data, I would like to go through the structured part of the interview and pick up on why you think, uh, on your thoughts on operationalizing.

4. I beg your pardon.

J.B. I would like to go through the structured part of the interview and then pick up ---.

4. To a few of your questions?

J.B. Right. And then pick up on the operationalizing soon, on its introducing some artificiality.

4. O.K.

J.B. What do you think Sullivan did mean by participant observation?

4. That the role of participant and observer is intrinsically, inherently present. The next step that he is into would deal with the recognition that that exists.

Even if you think you are the mirror analyst somewhere something else is functioning.

J.B. Let me interrupt you for a second cause I've been meaning ---- (I check recording levels.) Fine. I just wanted to check that.

4. Can I go on from where I spoke?

J.B. Yes. Absolutely.

4. That, from your reading of Sullivan, you probably ran into a statement that each person brings his bias into it.

J.B. Yes.

4. Therefore, that the bias, whoever you are, a bias that may be favorable, but is still a position, effects how you experience, how you think you observe, or how you actually observe in other words.

J.B. Is this bias uhm ----.

4. Meaning, let's say, someone who is opposed to, has a bias against homosexuals.

J.B. Right.

4. O.K. Or someone who has a bias against someone identified with certain political beliefs.

J.B. Yes.

4. Or a bias that there is no such thing as malevolence.

J.B. Yes.

4. Bias, meaning the fact that we all of us have a priori positions, which may or may not interfere with our functioning.

J.B. Yes. Is operationalizing for you an example of a kind

of bias? You said that to attempt operationalizing would be introducing something artificial. Would that be an example of a bias?

4. I just did.

J.B. Right. Would that be an example of a bias? The operationalizing?

4. I can't make that correlation. That's your task.

J.B. O.K. Fine.

4. All right?

J.B. O.K.

4. You see I used that as an illustration of Sullivan's position that the analyst is a person and brings into therapy whoever he is.

J.B. Yes.

4. That also that the analyst is involved in an interaction, just as you and I were a moment ago.

J.B. Right.

4. And that you may be observing and I may be observing. It was still something of two people interacting. Do you have direct experience with counseling or therapy?

J.B. Yes.

4. Well, then, do you have any response on your side to this position?

J.B. The position that -- I'm not sure what is the 'this' in this position?

4. The position that the therapist, the professional person, brings into the counseling or therapy situation who he is as a person including what his orientation is.

J.B. Yes.

4. That's all.

J.B. Absolutely. I feel that is absolutely the case. A lot of the clients I am presently working with ----

4. Tell you what I would like to do. I would like to record this.

J.B. O.K. What I was about to say was to give an illustration of what, I think, is my own bias and one of the ways that it has functioned as an interference cause I think when it functions as an interference I, at least, am most aware of the bias itself, and that is last year when I began to do psychotherapy with clients in the clinic attached to City University, many of the clients are from the lower socio-economic class, and I'm on the border line between the middle and lower socio-economic classes, and for a while it was very difficult for me to figure out what was not happening in the communications because a lot of their concerns had to do with school performance until I figured out that we came with rather different biases towards what school meant and what performance meant and how you went about it. That's one illustration of how I think that bias exists.

4. You see I think Sullivan used the term 'bias' not in its more usual limited sense of a prejudice, but he used it to include that and the fact that we have orientations of positions. So though I used his term, I don't want to hold on hard to it because I think in our usual

sense we tend to take bias as meaning something hostile, perjorative, and he had a slightly sardonic style at times so he might put it that way in order not to come out as being full of sweetness and light. So I think that aspect of his personality needs to be included because he certainly did not mean it in the usual narrow sense, and if one took it that way and operationalized it that way, it would end up as a little distortion of him.

J.B. In his writings he talks about refining one's self as an instrument of participant observation. I assume by that he is talking about the processes essentially of supervision, though possibly also lectures and other ways of educating people. Now you were directly supervised by Sullivan. Were you not?

4. I was supervised by him, by Fromm, by Freida Fromm-Reichmann.

J.B. How did he teach you to refine yourself?

4. Well, on the whole we were concerned with the whatever he could infer about what my patient was like, and where again the formulation which is correct, of course. What did he teach you? how did he teach you? does not capture the experience of it, the subjective experience. So he didn't in supervision do that kind of formal teaching, which he did in lecture. Now one thing -- one experience that might fall under that rubric, having made my repeated comment about what the translation into operationalism does to the direct experience, one thing

that might fit into this was his asking me when I had a kind of compensated chronic schizophrenic man, as to how much I was into and let myself practically enjoy the fantasies of the patient. Now his point was that that as a kind of private interest of my own might well not be in the service of the patient. That for the patient, it would be more helpful to get into how he was using the fantasies, or what had happened to precipitate them, rather than for me to be fascinated by the interest, let's say, in the ingenuity of the logic or the illogical whatnot. So that would be one instance of where what I was involved in, let's call it a 'private interest' for the sake of keeping it accurate enough though simplistic, was that I was removing myself as a participant. I was over involved completely, privately, that what I needed to do was to use whatever it is in the interaction for the patient. So that's one example that comes to my mind.

J.B. I'm told that Sullivan in actual supervision was a great believer in short simple talk and that he, the way he was when he was supervising, was very different from the way he wrote. Is this accurate?

4. Well, one thing that I would need clarified is what's the sense of disparity. I sort of don't quite know what's being implied or inferred.

J.B. I think it is really essentially a very simple point that his writing tends to be rather long and at times convoluted. And one of the first things I was told in

an interview was, for an example, that he would never use the term 'participant observation' in the course of supervision. He would more be doing it and be working with you in a much more direct sort of fashion.

4. Well, in fact he was operationalizing in his writing, which shows the difference between speaking or writing in the operational mode and a colloquial exchange.

J.B. After the course of your training with your supervisors, did you then apply participant observation in your own clinical practice?

4. Well, just to start with I will recall to you my very early statement which is that it is inherently present. For me, it's not applying participant observation, which again has a kind of formalized taking a position, but a kind of being in touch with myself.

J.B. Yes.

4. And the being in touch with myself would involve say getting a sense of the interaction, getting a sense at times of what I was experiencing, even if I wasn't literally conveying it to the other person, but that some of the observation involved my being in touch with my own direct experience of the other person, not only on an intellectual basis, but experientially including either subtleties of emotional experience or a larger more tangible emotional experience and getting a sense, as best I could, of how the other person was responding in his or her end of it, outside at times, of the spoken content. So I would say that participant observa-

tion is like an irreducible ingredient as far as I'm concerned. That one can be a participant and not realize it, and thereby the participant becomes a non-observer of the participant. So I think the emphasis involves the awareness that you are in there participating and as well as observation of what's going on, as best one can, ascertain it in the other person.

J.B. Since for you, since it's your understanding that participant observation is not something which can be held as if it were a position, but is essentially , if I understand you correctly, is essentially an irreducible of the ingredient, then I think I would change my next question.

4. Well, I would say that it's an inherent ingredient. Let me refine it and make it more accurate. In the sense that inevitably one is participant, hopefully, one is observing one's self and one is observing the other. Now the cultivation of that dual observation is part of one's ability to start with, part of one's skill as one develops it, is part of one's repertoire as hopefully one matures in work. So I would say that somewhere along the line one is participant to some extent just by being a person. That the degree and variety of observation depends on these elements that I just mentioned.

J.B. Yes. After your training, this is going to be a substitute for question four that I think is more in accord with your understanding, after your training did you

ever come to any fundamental change in your understanding of participant observation and how you were utilizing it in your practice?

4. Well, I would say those along the lines that I just voiced.

J.B. Yes.

4. And there's one other aspect in the participation, in the participant part of it, which would have to do with whether one maintains as the prime principle the mirror analyst and avoids explicit participation or whether one goes beyond being the mirror analyst and allows more direct participation, so that there might be an interaction with the patient that, let's say, a mirror analyst might refrain from. So that would be another aspect of the participant component, which is whether one goes along with that and permits more of one's own expression or commenting or inquiring of a person. So that's another component of participant.

J.B. Yes. Have you done any formal teaching of classes?

4. Have I done any form of teaching?

J.B. Formal teaching of classes in an institute or college or any of those settings?

4. Yes.

J.B. Have you utilized Sullivan's works, his understanding of participant observation in your teaching?

4. Yes, I do.

J.B. Trying to think of what is the best way now to phrase this. For this generation of clinicians who are com-

ing along, essentially one full generation after Sullivan, our introduction to participant observation is embedded in the presentation of the interpersonal theory of psychiatry. We generally were given that particular book and work along with that book. Do you think that in some way the interpersonal theory is very tightly knit, and that if you accept participant observation as a given, you should, more or less the rest of the interpersonal theory follows, or do you think that the theory is not so tightly knit and that participant observation can be accepted as being sort of a part of reality without necessarily accepting all the constructions of the interpersonal theory?

- # 4. Let's see. Sullivan's position was that participant observation is actually a specific instance of interpersonal reality, and that it seems to me that interpersonal reality functions whatever else you do with anyone's theories, and that Sullivan's interpersonal presentation of his conception of interpersonal reality includes the intrapsychic but with a different emphasis. For instance, his view of what goes on privately might be considered to have a correspondence with Freud's presentation of the unconscious, but it is vastly different in that, let us say, the id as one aspect of the unconscious is described as the realm of turbulence and so on, and Sullivan's way of putting what goes on privately in the prototaxic component, and what he later called

the autistic component, does not put this emphasis on the kind of vast turbulent commotion, so that there are seeming overlappings, let's say what Freud presented and what Sullivan presented, but with such specific differences that qualitatively they are different. So when you ask about can you separate out one from the other, well in a way you can't because I think by now no Freudian, including Hartmann in one of his statements in his book on ego psychology, he talks of interpersonal without mentioning Sullivan's name or participant observer without mentioning Sullivan's name. So that it is possible to - it is functionally possible - to use this or that concept without formally indicating that it has been an osmosis or adaptation of Sullivan's statements - formal statements.

J.B. Do you think that the way of actually doing psychotherapy of those people who have adopted participant observation is fundamentally different from that which a competent therapist who espouses another theory would be doing?

4. That's very tricky for two reasons. One is that an analyst may take a formal theoretical position and in actuality, without its being a matter of inconsistency or not being authentic in someone, just as Sullivan could speak colloquially and write operationally, so someone else may verbalize a theory and humanly interact however he interacts. So I would say that there does not have to be a one to one correlation. Now there are

some persons - therapists who regardless of how they speak about there, in the actual functioning with a patient may adhere quite tightly to the school of thought that they were brought up in. So I would say it's possible to criss-cross these things, and one would have to get more clear as to how that particular analyst does function, but if one were to adhere literally without getting into the fact that people vary, in someone that functioning in Sullivanian terms means that there is more explicit and active involvement in, at times the analyst making comments, or asking further questions for elucidation of something that seemed promising and was not developed. If the patient gave an inference or his own, if you will, theory as to what had happened, Sullivan might say "Now I wonder if you can think of another hypothesis about what you say happened.", and that approach is definitely Sullivanian whoever uses it, whether it is so labeled formally or not. Whereas if one were to follow the format, as given, of the opposite, the mirror analyst, the position would be that if the patient speaks long enough in the analytic situation, on the couch, that ultimately the patient from his unconscious made conscious by the continuing presentation from the patient, the patient would begin to see and experience the connections. And as I heard someone quote that the analyst should not make such comments because it would be like throwing a stone into the pool and muddy-

ing the waters. So if one were to adhere, whoever one is, in the usual interpretation of the Sullivanian style, one comes out with a different kind of interaction. If one is involved, as formally stated, in the other mode, then the method is different, and the patient's communication is different.

J.B. One last question.

4. Beg your pardon.

J.B. One last question, which is, out of your experience, what do you think of as a single most central recommendation for a beginning psychotherapist?

4. Cultivating awareness of what one is experiencing, partly in response to what the patient is into, whether it's one's anxiety or a sympathy or an apprehension or an irritation or a tension, any of the range, or even one's own spontaneous recollections. So that one needs that as to how one is responding, and if one cultivates that sensitivity one should also be cultivating a parallel track close to simultaneous what one tunes into, what the patient is experiencing, his anxiety, or resentment, or blocking. So that I think a fundamental would be cultivating that awareness of what each one is experiencing.

J.B. That reminds me very much of what Harold Searles has emphasized.

4. I beg your pardon.

J.B. That reminds me very much of what Harold Searles has emphasized over and over, both in The Non-human Envi-

ronment and in his Collected Papers.

4. Well, some of these, I think Searles and Freida Fromm-Reichmann and Ronald Laing actually, though each one has an individual style, has been closely connected with the Chestnut Lodge environment and that school of thought. So Ronald Laing has drawn heavily on Sullivan and Fromm-Reichmann and in one of his books has indicated that, in say like Chapter I or so, that he has been influenced by Fromm-Reichmann and Sullivan and gone on from there. Since they are his predecessors he couldn't invent them because they had done the work.

4. And so I wonder whether you'd be making transcripts.

J.B. Yes.

4. Could you send a copy?

J.B. Yes. Let me make a formal note of that.

4. Yes. Though I have this, I don't think I'll get into necessarily transcribing, though I might at some point just out of curiosity as to where we were. Now, at this point since what you needed for your notes has been gone through, I was wondering what your experiences have been in how the interviewees discuss quotes "intuition" and so on?

J.B. Usually very respectfully, but also with difficulty and bafflement as exactly how to put this process into words. For example, interviewee # 3, I was amazed, I would ask her a question, and she could speak lucidly and clearly and so forth and so on. It seemed like

she could just go on at will answering the question for as long as she wished. About intuition though she paused considerably, and there is more considerable sense of work in trying: what exactly is it? I think that has something to do with the essential quality of intuition. Is my own guess. That it's essentially a process which isn't a verbal process that when you try to talk about it, it's like really trying to talk about how you paint a painting. It can be done and it's a useful exercise, but it's not a particularly easy one. I'm sort of drifting from your initial question. One thing that did seem to come up was - that was a sense of a function of experience. People relaxed more and then --

4. And then became more intuitive.

J.B. Right and oh, yes, emphasized that Sullivan had a way of really sharpening a person's intuitive abilities that that was one of the things that was the net effect of being supervised by him -- was that something in his style. Also there was a frequent mention of how intuitive he himself was, and how that he could sort of like come to conclusions which were on the basis of a relatively small amount of given verbal information. Also I think what interviewee # 2 is talking about - the healing personality, I more or less suspect that he is talking about a phenomenon, which other people talk about in terms of intuition, that in order for the healing personality to exist, you have

to be pretty intuitive as to what is going on in yourself, and what is going on within the other person.

4. What I said when you asked what would be the most important suggestion - suggestion I think most important, I wonder how that matched with some of the other interviewees.

J.B. Almost word for word duplicates, if I remember correctly, interviewee # 1. I'm blocking for a moment on what interviewee # 2 said. Let me go to what interviewee # 3 said. Interviewee # 3 suggested in the beginning a very -- doing as much reading in as many people as you possible can and not to center on any theory or theorist or person, but to try and be open to them all and then she suggested that - her recommendation was a very - as thorough going and deep and as powerful personal analysis as you possibly could do.

4. Who said that?

J.B. Interviewee # 3. Now what did interviewee # 2 say? I interviewed # 2 and # 3 on the same day. I may have them both subsumed under her.

4. So I gather that though some of the way each of us put it as individuals that there still is something that has a cross roads, more in common and so on. Let me add this to Sullivan's intuition, with whatever his initial endowment was, he put in an awful lot of study of his own direct experience as in his case reports, which are detailed and detailed and detailed because he was trying so hard to be accurate in his observa-

tions. So though, as we knew him, he could move from here to there quite directly, it wasn't simply magical. It was hard earned as well as whatever his endowment was. O.K. Thank you very much.

J.B. Thank you very much.

4. It's a mutual interest. Good luck to you. You and your project.

J.B. Thank you.

Interview with # 5

5. ----- people who have had a lot of contact with Sullivan. I think it might be very interesting for you to talk with them, one is Bob Kavarne, who is the editor of this volume. That's Robert Kavarne K-A-V-A-R-N-E-S.

J.B. Ah, it's this person.

5. Yep. And another is Robert Cohen C-O-H-E-N. Kavarne is at the Washington School of Psychiatry, Director of that in Washington, and Bob Cohen is at N.I.M.H., Director of Clinical Research there. - - - - - They knew Sullivan very well. I'm sorry you can't get to talk to Mary. She certainly knew him very well, and I think had something to do with instituting some treatment for him in his illness which preceded his death by a couple of years. He had some kind of bacterial endocarditis. She was an internist before going into psychiatry. When do you get your doctorate?

J.B. A year from August. I finish up the Ph.D. work, the dissertation per se should be finished by August the 31st. My internship starts September 1st at ----- . The requirement is you can't take your orals until you finish the internship - so my internship will finish some time a year from August, and I'll take my orals then.

5. One other person, just let me give you the name, if you don't have it, and that's Edith Minor. Edith is a woman in her - must be mid or late 80's. She's a full

time analytic practitioner, a very, very able person. She came from Europe, I think, probably in the mid 30's, knew Sullivan well and is very worthwhile talking with. Bob Cohen and Bob Kavarnes were students of Sullivan, took classes, seminars, were supervised by him. You are touching mainly the New York people, and well, in those days, as you know, there was a great deal of interchange between Washington and New York City.

J.B. I've had some contact with the Washington group so far through Dexter Bullard, who couldn't do the interview at this time because he had a tragedy occur in his personal life.

5. Yes, that's -- Dexter. I should have mentioned. He lost a grandchild. I haven't talked with him directly except briefly by phone since that event. But he's a marvelous fellow so if you should go down there, maybe you could ask Dexter again. He may be able now to talk with you some. You see a lot of these seminars that eventuated in that book called Studies in Schizophrenia, and some of those are brilliant (inaudible) were seminars held at the Bullard home there. I never had part in them. They must have been very interesting. Well, more to the point.

J.B. The first section is: At some point in your life career you encountered Harry Stack Sullivan, and I'm sure he must of used the term, participant observation. What did you think he meant by that term?

5. Sullivan used to refer to the work, as you know , of

Percy Bridgman, Harvard physicist, who wrote a delightfully entitled book The Way Things Are. I think that was just a fine title (laughs), and Sullivan used the word, operationalism. I knew and know very little about physics or mathematics. Sullivan was very much interested in both those fields. But the little that I had learned, elementary studies of physics brought me into some contact ---- that was back in the 30's with some of the rudiments of field theory in physics, and then I was a little interested in the work of Kurt Lewin. I was never expert at this ----- but I had read about his concept of the field, and I was interested finally in Sullivan's work with the interpersonal field and his attempts to construct a field which would not have to be a so-called instantaneous field. It would include some predictions of the future and reflections of the past. I think he then tried to use the term, eidetic figures. These figures populated the field - I believe taking that term from Jansch, or however you pronounce J-A-N-S-C-H. I believe he had this idea of eidetic people. - Well, that gets around then finally to my saying that the idea of participant observer to me simply meant that one was bound to be influential in the social field in which he participated, and that you couldn't get away from this business of influence. Secondly, that it is pretty important that you get some idea as to how you might be influencing the field, at least in terms of what you

yourself were doing. You might not be too clear as to how the other fellow had experienced what you're doing, but you ought to have some idea as to your own donation. With the idea that you couldn't sit aside as some sort of a fictive reflective mirror. You couldn't sit aside as some perfectly objective observer. So you might try to know at least what were the major ways your behavior influenced this field. The same time you were also a participant and that in order to exist in the field, the social field, in order to be influential inevitably you were bound to participate in it. And that participation varied in kind and degree so that sometimes you were more participant than observer, as a matter of fact so much to the extent that you might not be a good observer at all, and at other times you might be a pretty good observer, but not much of a participant, in which case maybe nothing very important happened in terms of the patient feeling that you were even around. I've seen it. I've seen this concept stretched in different ways, by which I mean because therapy itself is an awfully vague matter in the sense that despite our theories and our techniques, and sometimes I've seen therapists, and I would include myself, finding that his knowledge of theory and use of technique doesn't seem to bring about much of profit, either in change in the patient in a favorable direction or in the therapist's understanding. The result then may be

that the therapist, more or less wittingly I think, wants to rely upon his personality, the goodness of himself or maybe some hopefully present attribute of hidden abilities. Then I, most of us as therapists, then discover, I think, that there isn't such a quality in ourselves that is so healing but again, sometimes in our discouragement with therapy we may try to be other than the participant, to really abandon the therapeutic role, try to be a friend, a resource of information, a reassuring person, someone who can demonstrate pure love and affection and so forth, and in that case one has gone to the extreme of participant to such an extent that he no longer, I think, is effective as a therapist. On the other hand, I've seen people and again I've committed these sins or gotten into all their difficulties would be a better way to put it. One may attempt so much to be an observer that he does remove himself in some ways from the therapeutic field, but still is a participant in the sense that he is trying simply to be an objective observer. That changes his role - the kind of thing that leads some of us to think, well can you use data, or try to collect data from working with a patient and do that collection for research purposes while you're working with the patient. I've certainly wondered about that in the last 15 years or so, excuse me, in which I've made an effort to keep fairly careful records on some of my work, but then am I beginning to

attempt to objectify the work in such a way that my own attitude begins to change. Well, that's a rambling statement about what it means to me, but more concisely it means that you shouldn't get out of either one of these roles. You're bound to shift a little bit more from one role to the other at times. I suppose they're not different roles. They might be said to be one role, the participant observer, and you may get into one role or another. You may intensify one role or another in response to your own anxiety, and that's the responsibility of the therapist to note that. I mean if I'm made anxious by the patient I may now become more, as I think of it, as a scientist really observing these phenomena ---- to heck with this emotion on my part, and another time I may feel 'Oh, my God, I'm so cold as a scientist', and the patient may say that to me "You're a cold unfeeling man. All you're interested in is the phenomena and not in me as a person." If I'm made anxious by that then I may try to indicate that I really am a warm sensual sentient human being, and that may get too far away from the observer, but it's this fluctuating quality that to me constitutes the participant observer.

J.B. One of the things I'm curious, if you came to any conclusion as to whether or not you can collect data from the patients with whom you're working in therapy and not have that interest of yours be detrimental.

5. I have an example, in which I think it was detrimental.

I had thought that I might, within three years time, beginning work with a patient, this was many years ago, go into work at one of these study centers to do some writing. I wanted to keep a very careful record on one of the patients with whom I'd just begun work, and the idea was that I would use what experience I had then, supported by this careful record, to formulate some idea more clearly, but I began to work then, as I look back on it, a little too actively with the idea we ought to get all this data within three years time and so on and so on, and I got a bit too pressured. I didn't as I saw it. Although in the long run with the patient, the results were fair enough, and I didn't go to this particular center, I felt that my work was somewhat handicapped just by my own pressure. Now I have always in clinical work for all the time I've been in it kept individual and fairly careful records. A long time ago I would record sessions with the patients. The recording machine was always right in the room. In those days we used lapel microphones so there was no secrecy about it. It was with the permission of the patient, and we would listen back to the recordings at times. Those were disks that we used in those days rather than tape.

J.B. I've seen the disks. Interviewee # 1 has a pile of them.

5. I'll bet (First name of interviewee # 1) does. Yes.

Now we would listen back, the patient and I together sometimes. Now also at one time I studied these disks.

I would listen to them, listen to the recording after every session with the patient. Then I would discuss, with a group of colleagues what arose - our observations on these recordings. One of the others would listen to them also. I found that beneficial in terms of helping me understand the process some, and I also felt it was beneficial to the patient. There was no secrecy about any of this. Sullivan once, when I was a patient of his, said that he found my communications to be unusually obscure at some time, and so he thought he would put it on disk and see if he could make anything of it. I didn't know whether I was offended by the obscurity or pleased by the fact that I was of such importance as to be a model he might want to untangle. (laughs) So he made a record of that for a little while. That didn't bother me as far as I could see ----- . Lastly, I haven't had a patient in any what you would call, what we would call a well defined research project with design and we're going to find out this and that. I've been interested in studying some of the patterns of behavior that develop over the course of treatment. I keep the notes so I can go back and identify some of these patterns. I think that to me has been illuminating. I have not felt it was hurtful to the patient. Some times patients have criticized me for that, saying they know I keep notes. I don't write notes in hours, you understand, and I don't any longer record, but they know why I keep these notes

and sometimes I may present some material in a lecture or teaching session and, of course, at staff conferences also as one does in a hospital talk, in staff conference presentations, and some patients complain about that, saying, as I suggested before, -- well, I'm only interested in studying some technique or this is invading their privacy ---- but I've had no serious complaints about it. That's in part because in some instances the patient has looked at the notes that I have made and gone over them with me. There shouldn't be anything in the notes as much as -----maybe some personal comments about myself and my own feelings, which I may question and retain privately, but I find them very useful, and I don't think it's destructive. Just to take on a patient as a sole --just because this is a research case and I take on Patient A to do that, I haven't done that and I don't understand how that would be. I would add this ---- that over the long haul sometimes with a pretty troubled person in which the movements of treatment are difficult to grasp and clarify and one may feel discouraged and even bored at times, then I think it's useful to have the investigatory - investigative or research interest. I think that's a perfect proper motivation. That's part of the work. That's my view about it.

J.B. Sullivan seems to have taken very seriously the notion that we ourselves are the actual instruments in this work, and he has a phrase, which I don't think anyone

else uses, he talks about refining yourself as the instrument -

5. Yes.

J.B. Of participant observation. Now you were in supervision with what he called the "chronic consultant" with Sullivan, were you not?

5. No, he never supervised any of my work. I did indeed talk with him on occasion about a patient, and I was in some seminars conducted by him, but I was a patient of Sullivan's for about $2\frac{1}{2}$ years or so. I first met him professionally as a patient, in the beginning of the summer of 1946. He was then just convalescent from a severe cardiac difficulty, and then he died in January of 1949. So it was in that period of time that I knew him as a patient, but I didn't come in to be supervised. Kavarner and Bob Cohen, they supervised me.

J.B. Do you feel at home with that phrase refining one's self as an instrument of participant observation?

5. Yes - yeah.

J.B. How do you think you did that? ----- or how did that happen to you if it is your sense that it was less something you did than something that occurred?

5. You mean the refining one's self as a therapeutic instrument?

J.B. Yes.

5. Of participant observation?

J.B. Yes.

5. Well, the term was satisfactory. It is satisfactory to me. Maybe partly because in my medical training a great deal of emphases had been placed on the therapist's objectivity. I mean the physician's objectivity and skill, and the use of the term, instrument, didn't have a cold or objective ---- falsely objective quality to me. As a matter of fact, as I look at it now, I think I found the use of such a term particularly congenial to me because it helped bridge the gap between my sophomore objectivity in medicine and what seemed to be at that time and still is a lot of obscurity in psychotherapeutic practices. What was imperative and was emphasized, and I still think is the case, was the need for personal therapy for the therapist, and Sullivan spoke about it and wrote about it, and in his introductory lecture to students at the Washington School of Psychiatry he makes a point of it. Have you ever seen one of those? If not, I'll make a copy available to you.

J.B. I think I have seen those.

5. They may be published in "Psychiatry" and if so, you'd find them about 1947.

J.B. Oh, yes, those. Those I've got.

5. Three introductory ----

J.B. Yes. Somehow I didn't connect it up with that school.

5. Well, personal therapy was the first. I had therapy for a time, as I said, with Dr. Sullivan and than later with Fromm-Reichman after he died, of course, and it

seemed to me that, and as he said, that isn't going to resolve anything, but at least it gives you the opportunity to take a pretty careful look at some of your own ways of behavior and hopefully to get a clearer idea as to why other people see you the way they seem to see you. Now I thought that was very helpful because I wanted to get some ideas as to how a patient might see me. Not infrequently patients say to me that I seem severe, or maybe a bit chilly, or austere, and one said to me yesterday that she was rather afraid of me. She thought I would be angry and had actually shown anger to her based on some consultation.

J.B. Well ---

- # 5. All I'm getting at is that it's important that I see how a patient could see me. That way I have heard this enough that I could see how I could be austere to some people, or at times irritable, or at times withdrawn, and so on. So I don't have to go around thinking I'm always an amiable pleasant warm-hearted fellow, and I can't see how somebody could be so crazy as to see me as austere. That's a step in refining the instrument. It seems to me that's one of them, and the next thing, well, you know all this, of course, it's the use of personal supervision, meeting with another therapist, colleague. It doesn't have to be the most senior person in the world either. It could be somebody your own level of experience, sometimes even less, and talking over a bit about what you've gone through with a patient, and

hearing from the other fellow how he views it, doing the same sort of thing in the seminars where cases are presented. Class room work, I don't consider to be in the same category of importance which is not to devalue it. Some years ago the American Psychoanalytic Association sent out, as I recall it, a questionnaire asking something about what analysts considered to be the important factors in their development as therapists. And first, as I recall, of importance -- I mean in the replies to the questionnaire was the personal analysis, and second was the individual supervision, and third was the seminar contacts with a group of colleagues, and fourth the formal lectures. Now another thing that leads to the refinement is experience, and I don't want to make too much of that, but I certainly don't mean by that as we grow older we get wiser or more knowledgeable. I'm not sure we always do. I'm not sure that I do by a long shot, but because experience can tend to confirm some things that ought not to be confirmed and to harden up some false ideas. But still if one can learn through time and experience and live through his failures and disappointments and misadventures and not just try to deny them, or not to be overwhelmed by guilt about them. Then this instrument, the refining of which, has begun in part with formal training and so on, can be further refined throughout the years. And the primary agent one of the great --- one of the agents in doing that in the field is the patient. They literally do teach us. If

they don't, then I think something is being left out of the therapy because one of the things that a patient can give to the therapist. He can't really give him reassurance, and he shouldn't, or love and so forth and so on. He may come to admire the therapist or like him, but he can give the therapist experience and he can show him some things about living that the therapist still hadn't learned. So that's part of it. The last thing I can think of at the moment is that the instrument itself needs a little bit of refining before all of this formal stuff begins, and we used to think sometimes, just to exaggerate a point a bit, that as psychoanalytic psychotherapeutic work became more popular and acceptable, where I was as a medical student it was neither popular nor very acceptable, back in the thirties, then one might find more applicants for such things, and one might see applicants for admission to training institutions - applicants whose whole life had been largely in school - spent in school and the breadth of their experience in some ways not as wide as it might be. I wouldn't exaggerate that point, as I said, but I still keep the point in mind because you don't just take any personality and make a good therapist out of it, no matter, in my opinion, how good the training. Sullivan, as you know, at one juncture wrote a number of comments about it, what he considered to be a suitable background for the therapist and some things he felt weren't so good.

J.B. He said something about those whose life had brought nothing but a flood of trivial something or other problems..

5. He grew up in some placid by-water of the culture, something like that he said. He didn't think it was good to be just a preacher either. If you wanted to convert somebody, why go into another field, (laughs) but, so, that instrument has developed a lot before we ever get such training. Well, there is one thing I ought to add to that. I think there has been, and I don't know if this is in regard to Sullivan's statement, but at times I feel that there has been an undue amount of emphasis placed on the idea that we heal with some kind of inborn healing quality, and I wouldn't put this aside --- the personality of the therapist --- certainly not that --- but the gross exaggeration of the concept that one just heals through just being a fine fellow without regard for technique, theory, and so on, can at times, I think, lead to people abandoning all semblances or many of the semblances any how of an observant approach, and then simply trying to bring about some useful, or hopefully, useful change in the patient through loving the patient, or just being a good friend, or advising the patient and so on. I hesitate there because then one reads about the work of Schehaye, for example, with the girl Renee, that I think that it was a fairly planned and from my point of view very excellent work. I don't think that was just blind involvement,

and the book by Gertrude Schwinck. Have you seen that book? It's ----

J.B. I recognize titles better than authors.

5. It's titled The Way to the Soul of the Mentally Ill.

J.B. I've seen it. I don't think I've read it.

5. It's a very short volume. Schwinck was a nurse who worked with Paul Federn and turned out to have a very considerable degree of skill in simply making some kind of increasingly clear communication with very troubled people, and she later became an analyst and went into more formal training. That's a very nice account of a very talented person who, for reasons I don't know was able to make contacts that many of us with much training experience could not do. I just want to say that in talking about refining the instrument, the instrument itself is important, and I knew Sullivan well enough, at least I think I did, that he would not for a moment be talking about some kind of blind abandonment to 'let's just get together and hopefully that will make you better' to the patient.

J.B. Just the sheer fact of his emphasis on alertness would eliminate that as a possible interpretation.

5. I think so. Yes. I agree with you.

J.B. As you went on did you find -- in your career -- did you find that your understanding of what participant observation was change say over the course of the decades of your work.

5. I would say so, but I said earlier in response I think

maybe to your first question. It's, of course, said in retrospect. I think that's what I thought.

J.B. Yes.

5. I suppose throughout these years had some one queried me as to the meaning of the term I would have spoken maybe somewhat as I have now. I wrote an introduction to Sullivan's book The Psychiatric Interview. I haven't read that for a long time, and probably won't ever read it again, but I have a hunch that I said something in there about participant -- what I thought of participant observation. That would have been a long time ago ---- 20 years or so - no --- not quite 20, yeah 18 or 19. But in my experience as a clinician under certain pressures at times not only from patients but from contacts with colleagues you know that despite what is said what I would say about the meaning of this phrase to be I've always said at times how I thought of it. One time at the Lodge it seemed to me a tremendous amount of emphasis was placed on the role of the therapist, even to the extent that, in a very exaggerated way, one might say "Well, you cannot be crazy without a partner." There is something to that. In the studies that Vince has made in (inaudible) the Family and Stanton & Schwartz in The Mental Hospital, and there have been many others since.

J.B. The Lodge, by the way, is Chestnut Lodge?

5. I beg your pardon.

J.B. The Lodge is Chestnut Lodge?

5. Yes. Yes. That's where I was for a long time. I guess I act as if that were the identifying word. But the idea then could be exaggerated so that instead of noticing that the patient was a very disturbed person, and the reasons for his disturbance, if known at all, came to a large extent from his past. One might seem to ignore those possibilities and then act as if the disturbance was entirely related to the other member of this meeting. So at the Lodge for a while we would say things like "Well, if the patient is so crazy then it must be that the therapist is very upset, driving his patient crazy, and if the patient's therapist would just get clear as to what the hell he was doing, the poor patient could stop being crazy." I fell into that for a while, a lot of us did. There is something to it, you know. Sometimes you learn by exaggerating things, but I remember once I was describing some therapeutic situation to Sullivan, and he was rather sharp with me, rather discouraged by my remarks, I take it not annoyed, said something to the effect that for God's sake he thought the poor patient had enough to worry about being schizophrenic without worrying about all my personal things. See in effect I was saying to the patient "Well, maybe you're upset cause I'm angry or maybe you're upset because I have some obscure motivation." The poor patient, listening to voices and all that, and here this doctor was yapping around about things that were quite irrelevant,

trying to say "Look I don't want to pay attention to you. I want you to pay attention to me." That's a terrible exaggeration, I think. But I would say then that had I been able to speak accurately at that time, I would have spoken more of the gains of being participant. The other thing that came up again and again is the recurrent emphasis on the personality as a healing factor. As I said I don't want to belittle that, but I must say I'm not clear as to just what that means. I've seen different personality types that seem to work pretty well with some patients and others that don't seem to. Each one of us as a therapist as far as I know has preferences for patient types. Some people find that they feel very comfortable and they're effective working with more depressed people and some not and so on and so on. So I think at other times I've swung, feeling that it's so easy to become immersed in this more emotional side of the work, self-criticism, and what am I doing to contribute to that other person's craziness. And I always swing over to greater emphasis on what I considered to be the objective side, as now I'm a scholar, or I'm a theoretician, an objective observer, a scientist, none of which I am, but those shifts in talking about them now actually may take place in one session with a patient, and those are shifts in terms of personal anxiety on the part of the therapist, anxious in one period, shift over maybe in the other. Only a couple of days ago a senior colleague here said to me

that he was wondering a little bit more about what the nature of therapy was and so on, although he has emphasized technical approaches a great deal and has felt there's a right way to do therapy and a wrong way to do it. In his supervision of somebody's work recently he said that he noted that that person often did things that seemed to be wrong technically, but the work went along pretty well, and then he got to thinking about the underlining character of this therapist who's a very decent, very well qualified intellectual thinking person, and so although he may not say quite the right thing thus and so in terms of how we would look at it technically, the underlying current, I think, of true interest in the patient and of willingness to see the patient grow was among the major factors in the growth. So I suppose throughout the years I might have given pretty much the same definition. I think my own view of the thing has been refined a bit over the period, but still is --- I think it is a useful concept.

J.B. Now as I understand it you have done a considerable amount of teaching in addition to your work as a clinician.

5. Yes, I have. I've been fortunate in that regard.

J.B. In your teaching did you find yourself utilizing either the concept or the actual process of participant observation? In short, how did you ---- if you accepted it, how did you then teach it?

5. Now -- well, I hadn't thought of it quite that way, but your question is very useful. It's illuminating. I do some lecturing in which may be more formal lecturing about something. As years have gone by I hardly ever present a lecture without inclusion of some clinical material, which is an example of what I'm trying to talk about. A fair amount of my teaching has been in seminars. They usually ask me to present some sort of a lecture, you know, and then they have a seminar maybe the afternoon after that and so on and so on. More precisely I would prefer to present the thing - the idea in terms of the process - if that's the right way to phrase it. Well, I'll give you an example. I did present considerable detail for an hour about my work with a patient some years ago at some university group, largely residents and staff. This was a rather detailed account of a selection of a number of hours in the earlier course of the work with the patient including a detailed account of the initial interview with that patient - an interview which lasted some $2\frac{1}{2}$ hours. Then having presented this, then we would say that we take a look, if this is what I wish to emphasize on the concept of participant observation because here's a pretty good, as best I can present it, operational account of the problems involved in just this. This is an account of working with a rather disturbed person in which you simply aren't in the position of sitting down while somebody describes something about

255.

their history and their current difficulty. This is a patient who gets very anxious, moves around, gets upset in the session so that that kind of presentation enables one to show how easy it is to swing from being a participant to observer and how you try to keep these two roles and so on. So I wouldn't feel that I would ever be able to try to give a definition such as you and I were talking about a few moments ago without demonstrating, as best I could, from actual clinical phenomena. Is that a response as to what you have in mind, or not?

J.B. Yes. Let's see if I can be a little more clear. What I've been trying to find is how people approach the process of teaching this skill of participant observation, and I think ---

5. Oh.

J.B. In short what we're seeing is that you would try to give some instances from ---- describe instances of your work, and then try to show how well -- Look! In this particular situation I did this and let's have a little shifting back and forth here, etc.etc. etc., but you would perhaps begin with the demonstration.

5. Yes. I don't interview patients publically -- a lot of people, you know, who are older are asked to do that. I don't like to do it. The first place I would feel awkward at it. I don't think I would show any great skill. In the second place I would be trying to prove something with a patient ----- demonstrate something

and that wouldn't be real. Some people are very good at such public interviewing. Harold Searles, I think, does a lot. I haven't seen Harold, but I imagine he's top flight at it. It's not my cup of tea.

J.B. I saw a film of Searles and R.D. Laing both doing an interview with the same patient. They stuck me as absolutely (inaudible).

5. I would like to see that. I didn't know they had done it. I talked with them on it. Of course, I know Harold. I've known him for years. That would be fascinating. Is that for public purchase? Is that around?

J.B. Yes, because it was recently done at the White Institute in New York City and I don't think it was a private -----

5. I'll have to ask them about that. Thank you. I'd be interested in it. They are both very interesting and capable people. But what I ----- the point I wish to make is that I don't use that as a demonstration.

J.B. Yes.

5. So mine would be second-hand clinical material. I suppose about as good a way to demonstrate clinical participant observation as any is to work with a patient. I mean certainly in this training analyses, if you want to call them that, but the student of therapy who is in therapy himself should be -- has a fine opportunity to see how a therapist may deal with it and begin to deal with it himself because he's asked to do exactly that.

He's not going to sit there and be a recipient of the therapist's alleged or actual wisdom, and he isn't going to ----- you know, he's got to participate in the damm thing, and at the same time try to know what's going on. Once he's able to do that pretty well he's probably through therapy. (laughs)

J.B. Now, let's see this generation as we come along we see participant observation essentially as a concept that's embedded within the whole of the interpersonal theory. Now, do you think that if some one is struck by the notion of participant observation that it's so tightly interlaced with the whole of the interpersonal theory that if you take one, it makes sense to take the whole, or do you think that it some how is more loosely connected with the body of Sullivan's theoretical statements?

5. I'm not enough of a theoretician to give you a very good answer to that, but then it's not --- you just asked me what I think about it so I don't have to worry about that. It seems to me that his, Sullivan's, theoretical concepts were very closely intertwined with his self as a clinician. I think of him as a theoretician, but he is pre-eminently it seems to me a clinician, using the clinical experience to support a lot of his theory, so as I think about it the concept of participant observation fits very closely into his schemata of development of the human being. But we don't talk about it this way in the detail, of course, that the later in-

investigators have, particularly the work of Mahler more recently I would say and some others I don't know as well. Still they're talking about exchanges between the mother and the child, the maternal person as well as others later and how these exchanges tend to bring about increased self-awareness and so on and so on. I won't elaborate on that. You know better than I do. And I think Hilary Brooks worked on that concept of needs, in which he talks about the refinement of the early tensions in life and to recognition of some needs and so on and so on. Well, that's all based on interpersonal exchanges, if you want to use that phraseology, and most everyone I know writes about that to some degree so I think that what Sullivan is talking about there to me is a more professional use of this interchange -- now labeled for professional purposes, participant observation, but hopefully a person who develops and does not need therapy, let us say, is a pretty effective person in dealing with other people. Probably is quite skilled in doing just what we are talking about, more or less in awareness. He has to size up the other fellow. He should be able to see how the other fellow views him to a considerable extent, and he should know why he views the other fellow the way he does. I mean not just dislike or like blindly but have some idea why. Then as he goes along in conversations with the other he should, it seems to me, recognize that he wants to observe and so on and

so on. That was to me an important aspect of it, so I wouldn't separate the two at all, and I look upon the participant observation thing, per se, as a narrow definition of an important aspect of human relationships.

J.B. This question, the people that I have interviewed, have all found to be very difficult. So - do you think that the way of doing psychotherapy that's actually based upon participant observation is in some way fundamentally different from the approach that a person who was holding an entirely other theory of psychotherapy, but was also competent, would use?

5. What was that - but was also what?

J.B. Competent.

5. Competent. Oh, yes, yes. Well, I don't know. I suppose that one can kind of smooth over differences, etc., and I have a happy position in some ways because I don't know enough of all the therapeutic or the theoretical differences and their refinements, and that's not a snide remark. It's simply a fact. Of course an experienced or a skilled theoretician could see some of the minor differences, but I think of the concepts of transference and counter transference -- terms which I use, ----- and I don't use the word parataxic distortion very much any more. It's far from commonly used. I liked that term because it had a broader feeling to me. It seemed to fit more into the concept of field in the theory, but fair enough. ----- Without going into the

detail, which God knows you don't need, the early idea that a therapist should get some therapy and do away with their counter transference reactions and then transference is an essential part of the therapeutic enterprise. These two terms come to merge together to me -- transference counter transference -- terms which came to describe any interpersonal theory. They're there. They're inevitable there. That to me was an advantage of the term parataxic because it had broader connotation. Well, in talking with analysts, and I don't talk with many of them in terms of detailed theory, but when we talk about patients with each other -- trying to make some sense out of what's happening -- and are not defending some theoretical approach, then it seems to me we talk fairly comfortably, just in the terms we're discussing, and there the participant observation theme --- get away from that term and get away from transference counter transference -- you are talking of how in God's name can two people stay together and talk with increasing clarity about some fairly personal matters without anxiety getting to such proportions that communication is obliterated or grossly reduced. That's a maybe somewhat vague way, but I think it's an operational way, of talking about the essence in many ways of this therapeutic field, but it leaves out all kinds of things, such as interpretations and growth and development and libido and so forth. It has to do with the only vari-

ant I think in which the therapist can actually show his true ability and that's to deal effectively with anxiety, and that to me involves that. So if you want to talk, or if anyone does, about transference and counter transference that suits me fine --- no trouble with that theory. Now what I'm about to say is maybe a reflection of my being ill-informed, so you'll understand that. It could be useful. I used to hear some talk, and it was all indirect, regarding some so-called behavioral therapists, and I say so-called because I'm not sure that's quite the term applied. But, oh, some years ago down at the University of Virginia, Dr. Wolpe was there at that particular time, and though I didn't meet Dr. Wolpe then, there was some talk as I recall it --- it's rather dim in my mind --- some of his younger colleagues then, and there was some question as to whether they could carry on the work that Wolpe was then describing without the introduction of so much of the personal aspect of the therapist, and that this work could be carried on without the transference element being strong. That's what I heard. Now I felt that there would be transference. That is tendency to respond very strongly one way or another to somebody who assumes the healing position - approach and does so with a specified technique and with a certain sense of power. It seemed to me inevitable. Now I don't know what would be said about that at the moment. My impression has been that there has been more

introduced into some of these techniques, the idea that the interpersonal is also data, that personal transaction is important in addition to the simple application of the technique.

J.B. I was fortunate enough to have the opportunity to watch Dr. Lazarus through a one-way mirror while he was doing therapy, and one of the things that struck me about that was - well - just how much the kinds of things that I would think of as being transference were abundantly there. He was handling them in much the same way as some one with entirely other theoretical orientation would.

5. Yes. Well, that's been my impression. Who was it? Lazarus? that I heard speak in Paris. Oh, well, I've forgotten, there was one of these chaps, a behavioral therapist, spoke over in Paris at a meeting a few years ago, and it was apparent to me --- I thought he would probably be a pretty good therapist under any classification, though he wasn't emphasizing some of this other, so I don't see how you can get away from these phenomena, I really do. That takes us back to the concept of Bridgman's operationalism where the uncertainty principle and all that sort of thing. So that's another slightly variant point, by which I mean that I'm inclined to think that one of the better ways to preserve the pristine pure nature of the theory is to avoid work with patients.

J.B. (laughs)

5. It seems to me that any theory to which I have become more or less endeared is questioned again and again by our daily experience with the patients. If we're successful, we all are to some extent, in regarding some of our observations, maybe the theory will seem to gain strength, but in order to do that you pretty well have to stop listening to patients. So, you know, it comes up to my mind 'Well, this must be so and here's an example of it', and then I think 'Oh, God, here's some examples which indicate that it doesn't fit just right'.

J.B. One last question, which is this: Out of your whole experience as a psychotherapist, what do you think of as the most central recommendation that you would have for a beginning psychotherapist? You don't have to feel restricted to a single ---- "the most central".

5. As I look back at my experience you're asking what do I consider to be a major factor in growing?

J.B. Yes.

5. In what? Development?

J.B. Well, development of the psychotherapist.

5. Of the psychotherapist. I hesitate there because it seems to me that what I'm about to say ---- it might place an undue emphasis on a certain aspect of living, and I don't want to sound, and I don't want to be --- in any sense seemingly dramatic, or -- I can't think of the word -- sort of unduly affectively involved. I would be inclined to think that you've got to have

some things happen to you in your growing up before you ever start to be a psychotherapist that would lead you to get somewhat interested in psychotherapeutic work. I have a little hunch and dammed if I could (tape has to be reversed)

Well, what I had in mind is this that one of the things that I think one sees often in working with people, who become schizophrenic, is that sometime when they were growing up they have acted as if they should be responsible for their parents and actually almost as if they were the parents of their parents, have to take care of them and so on, protect, assure the preservation of the parents. That's it. So it seems to me that many therapists, I certainly can't speak of all of them and I don't know if this is an outstanding quality, but I'm inclined to think that if any therapist has engaged in some variant of the therapy role as he grows up -- to put it another way -- the caring role, but I suppose that should be a component of every human's growing up with his siblings, if he has them, or with other people, elderly people, friends, or whatnot. I think that may be a fairly strong factor in the development of the therapist. Also it seems to me that another factor is the experiencing of some anxiety. I say "some", but I suppose everybody experiences quite a lot when he's growing up. What I'm thinking of is the experience of anxiety, which is intense enough so that you damm well know it's there. It isn't just washed away by events

and forgotten. Becomes significant in one's life - may be puzzling in one's life, and it may be recurrently troublesome, and may even lead one to want to investigate it, and if one does run into the misfortune of pushing such phenomena aside and saying in effect that this is the way I was made to be, or it's just the weather that brings this about or something, then the wish to investigate it may lead to being interested in the more formal therapeutic role. Give you a little bit of a personal example briefly because I always had a lot of separation anxiety -- most of us do. It used to puzzle me, and I would think about it in therapy and so forth, but I didn't learn until actually much later in my life, by much later -- in my forties -- that actually I had been separated from my mother because of my father's illness with tuberculosis and her need to care for him when I was about six weeks old, and cared for then by some black lady who lived with me and my grandparents ---- I never was clear on it -- until I was about two years old at which time I left her and returned to my parents. Well, having learned those facts, it was very helpful. But the persistence of that kind of anxiety was a puzzling thing to me, and I think it was a factor in my continued interest in therapy with people who sort of were similar. Now having gotten beyond one's personal background, I'm not saying that I think to be a capable therapist you have to be psychotic, or go through the horrors of

terrible mental illness, or that you have to be always prowling around immersed in anxiety. I don't mean that at all. I think the therapist who suffers too much of all that is in no position to be an observer. He's just always being anxious and the hell with that. I don't believe (inaudible) good for himself. I think it's well to get some formal training, even though one may find that he exhibits skills in dealing with disturbed people. You see people who are psychiatric workers or aides in hospitals or nurses and so on show great skills in dealing with very seriously troubled people, who are anxious people. I think those skills without question in my mind can be much improved through more formal training, and for whatever field. To get into personal therapy, at least, that's what I would say to analytic people. If you are going on to analytic training - something like that, get your head examined. Take part in this experience, and then in work with patients, I'd get some supervision of some kind. That's what we were going over before, and there is some advantage I think in going to a formal institute for a while and getting some training providing you don't get stuck in it. I've seen colleagues spend eight, nine or ten years and so forth being candidates at some institute -- I'm blessed if I know why -- except maybe they just can't break the tie. Why they want to do that all the time. While I think the formal education at an institute is of use, but I would

not consider it to be the primary factor. You have some personal life experience that leads you into the interest. Then I think you'd better find out what that interest is about. Otherwise you'd be trying to find the answer to it again and again with patients, or you'd be trying to influence patients to provide you with the answer, or to provide you some relief about your own anxiety. If one has had a very anxious and troubled mother in his growing up and had been disturbed by that, and then perhaps would like to have helped her, and then wants to help patients in the way he wished he could have helped his mother. I think that may be a useful motivation, but if it's carried out blindly, the therapist may always be attempting for the patient to quote "get better" in order for the therapist to feel more secure and the therapist to feel -- to exaggerate the matter - "Ah, at last I've helped my mother", but if he has personal therapy and supervision and recognizes this motivation that you've just invented - that I think some times is actual - then I think he'd be more effective. I think that is somewhat repeating what we've said before, but that's what I have in mind.

J.B. There is only one other thing that I would like to follow up, which is about the parataxic.

5. Time's all right. It's not -----

J.B. The parataxic distortion notion, which is one of the things that struck me - that I really liked about the

term - I'm not sure whether it's my creation or something that Sullivan intended to put into it - was that by the time a lot of transference counter transference is worked to the point where you have it in sentences, in words, it's practically ceased to exist as something troublesome, hence parataxic because while it's going on it's in some way not being processed verbally. Is that an accurate understanding or something that I just sort of put in there?

- # 5. No, I think that --- as I follow you I think that's o.k. As I understand the concept, practically all our conversation has a parataxic quality to it. To get into the so-called syntactic mode, one would have to have symbols of communicative exchange that were clearly agreed upon as to their significance and have a public agreement. I would guess that some of the mathematical symbols might move more in that direction. Some of the concepts of physics though more currently, as I hear about such things as "charmed quarks" and so on that it seems to me to move away from it. (laughs) Some of the precision that we hoped existed in physics and whatnot ----- it seems to me that the concept of the parataxic simply gives recognition to the idea that past experiences and anticipations of the future are components of our evaluation of any present situation, and that external reality, so-called, is only a representative of how we ourselves view and respond to certain events. That as we recognize this fact, this

doesn't mean we have to go constantly around living in some kind of misty vagueness, or we can't even add up two figures or something, or can't know clearly we dislike some guy. Hell, we dislike him. That's all. You don't have to analyze it for ninety years. To get away from those extremes, then to notice that in some situations often of great importance in making decisions in your life, we want to have some idea as to how our personality, our past experience, which is, of course, personality in many ways, and what we anticipate, what's going to happen influence the judgments that we have to make. That's all very relevant to certain types of situations in which we are and certain decisions which we must make. A man is going to get married or get divorced or get remarried or change his job and so forth, or get into a situation with his boss that's very difficult. It's well to think of the things I'm talking about, but if he's going to decide whether to have fish or meat for dinner, he might as well let all that go and just decide. The hell with it. I like one or the other. If he is going to be disappointed because he bought fish instead of meat, too bad he didn't do something different. In other words a lot of the observations of these rather complex operations aren't worth making in certain situations.

J.B. O.K.

5. Sullivan put it so neatly, I think, it's very important in our work and in our life too to make a clear dis-

inction between the possible and the impossible, and I think also between what is necessary and unnecessary. So that the analytic process in its more refined state, it doesn't want to be carried out all the time. If it did, you'd never get anywhere. In that case you'd be one of the delightful representations of the severe obsession state in which one stays a patient forever in sort of ruminating tension state of nothing.

J.B. O.K. Well, thank you very much.

5. Well, it's been good talking with you.

J.B. Thank you.

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Dear Doctor

has given me your name with the idea that you might be willing to be interviewed on the topic of participant observation.

Participant observation seems to have been a central concept for Harry Stack Sullivan whether he was working as a clinician, as a theoretician, or as a researcher. I am now engaged in a doctoral thesis out of the clinical psychology program of the City University of New York. The purpose of this thesis is to elucidate the concept by determining a group of operations which are instantiations of participant observation as it is used in clinical practice.

Since you were a student of Sullivan himself, I would greatly appreciate an opportunity to interview you as to your understanding of what he meant by participant observation, and as to how you may have applied this in your own work.

This interview would be especially helpful as the published material appears to be an inadequate record of Sullivan's work. Accordingly, I have enclosed a synopsis of my dissertation proposal should you wish to read it. I shall call you within the week to discuss this further with you and answer any immediate questions you may have.

Yours sincerely,

Joseph Belanger

APPENDIX C

A Synopsis of a Dissertation Proposal on
Operationalizing Participant Observation

In 1931, Harry Stack Sullivan wrote that psychotherapy was a highly intuitive art that was in the process of being converted to a group of formulations for which a consensus had been reached as to their validity. In 1975, my approach to this task has been to first read that literature which seemed to be most addressed to the practice of psychotherapy and which simultaneously was neither oversimplified nor over-jargonized. Accordingly, I read the works of Sullivan.

My second step was to choose according to criteria which follow a concept used in this material. The concept would have to be reasonably central in the formulations. It would have to be as directly related to the actual work of doing psychotherapy as was possible. There should be a reasonable chance of operationalizing that concept i.e. of pointing to instances of the application of that concept in a session. I settled upon the concept of participant observation and gleaned from the literature slightly over 250 non-redundant references to this concept.

I then inferred a pro tem definition: participant observation is used to formally acknowledge that the universe under consideration is a highly coupled variable system in which the observer interacts with the observed. It is also used to denote a method of psychotherapy. As an illustration

of the simultaneous application of participant observation as a theoretical construct and as a method, consider the following quote.

We can study the phenomena that go on between the observer and the observed in the situation created by the observer participating with the observed. I hold that this is the subject matter of psychiatry; some rather remarkable results have already come from its definition.
(Sullivan, 1940, P.12)

My third step was to review Sullivan's material again, noting all instances of the application of the participant observation method of psychotherapy. Such instances are scattered throughout his work but the single greatest concentration occurs, understandably enough, in The Psychiatric Interview. I then reordered this list of operations, first dividing them into strategic and tactical operations.

Strategic operations are defined by their applicability for the entire duration of a course of psychotherapy. I included the heuristic subdivisions of a course of psychotherapy in the group of strategic operations because they must be consistently maintained in order to function as subdividers. Tactical operations have reference to some particular situation that arises in psychotherapy with sufficient frequency to be noted.

The procedure of tripartite functioning is an instance of a strategic operation. This procedure states that the therapist has three tasks: to understand what is being communicated to him; to see that he is understood in his communications; to watch over the possibilities of the immediate future of the ongoing interpersonal relationships. Several

less general but still strategic operations are nested within this procedure. For example, a principle difficulty in attempting to understand what a person means by what he says is that the clinician must be doubly wary of comments which are truisms.

Another type of strategic operation is the statement of an action from which the therapist is enjoined as that action is so typically followed by a disaster. The first and most important of these restraints is to avoid rigid and precipitate application of technique. This introduces the fact that I think both the strategic and the tactical operations, except for ethics, tend to be heuristic. Also, as the field is so complex, no listing is exhaustive.

The tactical operations consist of three main and non-mutually exclusive types. Some tactical operations are applications of a strategic operation in specific and especially difficult situations. Others are designed to meet one or another common difficulty in the practice. The last group are those that are intended to be useful with a particular type of client. The client-type operations I included under the tactical grouping as I thought that 'type' was not a static category but a referent to likely behavior patterns. These behavior patterns are susceptible to change during the course of psychotherapy and so the associated operations are not necessarily strategic.

There is a strategic operation of maintaining an optimal level of anxiety 'in' the interpersonal relationship of client and psychotherapist. The task, and no easy one appar-

ently, with a terrified psychotic patient is to reduce anxiety. Sullivan (1956) believed that if you could hearten this person to the task of observing what provoked this fear, he or she might realize that the threat was apparent rather than actual. If, however, you attempted to reassure the patient, you were almost certainly foredoomed to failure.

To illustrate "common-difficulty" tactical operations, consider the occasion on which the psychotherapist wishes the client to engage in a specific technique. In Sullivan's time, the technique was mainly that of free association. He found that a description of the technique and an exhortation to perform said technique were not notably effective inducements to practice. He eventually discovered that if he could induce a few demonstrations of the technique working successfully, and then point to those successes, he was marvelously equipped for enlisting the client's aid in this particular practice. (Sullivan, 1954)

Client-type tactical operations include a rather ingenious maneuver for obtaining information from people who are quite paranoid. The difficulty is that the more patient and understanding that you become, the more highly do these people suspect your motives, particularly as patience grows thin. Sullivan dealt with this by behaving disagreeably though non-assaultively. It is difficult to suspect a man of insidiously malevolent intent when he is being grumpy with you.

With the strategic and tactical operations outlined, the fourth step is to interview clinicians who were immediate

students of Sullivan. There are several reasons for this. Firstly, it has been claimed that studying with Sullivan the person led to an understanding of his theory and method rather different from that typically gained by studying his works. The idea that I get from the rather vague rumors is that the 'sense of the man' is largely lost in the literature.

Further my own understanding has minimally a bias generated by my personality. At most my understanding is incorrect. The only possible counteractive to this is the effort to obtain consensual validation. Personal bias being inevitable, this effort simultaneously attempts to correct for the biases of Sullivan's immediate students by searching for the implicit consensus.

Thirdly, these senior students have had the most experience with the Sullivanian method. This renders them, by definition, experts. These experts have had the greatest opportunity to develop the method or to reject it for some other conception. Either case constitutes information of no little historical value entirely apart from my attempt to analyze, integrate, and synthesize the interviews.

The interview itself is planned as being moderately open-ended and covering the following topics:

1. What do you think Sullivan meant by participant observation?
2. How did he teach you to refine yourself as an instrument of participant observation?
3. Have you applied participant observation in your clinical practice?

4. Have you amended or changed this principle as a result of your clinical experience?
5. Have you utilized either the method or the conception of participant observation in your teaching?
6. To what extent do you think that participant observation can stand by itself as a concept independent of the remainder of the interpersonal theory of psychiatry?
7. Do you think this way of doing psychotherapy is fundamentally different from that of competent psychotherapists espousing other theories?
8. Out of your experience as a psychotherapist, what is the single most central recommendation that you would have for a beginning psychotherapist?

A quantitative analysis of the differences among the answers of the interviewees seems to me premature. Rather I will attempt to note such differences as exist and sort them into two major categories, differences of style or tactic, and differences of overall aim or strategy. It is my understanding that stylistic and tactical differences reflect the individual variation of persons and the existence of alternative approaches to a goal. Differences of strategy are serious differences and must be reconciled or if irreconcilable understood.

APPENDIX D

ORIENTATION AND GENERAL INSTRUCTIONS

Equipment list: Please find enclosed:

- 2 3" by 5" tally cards
- 35 8½" by 11" rating sheets
- 6 packets of specific attitude scoring instructions.
- One each of:
- Attentiveness
- Openmindedness
- Sensitivity
- Responsiveness
- Consideration
- Compassion

The general task is to rate five interviews on each of six attitudes. The complete rating of an interview for an attitude will use an entire rating sheet. Five additional rating sheets over the number that you will need have been provided as spares.

Each rater is being asked to keep a record on the tally card of the hours that she spends rating so that I may have an idea of the minimum number of hours that I owe her. I would recommend that you use the old standby method of marking the hours in groups of five thusly: ~~+++~~ . A second tally card has been enclosed as a spare.

The specific attitude scoring packets all follow the same format. The attitude is defined. Illustrations of a high level, medium level, and low level of that attitude are provided. By studying the packet you can learn what I mean by a particular attitude and the sort of thing that I consider to be indicative of varying levels of that attitude. The illustrations have all been carefully constructed to sound as similar to the transcripts as I could make them without in

any way actually duplicating any interview data.

GENERAL INSTRUCTIONS

Each interview that you will rate is divided into a number of parts. There may be as many as ten parts to an interview or as few as eight. The reason for this variability is that some interviews will have a prologue and/or an epilogue while other interviews have only the eight parts that correspond to the eight topics covered during the formal interview. I am asking you to rate one complete part at a time. The reasons for this request are these: were you to attempt to rate each and every sentence, the task would quickly prove to be too onerous even for the most dedicated; also, the unit of a sentence is frequently too small to allow for accurate rating of the presence of an attitude. Similarly, to attempt to rate an entire interview would prove equally onerous and also inundate the rater with too much material. The division into parts is my attempt to create a rateable section of an interview.

The general task in rating is to give a numerical value to each and every "instance" of the attitude that you are rating for that part. This will be explained in greater detail below. In general, an "instance" may be abstractly defined as an idea, or a topic, or, in the case of me-you interactions, an exchange in the conversation. The difficulty, if any, that may arise is that the "instance" may be of varying length. Sometimes a unit of two sentences would be a piece of one instance. This is exactly the same problem as defining what is one single response to the Rorschach. So, I am depend-

ing upon your considerable expertise as both psychological testers and psychotherapists to 'feel' when the conversation has changed and to rate appropriately as one, two, or more instances.

I am further asking you to rate all the parts of a given interview on one attitude before rating any part of that interview on any other attitude. In other words I am asking you to rate systematically: to rate an entire interview on each attitude before doing anything else and to rate full parts during each work period.

As I said above, the general task is this: while reading a part, make a clinical judgment on a scale of one to five of the intensity of the attitude you are rating each time you recognize an instance of it, and then record your rating. In order to have some shared understanding of what is meant by words like 'sensitivity' or 'consideration', I have provided specially created definitions of such terms. The definitions that I have created are clarifications and simplifications of ordinary usage, such clarifications and simplifications hopefully allowing us to have some clinical precision as to what we mean by attentiveness, or openmindedness or etc.

The only way that this will work is, of course, if I have succeeded in my task and if, also, you study carefully the definitions provided. At the same time please study the illustrations of varying levels of presence of the attitude. The same process by which we gain a shared understanding of what we mean by an "X" should also allow us to understand and come to an agreement as to how much of "X" is present.

The actual mechanics of rating are these. Each rating sheet has a space for your name, a space for the identifying code letters of the interview, and a space for the attitude being rated. Please fill in these spaces with the appropriate information. After this, please study the definition of the attitude that you will be rating and the accompanying illustrations of the high (5), medium (3), and low (1) intensity of presence of attitude scores.

Then, notice that the remainder of the rating sheet consists of some ten columns labeled: P, 1, 2, 3, 4, 5, 6, 7, 8, E. These correspond simplistically enough to the prologue, if any, of the interview that you are rating, the eight topics of that interview, and the epilogue, if any, to that interview.

You are now ready to rate a part. Begin reading and each time you recognize an instance of the attitude being rated, make a judgment as to intensity of presence of that attitude. Please feel free to make judgments of two if you feel the intensity to be roughly midway between low and medium, and four if you feel the presence to be roughly midway between medium and high. Please do not feel free to make judgments of $2\frac{1}{2}$ or $3\frac{1}{4}$. Use only whole numbers between one and five (inclusive). This judgment is the rating per se and is to be entered in the space provided under the appropriate column heading. Please do not be irritated if I compulsively remind you that the ratings must be entered under the correct column heading on the appropriately labeled sheet or the reliability measures are completely lost.

The number of instances of an attitude in a part will probably be quite variable. Do not be surprised, aghast, or ashamed to discover that there are no instances of attitude "X" in part P, but 14 instances of attitude "X" in part 3. Simply do you best to call them as you see them.

Each time that you resume the rating of parts on an attitude that you have previously studied, please review the definition and illustrations of intensity of presence. This should refresh your memory. Incidentally, the time that you spend in studying and reviewing the definitions and illustrations, along with the time you are spending reading these general instructions, and investigating your packets are most definitely to be tallied as hours spent rating. Also please round upwards on fractions of hours spent rating.

Two final notes: I would ask you to rate when you are reasonably alert and motivated in so far as this is possible. I am aware of the exigencies of our lives (notably internship) but please try. You may also experience some initial confusion as to the differences between one attitude and the next. Partially, this is inevitable as what I am basically rating here is an attitudinal 'set' that is predominantly non-verbal but which we must describe in words.

The task is similar to measuring the proportion of an amoeba that is given over to pseudopods. You place the amoeba on a grid and take photographs and then calculate the average extension. In this case the 'grid' is our words. Where I think that confusion may be particularly likely I have tried to insert some clarifiers in my attitude defini-

tion/illustration packets. .

In general try to remember such things as that it is possible to be highly sensitive without being overtly responsive, or flagrantly responsive to the situation without being sensitive as to what is actually ongoing. If a severe difficulty arises, I may usually be reached at my home telephone number (781-3876) after 11 P.M. Keep trying and once again THANK YOU!

ATTENTIVENESS

By this attitude I mean the capacity of regarding with considerable care the various performances of the other. Some roughly synonymous terms that might help you to get the feel of how I am using the word 'attentive' are: mindful, heedful, observant, vigilant, and alert.

With this attitude as with all the other attitudes, the instances of attentiveness will mostly fall into one of three general categories: actual demonstrations of attentiveness in the me-you interchanges, revealing reminiscences of cases, supervisory sessions, personal anecdotes, and what not, and direct exhortations to the practice of attentiveness. As there are no cultural restrictions on the overt discussion of this attitude, you may expect to find an instance almost anywhere in any conversation.

Here is an illustration of a high (5) level of intensity of presence of attentiveness. It is an example of the instance of direct exhortation.

So really what I would emphasize in working with the patient is that you simply must stay on top of things -- just all the time -- No sleeping.

The following illustration is not quite so high a level instance. I would rate it as four. It is an example of the revealing reminiscence.

Some patients are much more difficult because they are very scattered -- all over the map -- After a while though you have some ideas as to what is probably going on. Likely themes emerge from all that noise and then you can make a tentative interpretation or two -- See how it goes.

Notice that the hypothetical interviewee does not directly

state 'And you must do this by paying very careful attention'. That is simply implicit in the conversation and/or a reasonable inference to be drawn.

A medium range of attentiveness (rated 3) is shown in the following example of the instance of me-you interchange.

X.Y. (ongoing conversation) and so what I really think is, uh, is that o.k.?

J.B. Yes, I think so.

X.Y. So what I really think is (etc.)

Obviously something has happened in the room which was noticed both by the analyst and by myself. The relatively neutral tone of the exchange between us and the lack of any proper nouns means that whatever it was, it was fairly obvious to both. This is the primary justification for a medium level score of three.

The low (rated 1) level of intensity of presence may be illustrated by an obvious miss in the conversation.

J.B. So, is this an illustration of the Sullivanian approach?

X.Y. He is.

One must, however, watch carefully to ascertain that these misses are, in fact, instances of inattentiveness. Read the exchange following the purported miss to ensure that this is not a fancy R.D. Laingian knot of the form that X.Y. thinks he sees that I do not see the actual implications of the previous conversation and talks across my sentence to lead me to see what he or she thinks I do not. For example:

J.B. So, is this an illustration of the Sullivanian approach?

X.Y. He is.

J.B. Hunh?

X.Y. What I mean by that is this: that the person who is sitting there in the room with the patient must be very very careful in what he does with regard to the patient. In this way, it is more the person there than any technique he might do that constitutes the actual illustration of the Sullivanian approach. So I said: "He is."

More likely it is inattentiveness, but please check.

OPENMINDEDNESS

By this attitude I mean the capacity of being without strict prejudgment or other forms of prejudice: the attitude of being willing to hear and consider. Being willing to hear and consider, a person with this attitude is free from pretense in the sense of not being a know-it-all. Such a person is the exact opposite of a poseur. I wish to especially emphasize the accessible and receptive aspects of openmindedness in contradistinction to the free voicing of one's thoughts, attitudes, beliefs, etc.

This illustration of a high (5) level of openmindedness constitutes an example of the implied or indirect exhortation. The interviewee does not actually come out and say 'You must be openminded', but openmindedness is either directly implied or constitutes a necessary inference.

Learning is really a double edged sword; on the one hand, it's absolutely necessary, absolutely indispensable. If you don't learn the theories, you may very well just flounder around. But on the other hand, it can just junk up your head with being a Freudian or a Sullivanian or a what not.

Openmindedness may also be shown not just with respect to theory but also in the attitude to patients and clients. Sullivan's teacher's dictum "You must discover what the patient is trying to say" would also be an illustration of the

high (5) level of openmindedness. Incidentally, I would consider this to be an example of the indirect exhortation that practically verges on the direct.

Yet another way that openmindedness may be shown is by the admission of a mistake. This always shows a high degree of honesty and courage on the part of the interviewee, but it may be of varying degrees of openmindedness depending upon how much change of viewpoint is implied by the admission. This is to say no more than there is a world of difference between 'Yeah, I made a mistake. (I got caught.) and 'Yeah, I made a mistake. (Now, I will correct it.) This illustration, an example of the revealing reminiscence, I would rate as a high (5) level.

The funny thing about supervision is that what I remember most vividly after all these years is those times when Sullivan really hit me over the head for something or other that I had been doing wrong. I remember that I had a theory about schizophrenics and their mothers -- half baked to tell the truth. So I was always in there asking about mother. One day Sullivan opened the trapdoor on me by saying "While it might or might not have been true that your mother had tried to drive you crazy, it was certainly true that you were driving your patients crazy asking about their's at all sorts of odd times." Since then I have worked to just be there -- hear the situation with clean ears.

I shall illustrate the medium level of openmindedness with another case of the revealing reminiscence that is admitting a mistake. This should simultaneously highlight the fact that structurally identical instances of openmindedness may be of varying levels of intensity.

Well, actually once you got the sense that he, Sullivan that is, was on your side, he very rarely wasted any more time saying what you did right. There was one guy who frankly frightened me. I think he reminded me of the school bully from my grammar school. I would never

say anything to him. Sullivan figured this out and mind you he never said get in there and say more, but he pointed out what I was doing.

It is easy to confuse openmindedness with an essentially lazy attitude in which the statements of the patient/client are heard but there is no effort made to listen intently, no effort to understand what is actually the case. The following, yet another instance of the revealing reminiscence, illustrates the low (1) level of intensity of openmindedness.

Now Sullivan you see, he was forever after the patient, and after you. What does he mean? What do you mean? It was like he couldn't understand English or something. It made me wonder about the man. I never question my patients, or very very rarely. I just accept what they say. They'll tell you.

SENSITIVITY

By sensitivity I mean the capacity to detect existent, that is to say actual, changes in a situation while these changes are still rather minute or subtle. The sort of changes that are most likely to be detected are changes in the feeling tone of the situation.

Attentiveness and sensitivity tend to blur into one another. They may be most readily distinguished by virtue of the fact that attentiveness always involves some degree of effort to remain aware. Attentiveness does not necessarily involve a consideration of the feelings and/or the self esteem of the other. Conversely, sensitivity is always a psychologically-minded quality but it does not necessarily involve an effort of awareness.

As will be usually the case with all the attitudes,

a direct exhortation to the practice of sensitivity will be rated as a five.

There may very well be much more subtle instances of high level sensitivity in which the sensitivity is demonstrated in the me-you interactions. An interviewee may, for example, hear some of the implicit wishes in my questions and reply to them rather than to the overt statement. This will require a careful discrimination to distinguish this from the case in which the interviewee simply goes off on a tangent. I would consider the following to be a high (5) level of intensity.

J.B. It seems that for Sullivan participant observation was both given and trained. Let me clarify that.

X.Y. Uh, I think I know what you mean. It might be more simply put that while people are always participant observers, they can get better at it.

Obviously, I did not do the interviews to hear myself talk. The interviewee, sensitive to my fundamental wishes, responds appropriately.

The medium (3) level of intensity of presence of sensitivity can be illustrated by the following implied or indirect exhortation. I would consider this particular example to be a three verging on a four but on a forced choice basis, a three.

It's like Scylla and Charybdis. To have any psychotherapeutic effect at all on the schizophrenic, you have to say just the right thing at just the right moment in just the right way, and I mean really the right way for him, but at the same time you can't sound too poised or textbooky or like a psychotherapist.

The following example also illustrates the medium (3) level of intensity. This one is an example of a me-you

interaction in which I am not represented on the transcript because the part that I did was done non-verbally. These cases will require careful and empathic reading to be discovered.

What Sullivan meant by participant observation was that one should not just participate in things but observe them also --- But if I stop there that won't be very much help to you, so maybe I can elaborate on that a little.

The rater can easily imagine that I might well be crestfallen at receiving such a terse answer. This presumably shows on my face and the interviewee, sensitive, sees this and responds by elaborating.

The low end of the sensitivity continuum is unlikely to be shown in any massive breaches of decorum but is more likely to be revealed in an off-hand remark.

Well, one thing about the schizophrenic, these people are very tricky, very elusive --- you wonder if they are really all that disturbed or playacting or what --- very elusive in the therapy so you just have to have an excellent memory to put all the pieces together.

It is instructive to note that this same example would be rated as a one on sensitivity but as a four on attentiveness as it constitutes a rather strong indirect exhortation.

RESPONSIVENESS

As I am using the word, I mean 'responsive' to be the ready inclination to react in an overt though not necessarily large scale way to the suggestions or impressions one has gained from the environment. The ideal responsive act is apt, quick, ready, and right. As aptness is an integral component of responsiveness, those responses which are quick and

flagrantly overt but not apt earn a lower intensity score than less massive responses that are extraordinarily apt.

In this way responsiveness while definitely inter-related with the attitude of sensitivity is distinct from it. In order for an action to be highly responsive, it has also to be apt which demands at least a moderate degree of sensitivity, but any individual action could be at least moderately responsive with little or no sensitivity.

Let me emphasize that the major difficulty to be encountered in rating this attitude is that as the psychotherapist/psychoanalyst becomes more skilled, he or she becomes more precise in his/her actions. The high degree of responsiveness present in a minimally overt response may thus be easily overlooked.

As usual the direct exhortation to practice the attitude will be rated as a five. Here is an illustration of an indirect exhortation so intense that I would also rate it as a five.

When the patient is highly highly anxious, the worst thing you can do is to sit there like a lump on a log. The second worst is to run off at the mouth, prattling on just to hear yourself talk.

The example which follows is another illustration of the high (5) level of intensity. It also demonstrates that not all instances will fall neatly into my three heuristic categories of exhortation, reminiscence, me-you interaction. This is a combination of exhortation and reminiscence.

One of the greatest dangers is of going to sleep during the session. I don't mean literally falling asleep though that happens also but simply letting the patient

lull you into a semi-comatose state with words that sound very much like you are talking about something significant but in fact are what we used to call "glittering generalities". You don't want to barge in there and take his cliches away from the poor patient - there are reasons he has them you know - but there will come a moment when you feel he is less needful of them and then you can ask a question or make a comment, just a little thing you know - my obsessives were always putting me to sleep and Sullivan was always waking me up by pointing out that I didn't really know anything about them.

Notice that the exquisitely responsive question or comment occurs as part of a sequence that may also be rated on the attitude of attentiveness. You have to be very careful to guard against a psychological 'set' to the effect that 'I've already rated this one'. Such a set could cause you to overlook instances of multiple attitudes occurring cosequentially.

A medium (3) level of responsivity may be illustrated with the following rather indirect exhortation.

Now, I, myself, never feared Sullivan as a supervisor though I knew lots of people who did and that is one of the worst things that can happen, fearing your supervisor, because then you start to act "as-if" you were a psychotherapist when in fact you are! Patients will forgive you little lapses into as-iffness but it can play havoc with the therapy if you do it too much at the beginning. The patient will sense that you are 'removed' from them and who wants to pour out their heart to someone who most singularly resembles a department store mannequin.

Low (1) levels of responsiveness are likely to be found in the omission of a responsive act, when one would be expected in the conversation. Here is an illustration that is also an example of the me-you interaction.

J.B. After your time with Sullivan, did his supervisory comments somehow grow on you?

X.Y. No.

These low levels are also seen in responses that are distinctly though subtly out of 'tune'. The following illus-

tration exemplifies the reminiscence.

Oh, yeah, I remember I had this one girl and she was deeply troubled. She always felt she wasn't being treated as an adult, and she was in medical school --- we went round and round about this gal's competitiveness with men.

Not all short comments by the way are instances of unresponsiveness. Sometimes a terse answer can be exactly what is implicitly requested by the phraseology of the question.

J.B. So, would you say, that to sum up, in supervision, Sullivan continually demonstrated the attitude of a psychotherapist but that he rarely talked about it?

X.Y. Yes. He never lectured me.

CONSIDERATION

By this attitude I mean the capacity of being thoughtful or heedful of the comfort of others. The interviewees practice two distinct kinds of consideration. First, they show what amount to basic social skills, more or less what we ordinarily mean when we use the word 'considerate'. Second, there is a distinctly professional kind of being considerate; what you might call the limit of feeling for the other that you can have and still be fundamentally based in the notion that psychotherapy just happens to be a peculiarly difficult, though lucrative, way of earning one's living.

Due to the particular cultural mores within which we live, it is extremely unlikely that you will read a direct exhortation to the practice of consideration, such exhortations being given almost exclusively by parents to children. Should you run across one, it is, of course, rateable as a five.

Here is an illustration of a high (5) level of social skills consideration. It is also a me-you interaction.

X.Y. Excuse me, but what are you doing?

J.B. I'm just checking the recording levels to make sure that I'm getting this on the tape.

X.Y. Should I speak more loudly?

The following indirect exhortation illustrates a high (5) level of basic profession consideration.

If you are going to be of any worth as a therapist you have to be very careful that the patient maintains a certain amount of pride. Sullivan helped with this extraordinarily once. I had a patient who felt that she had fallen in love with me. Now from her perspective she was simply unfortunate enough to have fallen in love with her therapist. From mine she was stuck in the transference. Sullivan helped me to talk around the edges of the topic with her, changing the topic when it looked like she would do or say something that she would really regret later. In this way, she never became so ashamed that, later, it would have been impossible for me to function as a therapist.

The medium (3) level of consideration can be illustrated by the following example of a reminiscence.

The long and the short of it is that, well, whenever my patient would make me fairly anxious, and that was rather often, I would tend to get fancy and long winded about things. Sullivan would emphasize to me that if I couldn't say it in six words to my schizophrenics, I might as well forget it (etc.).

What makes this specifically a medium (3) level of intensity of consideration is that the emphasis falls slightly more on change of style as a technical matter rather than on being genuinely helpful to the people involved.

Here is another medium level illustration of consideration. This one is an example of the me-you interaction.

X.Y. So really childhood is the period during which the developing human is focused on the production of

syntactical though not necessarily grammatical sentences and it is really ended by the appearance of marked tendencies to go use those sentences in communications with playmates, right?

J.B. Right. Now do you feel (etc.)

The above illustration also shows how you must use your own clinical sensitivity in deciding what is being exchanged in the seemingly casual modifiers of sentences. If all the subtleties were put into words the actual exchange would look more like this:

X.Y. (etc.) right? (I will go on about this if you absolutely feel that you need it for the dissertation, but frankly I'd rather not.)

J.B. Right. (Thank you very much. I think that is enough so I shall pass on to the next question.) (etc.)

The instances of low levels of consideration are most likely to be seen in subtle but definite faux pas. For example:

Participant observation is by no means to be confused with the mere cataloging of what the patient does, even a behavior therapist can do that. You have to feel your role in it, how you are involved. This is what makes it different.

Without doubt the mere behavior therapist would take umbrage at the notion that he was blissfully unaware of the stimuli he was producing.

In order to count as a distinct faux pas, the mild gaucherie must be entirely without redeeming social value. Many of the interviewees have the disconcerting habit of saying socially inappropriate things with the intent of exposing those security operations that might otherwise interfere with one's capacity as a psychotherapist. These do not count as instances of being inconsiderate but fall under the general rubric of ruthless compassion and should be rated under that

heading.

COMPASSION

This attitude is one of profound feeling for and understanding of human suffering. It is further typified, in the modal case, by a concomitant desire to alleviate this suffering. Compassion differs from pity in that there is little if any sense that the compassionate person is in a more favorable position than that of the one for whom he or she has compassion. It differs from sympathy in the clear recognition of the self-created nature of much of human suffering. It differs from empathy in that there is not only an intuitive appreciation of the other's state of mind but also an understanding of that state.

As with consideration, it is highly unlikely that there will be a direct exhortation to the practice of compassion. Any such testimonial in which compassion is mentioned directly or strongly implied should be rated as a five. Illustration:

But what is not so good about the diagnostic system is that it can blind you to the simple fact that craziness, in my book at least, is very disordered communications -- these get so, so disordered out of fear and guilt -- and here's where the participant observation part comes in -- if you feed into that, start thinking "You crazy bastard" "How disgusting!!" -- all you will see is a disgusting crazy bastard who is getting more and more disorganized.

Here is a second illustration that I would personally rate as a four.

You can get really unreasonable about all this, it can happen with all the best intentions in the world, your patients aren't there to change for you so you can sort of slip it into the conversation at lunch or what not.

One of the great difficulties in rating the attitude

of compassion is that there are some statements which sound quite inconsiderate but which are, in fact, highly compassionate. This illustration of the high (5) level of inconsiderate or ruthless compassion is in the form of the revealing reminiscence.

Once I had been working with this woman for a year - she was being maintained on an out-patient basis - she and her daughter were having this malevolent relationship that got spun up out of the mother's fear of disciplining the daughter for being bad because then she would be bad. The mother was terribly terribly afraid of being thought to be bad by the grandmother. Anyway, one day we were going round this dilemma for the umpteenth time and she said "But she'll think I'm a BAD mother" and I said "So what?" Well, I'd thought I'd blown it, but Sullivan thought otherwise.

The following example of the me-you interaction is an illustration of the medium (3) level of compassion.

J.B. One thing about Sullivan's statement that it is really a matter of relative differences in maturity of the people involved when we are discussing madness -- that's sort of well, strange, but maybe I just don't see.

X.Y. No, no. It really is a little odd. It just isn't a matter of the schizophrenic simply regressing to the ways of an infant, but of having serious distortions (etc.)

Here the interviewee feels my nervousness about saying that I think such and such and moves the interview along in a way that is distinctly compassionate.

The following illustration I would rate as a medium (3) level of intensity of presence of compassion. It is an example of the indirect exhortation. Notice that what is actually said is the direct proscription of an attitude to which compassion is the exact opposite.

In psychotherapy it is often easier to say what you don't do. Aside from being against sleeping during the session

Sullivan was always also against walling yourself off from the patient, hiding behind degrees or technique.

Low (1) levels of compassion are most likely to be seen in subtle but definite self-aggrandizements. This illustration is a me-you exchange.

J.B. Did you then change the principle of participant observation as you went on in life?

X.Y. I'm glad you asked that question. As a matter of fact I have.

And this illustration is an example of the revealing reminiscence.

Sullivan did have an intimidating manner but he was never abusive. No matter how stubbornly your patient was acting out, he would never scold you for it -- he'd just keep on asking questions.

The above illustration should also help reduce any confusion that might arise as to how self-aggrandizement is inversely related to compassion. In short: with the attitude of compassion, you are there for them; with the attitude of self-aggrandizement, they are there for you.

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