TERRY A. KUPERS

PUBLIC THERAPY

The Practice of Psychotherapy in the Public Mental Health Clinic

Public Therapy

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TERRY ALLEN KUPERS, MD

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ebooks@theipi.org

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—T. A. K.

Introduction

I have two aims in writing this book. One is to share with therapists some techniques, experiences, and ideas about how to adapt what they know of psychotherapy to the realities of practice in the public mental health clinic. The other is to introduce a wider readership to some of those realities: the plight of low-income clients; the repercussions of inadequate budgets on the quality of public mental health services; the substitution of external controls where psychotherapy is not possible; and the conflicts and problems the therapist faces when attempting to practice in such a setting.

There is a double standard in the distribution of mental health services. An overwhelming majority of therapists practice in exclusive white communities while public clinics, which are generally the only mental health services available in minority and low-income communities, are severely underbudgeted and overcrowded. Consider the very different mechanisms whereby clients are distributed to therapists in the private and public sectors. In private practice, a therapist might choose to see four to eight clients in individual therapy plus one or two families or groups in a day. He or she merely fills these hours and the group with clients seeking therapy and then takes on no more clients until openings occur. No single therapist or group of therapists need worry about how the remainder of the therapy-consuming public will be served. And each therapist, once practice becomes lucrative, can select a variety of clients who will be

challenging and yet not too draining. For instance, the therapist may choose not to see more than one or two clients at a time who suffer from borderline character disorders.

A quite different mechanism prevails in the public sector. Each clinic is responsible for serving a certain geographic, or catchment, area. Anyone who requires treatment in that area—by personal volition, as follow-up to psychiatric hospitalization, or by referral from police, courts, or local physicians—and who cannot afford private therapy must be seen. Grossly inadequate budgets for public services guarantee that mental health clinics will be understaffed relative to the demand for services. Thus, waiting rooms are overcrowded, clients of all varieties are seen briefly, and excessive medications and involuntary hospitalizations are utilized to keep the situation under control.

Wishing to avoid collusion with this double standard, after completing my residency training in psychiatry I decided to practice in public clinics. I knew that in private practice, even if I were to adopt a sliding scale and charge only a few dollars per session, I would see very few low-income people. With grocery and rent bills to pay, they would still view psychotherapy as an extravagance, and current public insurance plans such as Medi-Cal (in California) and Medicaid contain too many restrictions and complications to permit much dynamic psychotherapy. I figured that by working for a salary in a public clinic, I would be able to offer psychotherapy whenever it was clinically indicated and not have to

wrorry about clients' ability to pay. I soon discovered that things were not so simple.

True, I can practice quality psychotherapy with a certain number of low-income clients. But at what price? The salaried job brings with it responsibility for the care of a large client population. In order to arrange weekly one-hour sessions for a small number of these clients, I have to see a much larger number for very brief sessions, perhaps ten to fifteen minutes every month or two. All I can offer in such brief sessions is psychotropic medication. Meanwhile, nonphysician therapists refer the bulk of clients they evaluate to physicians for medication and thereby make room in their schedules to see a smaller number of clients for fifty-minute hours. Thus a double standard is set up within the public clinic itself—cursory sessions and medications for a majority of clients, dynamic psychotherapy for a select minority.

Of course, there are always criteria available to rationalize this double standard. The clients who are seen monthly for a few minutes in "medication clinic" and given powerful tranquilizers are said to lack insight and motivation or to be "too chronic" ever to change. Freud was not interested in treating anyone who could not pay his fees and introduced such criteria to rationalize his stance:

> One may stand quite aloof from the ascetic view of money as a curse and yet regret that analytic therapy is almost unattainable for the poor, both for external and for internal reasons. Little can be done to remedy this. Perhaps there is some truth in the widespread belief that those who are

> forced by necessity to a life of heavy labor succumb less easily to neurosis.... In this class, a neurosis once acquired is only with very great difficulty eradicated. It renders the sufferer too good service in the struggle for existence.. . . For the middle classes the necessary expense of psychoanalysis is only apparently excessive.[1]

Many therapists, following Freud, believe that most low-income clients cannot usefully undergo dynamic psychotherapy because they lack the qualities that are presumed to be prerequisites for therapeutic success: insight, motivation, higher education, capacity for delayed gratification, and ability or desire to pay fees. Certainly, a therapist who believes this has few qualms about exclusive private practice or about seeing only the most motivated and educated clients at a public clinic.

I believe this approach to the selection of candidates for psychotherapy serves largely to rationalize the double standard in the delivery of mental health services. Of course, not everyone is an appropriate candidate for psychotherapy, and some selection criteria must be established. But I believe many clients who have been relegated to the “medication clinics” and the “chronic” cases can benefit from dynamic therapy, as can many less severely disturbed people who refuse even to set foot into the mental health clinic for fear of stigma.

So many times the public therapist sees a client who has suffered a traumatic event and then has constricted her or his experience in order to cope with that loss. The therapist knows that with a course of dynamic psychotherapy the

trauma might be worked through and the constriction removed, but there is not an opening in the therapist's schedule to see the client intensively enough, or the client is too concerned about stigma and social control to visit the clinic regularly. For instance, a forty-year-old woman who suffered the death of her husband becomes totally withdrawn and isolated. The therapist knows that in private practice there would at least be enough hours set aside to help the woman work through her conflicts about undergoing therapy, but in the overcrowded public clinic she will more likely resist until her depression worsens, and then have to be managed entirely on medications.

This is not to say that there is any guarantee of quality therapy in the private sector—the reality is much more complex—but at least there the fee-paying client is given more of an opportunity to tell his or her story, and there is the possibility of working through traumas and relieving constrictions. It is the inequality of opportunity and potential I wish to stress here.

Public clinic clients know about the double standard and about social control. It is not any absence of insight on their part, but rather the presence of very real insight that accounts for much of their underutilization of public mental health services. I overheard a verbal exchange that is illustrative of this situation. Two black men, a high school teacher and one of his former students, met on the street outside a county mental health clinic:

TEACHER: Why don't you go in there and talk to them?

FORMER STUDENT: I been in there to talk to them. They won't give you no job. All they'll do is tell you you're crazy!

Public therapists, or therapists who work in public clinics, know about such sentiments. And they know they would accomplish more with many of their clients if they could offer adequate jobs, education, and housing instead of, or in addition to, psychotherapy. Added to the problem of the underbudgeted clinic and the overcrowded waiting room is the material hardship of life in the community. As public therapists we ask ourselves if it is even possible to practice quality psychotherapy in such a setting.

Besides being confronted with too many clients and the issue of quality of therapy, a therapist working in a public system is constantly placed in the position of having to use coercion. Some situations require involuntary hospitalization; or the police bring people to be evaluated against their will; or the courts or probation departments order someone to be in therapy, or they subpoena the therapist's confidential records; or former mental hospital patients are forced to take medications in the clinic. While the private therapist can pick and choose clients and situations with which to become involved, the public therapist's job description includes many distasteful tasks and responsibilities, and he or she is constantly confronted by less-than-voluntary therapy candidates.

Generally, we choose to be therapists because of some wish to help others, and as therapists we choose to work in the public sector because of some wish to

serve a deserving but underserved population. But then, while working for a salary in the public sector, we find that we are still unable to provide the quality therapy we would like, and that significant parts of our assignment involve police or social-control work with low-income clients. Troubling questions arise: "Why am I wasting my time? Why don't I give this up, engage my full energies in private practice, work only with people who want to change, and practice a kind of therapy that will be noncoercive with clients and rewarding for me?"

Therapists react to the stress in various ways. One helpful arrangement is part-time work in a public clinic and part-time private practice. The therapist who chooses this course has a more balanced experience and gains different satisfactions in each sector. I have continually maintained a part-time private practice while working in public clinics, as have many other psychiatrists and psychologists. Unfortunately, this option is not available to the majority of therapists. Social workers, paraprofessionals, psychiatric technicians, and others often cannot find part-time jobs or have difficulty setting up private practices. And though part-time arrangements help with personal frustrations, they do little to eradicate the double standard. There are many other ways in which therapists respond to this inner questioning.

Some therapists leave the public sector altogether. Their social conscience and concern for the disadvantaged brought them to the public clinic early in their careers. They attempted for several years to provide quality services for the poor.

But continual failures, continual discomfort with the less-than-optimal quality therapy, distaste for colluding in coercive practices such as involuntary hospitalization, or even feelings of being unchallenged or burned out lead them to make a decision. “I’m not doing anyone any good here. It’s time to look out for myself and find a more stimulating and rewarding setting for my work.” Whatever their reasons, these therapists leave with a feeling of having failed, and for some time after engage in painful soul-searching about the morality of turning their backs on the plight of the low-income community.

Others who remain give up the idea of practicing psychotherapy. They decide that psychotherapy is “not indicated,’’ “not relevant,” or “not a priority” in a low-income community or a public clinic. They turn instead to community organization, advocacy, or preventive mental health, or in some other way they reframe the nature of their service to low-income people to exclude the whole concept of therapy. I have no real criticism of this choice. These services are important, too. In fact, there are many times when a therapist’s refusal to stand up as advocate for a client or to join with clients and community to protest blatant police brutality or to campaign against budget cuts in education precludes her or his real effectiveness as a therapist. I believe that a therapist who is unwilling to leave the office to help a client fill out an application, fight a legal battle, or strengthen a support network in the neighborhood is too stuck in a traditional role or too unsympathetic to the reality of clients’ lives to be capable of serving clients’ needs.

But I also believe that low-income clients deserve quality psychotherapy. When community organization, advocacy, and prevention entirely replace psychotherapy at community facilities then the poor are still excluded from whatever benefits psychotherapy might provide.

Nothing said here is meant to derogate the importance of advocacy or organizing. Others may argue that, given the shortage of resources, advocacy and organizing are more important than the provision of psychotherapy. I do not plan to discuss such arguments here. Rather, I will look at various problems that arise in the practice of psychotherapy. Then, in the context of a discussion about therapy, I will consider advocacy (Chapter 6), not as a separate activity, but as an adjunct to therapy.

Other therapists respond to those troubling questions by becoming administrators. In other words, another way out is up—up the administrative ladder to a position that does not include direct services. Psychiatrists generally take this route if they stay in public institutions. The institution's budget does not permit hiring enough psychiatrists or other therapists to make each of their caseloads compatible with quality clinical service, so many therapists find it desirable to cut down the proportion of their work that is clinical and to expand the proportion that is supervisory or administrative. Since mental health programs tend to select psychiatrists for leadership positions, the psychiatrist who so desires can move up fairly rapidly to become director of one program or

another. Then her or his contact with the everyday worries of therapists is limited to concerns about statistics on the number of clients served, or efforts to fight for increased budgets to cover the program's most glaring deficits, or comprehensive treatment planning for whole catchment areas. Again, these activities are important, and no services would be available to clients if no planning and institution-building were done. But this route also removes the administrator from the concrete frustrations of practicing psychotherapy.

Another way therapists can remain in public-sector jobs and handle their distress about quality of care or collusion in social control is to numb themselves to these disturbing considerations. There are some, of course, who merely ignore such issues and adapt themselves to wearing whatever blinders are necessary for "just doing a job." They harden themselves to the plight of clients enough to cope with the fact that a client they did not have time to see during the week committed suicide over the weekend or enough to allow them to force a client to take tranquilizers he or she does not want.

1 am quite concerned about an unfortunate selective process that occurs. Of those who practice therapy in public clinics, a certain number develop this kind of numbness out of necessity, and most of those who cannot become numb leave to go into private practice or to do other things. Short of total numbness, the tendency in this direction—the hardening to a disagreeable aspect of one's work —is so contrary to the kind of sensitivity psychotherapy requires that the effect is

one more major hindrance to the practice of quality psychotherapy with low-income people.

Recently I spoke with the director of admissions of a large county psychiatric hospital. I asked him how he felt when he turns someone away who is potentially suicidal, someone whom he would ordinarily admit to the hospital for observation if it were not for the lack of available beds, and then that person goes out and kills himself. The director replied without even a pause, "I just figure that the fault is not mine. I made the best evaluation and judgment I could, and, given our resources, made the decision I had to, and I go home with a clean conscience and lose no sleep over it." What are those of us to do who lose sleep more readily?

Here is a dilemma for the public therapist. *Is it possible to practice high-quality, noncoercive psychotherapy in the public clinic?* I believe that it is possible—or, perhaps more accurately, that the struggle to make high quality, noncoercive psychotherapy available to low-income clients is a struggle worth joining. In order for the public therapist to be effective—and this book is intended to demonstrate my belief that he or she can be effective—the public therapist must at all times keep in mind complex psychological and social issues. To describe what I believe to be the public therapist's task I have chosen to discuss some everyday issues as they arise in the public clinic: clients who "no show"; interracial tensions that complicate staff and therapeutic relationships; social and economic hardships that magnify depressions; dependent and "chronic" clients; effects and side effects of

medications; and therapist "burnout."

Before proceeding, I will mention three prefatory issues: the problem with *generalizations* about race and class; the place of *diagnosis* in public therapy; and the delicate matter of *confidentiality.*

Generalizations

In the United States the great majority of social science researchers have been white academics, and many of their studies of Indians, blacks, factory workers or low-income people have been biased by their class and racial perspective. In recent years, other researchers have reexamined earlier studies, have pointed out these biases, and have attempted to control them. Of course, a truly objective study is not possible. As Jean-Paul Sartre wrote, "The experimenter is part of the experiment."[2] For instance, there is no way for a researcher, black or white, to stand outside race relations in our society and objectively portray social events. But researchers can take racial tensions and experimental biases into account, adopt a critical stance, and present an account that is at least well grounded in the subjective experience and meaning of the population studied.

Continuing with the example of race, the "Moynihan Report" on black families, *The Negro Family: The Case for National Action,* published by the U.S. Department of Labor in 1965,[3] described the black family as a "tangle of pathology" and contrasted it with the white family, which had "achieved a high

degree of stability." The report described the black family as necessarily matriarchal, and claimed that this matriarchal structure, "because it is so out of line with the rest of American society, seriously retards the progress of the group as a whole."[4]

The reaction of black social scientists was intense. Andrew Billingsley countered that black families were not so often matriarchal as they were equalitarian.[5] Robert Staples protested that many of the assumptions Moynihan used were actually racial myths.[6] Various black investigators, including Billingsley, Joyce Ladner, and Bettylou Valentine, offer views of black family life that emphasize its strengths.[7]

The critiques of racial bias have not come only from blacks. Some white researchers, notably Elliot Liebow and Carol Stack, attempt in their methodologies to correct some of the more blatant biases of earlier white research.[8] They do this by living among the people they are studying and by discussing honestly in their reports the biases they discover in themselves and their fears that they will not be entirely successful in correcting these biases.

I mention this trend in research in order to illustrate the danger of generalizations and the need to remain open to the possibility of bias. I am not primarily a researcher, and psychotherapy is not a science. I am a white psychiatrist. I work in a public mental health clinic where half the staff are black,

all the clients are low-income, and a majority of the clients are black. I am writing about therapy that often occurs between therapists of one class and race and clients of another class and race.

I do not mean to imply that any of the patterns I observe among any particular group of clients are generalizable to any larger culture, class, or race. If anything, my observations are generalizable only to subgroups of clients in public mental health clinics. I have not studied the process by which clients are selected or select themselves, though I will offer speculations about this. But nothing I say about black clients, low-income clients of any race, unemployed clients, or previously hospitalized clients can be usefully generalized and applied to *all* black people, *all* low-income people, *all* unemployed people or even *all* previously hospitalized people. I describe individuals only to illustrate points I am making about the practice of psychotherapy. It is only that practice, as it occurs in a particular setting and context, that I am attempting to generalize about.

Diagnosis

Accurate diagnosis is important in the evolution of strategies for psychotherapy. It makes a great deal of difference whether the client's experience fits the general pattern of a psychotic episode, a neurotic mechanism, or a personality disorder. The therapist would proceed differently if the diagnosis were borderline character than if it were narcissistic personality or schizophrenia,

or manic-depressive disorder. A therapist must be able to differentiate between "functional," or psychological disorders that might respond to psychotherapy, and "organic" disorders that result from physical damage to the brain and require medical or surgical treatment. A therapist must be knowledgeable about the diagnostic process if he or she is to understand the literature about psychotherapy and know when to apply one therapeutic tactic or another in working with any particular client.

At the same time, there are dangers attached to the act of diagnosing. There are biases built into the process. For instance, low- income people and minority members tend to be given more extreme diagnoses than their more affluent white counterparts. H. S. Gross has shown that when black and white patients come to the emergency room with approximately equivalent signs (e.g., withdrawal and delusions) and histories, the black is more likely to be diagnosed psychotic or schizophrenic and the white more likely to be diagnosed neurotic or depressed.[9] Gross speculates that the white professionals making the diagnoses act on racial bias. Part of that bias is the assumption that a more affluent white patient would be more harmed by the stigma of a diagnosis of schizophrenia, and that such stigma would matter less to a black and unemployed patient.

There are other dangers in diagnosing low-income and minority clients. Once diagnosed psychotic, a client is likely to be taken to a mental hospital every time he or she is disruptive or arrested by police, and is likely to be given

Thorazine or some other strong medication. The client's medical chart, including the diagnosis, might be subpoenaed and used against him or her in court. And the stigma attached to the diagnosis might make it hard for the client to find work.

It is often difficult across class and race lines to distinguish between pathological symptoms and culturally rooted adaptive mechanisms. A middle-aged black man whose son had recently met a violent death told me that his dead son had visited him in the night. As he described their conversation, I asked if he could be imagining the incident or dreaming. He insisted that his son had actually visited him and he described in great detail where his son stood, the expression on his face, and what he said. I wondered if he was hallucinating. Several weeks passed. He reported several more visits by his son, and each time the topics they discussed—old quarrels and misunderstandings, fond memories, and loving feelings they had never shared—seemed to be appropriate parts of the mourning process. After a month the visits stopped, and the father's grief lessened significantly. Had I assumed that this man was hallucinating and treated him for pathological grief or a psychotic depression, my treatment might have interfered with his very adaptive mourning mechanisms. Worse, I would have been redefining as madness the spiritual or cultural experience I did not understand.

Diagnosis often serves as a barrier between therapist and client. For instance, a therapist experiences discomfiting reactions to the client's distrust and hostility. By deciding that the client is paranoid, the therapist finds a way to

understand the client's behavior and thus feels less uncomfortable. But then, too often, the client becomes less a person in the therapist's mind and more a representative of a diagnostic category. When, instead of utilizing diagnoses to understand clients better and strategize therapies, a therapist uses them to distance himself or herself from the clients' pain or to hide from the clients' challenge to the therapist's values, then the diagnosis becomes a formidable barrier to communication. When the client complains about one or another problem, the therapist likely relates the complaint to the psychopathology. This use of diagnosis can cause the therapist to "blame the victim" for a plight imposed largely by poverty or racism, or it can prevent the therapist from focusing sufficiently on the client's strengths and constructive coping mechanisms.

Finally, the most thoroughly trained professionals are the most knowledgeable about diagnosis. When rigorous diagnosis is a high priority in a public clinic, the professionals are viewed as the sole experts, and the paraprofessionals or professionals with fewer years of training are viewed as very nearly incompetent. This tends to devalue the skills of certain members of the staff, who often are very proficient therapists because of their understanding of people and their talent for helping but lack technical training in diagnostics.

For reasons such as these, I will not focus very much on diagnosis in this book. I will describe some people and their therapies. In each case I will have some ideas about diagnosis, and in some cases I will mention these ideas. I will do

so only to help the therapist who is interested in diagnosis to integrate what I write with what is written elsewhere. I believe that eventually all therapists must be well versed in the principles of rigorous diagnosis, but meanwhile much quality therapy can be accomplished by therapists who are not yet so well versed. I hope that as public therapists become more sophisticated diagnosticians, they will retain a critical stance so they can avoid the dangers, biases, and objectifications built into the traditional diagnostic process.

Confidentiality

Clients in public clinics often resist talking about their personal lives in therapy, saying that they do not want their "business put out on the street." After more trust develops, some clients tell a therapist or a group about incestuous sexual abuse during childhood, about crimes they have committed, about their impotence, about their deepest fears. How would such clients feel if I were then to write in an undisguised way about these intimate details?

For this reason I have altered somewhat the life histories and courses of therapy I report. Ages, names, family constellations, geographic markers, vocations, and other details that might compromise clients' confidentiality have been changed. In doing so, I am sacrificing some rigor in the reporting of empirical data. This is an unfortunate necessity. In every instance I attempt to retain the essence of the clients' stories and of the progress of the therapies.

CHAPTER 1
A Brief History of Public Therapy

In Freud's time there were two very distinct psychiatries. One was practiced in asylums, the other in consulting rooms. In the asylum inmates were chained to the wall, forced into icy baths, and severely reprimanded for every bizarre act. In the consulting room the analysand was listened to with compassion and taught how to understand anxieties and dreams and how to use that understanding to create a richer life. The public therapist inherits the traditions of both psychiatries and has the difficult task of practicing gentle understanding in settings that represent the modern community-based version of the asylum.

A very simple and disturbing relationship exists in the practice of public therapy: *The fewer the resources available in a public clinic and the larger the client population to be served, the more the average treatment resembles the controlling psychiatry of the asylum and the less opportunity there is for therapist and client to engage in self-discovering or psychodynamic psychotherapy.* In order to explore this relationship, I will present some of the history of the two psychiatries and discuss the related issue of social control.

Asylum Psychiatry

There was a time, as recent as the end of the nineteenth century, when only lunatics saw psychiatrists, and only behind asylum walls. There were no private

therapists, no mental health clinics, no tranquilizing medications. The lunatic, forsaken by the community that deemed him mad, and having little legal or political recourse, could only hope some day to be declared sane and released. The psychiatrist held the keys to the asylum door.

"Treatment" was often a matter of external control, such as some form of punishment or torture applied whenever the lunatic acted inappropriately. There were chains, whippings, straitjackets, and beatings. Baths were popular—fifty to one hundred pails of ice water were poured over a restrained inmate, or inmates were held under water until they nearly drowned. Or they were strapped into whirling chairs suspended from the ceiling and spun up to one hundred turns a minute until they became unconscious, vomited, or bled profusely from nose and mouth.

There were reform movements. In 1793, against the advice of colleagues who feared that inmates would become assaultive, psychiatrist Philippe Pinel freed the inmates from their chains in the asylum at Bicetre, France. No assaults occurred. Inspired by Pinel's success, other asylum directors in Europe unchained their inmates. Cruelty and chains were, in some institutions, replaced by education, humane treatment, and "moral therapy." The last included the vigorous enforcement of clear and moralistic rules for inmate behavior. The psychiatrist was presumed omniscient, his wisdom to be sought and not challenged. An atmosphere was created in the asylum in which staff and inmates alike would take

delight in ridiculing other inmates whenever their behavior seemed bizarre or crazy. The "silent treatment" was added for recalcitrants. Michel Foucault writes of the conversion from chains to moral therapy:

> Such means as threats, punishment, deprivation of food, and humiliation were used; in short, whatever might both *infantilize* the madman and *make him feel guilty. . . .* The madman was to be supervised in his every movement, contradicted, and his mistakes ridiculed; sanctions were immediately applied to any departure from normal behavior.
>
> In the new world of the asylum, in that world of a punishing morality, madness became a fact concerning essentially the human soul, its guilt, and its freedom; itwas now inscribed within the dimension of *inferiority;* and by that fact, for the first time in the modern world, madness was to receive psychological status, structure and signification.[10]

Thus the earlier reliance on external constraints was supplemented by psychiatrists' attempts to inculcate in inmates a "punishing morality." Of course, even in the reformed asylums, the external constraints were retained for particularly unruly inmates— the locked rooms and wards, the straitjackets, and the beating by guards. But, in general, the emphasis shifted. Foucault comments: "The absence of constraint in the nineteenth-century asylum is not unreason liberated, but madness long since mastered."[11] Psychiatrists learned that control in the asylum was as easily secured by a shared morality as it was by chains.

The movement to establish asylums in the United States occurred somewhat after the invention of moral therapy. David Rothman describes that movement. Beginning in the 1820s, vagrants, imbeciles, beggars, and some of the more

disturbed law breakers were rounded up and placed in newly constructed asylums. The asylum movement was inspired by the ideology of Jacksonian reform. Inmates were no longer viewed as the incarnation of evil. Rather, their human frailties were believed to result from some failure on the part of the community to socialize them properly. Thus, the community felt obligated to provide treatment, and not merely incarceration or punishment. The optimism of the period, particularly about medicine's potential to cure, and the energy of those attempting the treatment led some psychiatrists to report 100 percent cure rates. [12] But as the years passed and many inmates failed to improve and many former inmates returned to asylums, the optimism waned. When the political spirit of reform dwindled, the more chronic populations of the asylums were once again chained, ignored, beaten, or less sympathetically treated:

> Both the failure of the asylums and their persistence had common causes. . . . The environmental concepts of the asylum founders at once helped to *promote* and *disguise* the shift from reform to custody. The post-Civil War asylum keeper all too predictably succumbed to the fallacy that in administering a holding operation he was still encouraging rehabilitation, that one only had to keep inmates behind walls to effect some good. Since the fact of incarceration was so easily confused with the improvement of the inmate, wardens and superintendents often relaxed their vigilance and allowed abuses to creep into the routine.[13]

Whatever its form and relative humaneness, asylum practice did guarantee one thing: Everyone knew who was mad—the fact that one was sent to the asylum established his or her condition. The existence of asylums, whether brutal snake pits or moral training centers, served to reassure those outside that madness had

been contained. Thus, the encounter of psychiatrist and lunatic served an important social-control function. Lunatics were confined, and people outside the asylum were given an example of what their fate would be if they acted inappropriately.

The psychiatrist who worked inside guaranteed his own sanity by erecting a wall of expertise about the madness he treated. Since cure was eventually considered unlikely, and since the general physicians of that time were enthusiastically involved in establishing systems of classification for all then-known types of diseases, psychiatrists concentrated on describing and classifying mental disorders. Emil Kraepelin was the master classifier, and his system of differentiating dementia praecox (later termed schizophrenia) from manic-depressive psychosis formed the foundation for much of modern psychiatric diagnostics. The psychiatrist of one hundred years ago, dealing only with the most extreme and incurable cases, did not need to ask his patients, "What do you mean?" A shift occurred with Freud.

Consulting Room Psychiatry

Not satisfied merely to classify mental disorders, Freud demanded to know the meaning of madness, even if that meaning was unconscious. Why does the hysteric refuse to see (hysterical blindness)? Why does the paranoid find the world so unsafe? Freud practiced outside the asylum. He found madness in new

places: on the medical wards, where he showed that hysteria was primarily a psychological and not a medical disease; and in people's everyday lives, where he uncovered the meaning of dreams, slips of the tongue, accidents, personality problems, and neuroses.

Freud was not primarily interested in applying external constraints or even in inculcating morality. He was more interested in freeing his analysands from neurotic blocks and "making conscious what was unconscious" so that they could better express personal feelings and desires. This is not to say that Freud was free of moralistic standards and biases. There is no "objective" observer and no "neutral" therapist. There was no way for Freud to avoid imposing his values on his analysands, considering their vulnerability and his influence over them, and this is true for today's therapist and client as well. Still, his stated objective was to understand human behavior and to use this understanding to free individuals from their personal constrictions. Dynamic therapists and psychoanalysts spend many long hours with each client in order to uncover successively deeper layers of defense and resistance, and ultimately aim to discover and help to emerge what is real and unique in each individual. Whatever their biases—and these must not be ignored—their stated objective is a stark contrast to efforts within the asylum to coerce or persuade inmates to comply with norms for acceptable behavior.

Consulting Room Psychiatry after Freud

Beyond the growth of psychoanalysis as a specific set of techniques, Freud's influence has reached ever larger populations through abbreviated therapeutic innovations and through the popularization of analytic ideas in psychology classes, books, films, television, and even advertising. Psychoanalysts, or at least psychoanalyzed therapists, originated most modern forms of therapy, including group therapy, crisis intervention, brief therapy, psychodrama, Gestalt therapy, sensitivity training, encounter experience, transactional analysis, family therapy, therapeutic communities, bioenergetics—and the list continues through a second generation of primal scream, Rolfing, and large group "trainings."

Since Freud there has occurred a veritable psychologization of modern life. It is not that people experience more intense personal difficulties, but that these difficulties are thought of and discussed in more psychological terms. As this psychologization invades ever more of our most private moments, the therapist assumes the role of expert on how we are to conduct our lives. There are social and historical reasons for this. Modern industry and technology provide, at least for the middle class, more free time to think about personal matters and relationships, while industry increasingly relies on psychological methods to ease tensions between management and workers in the workplace. Higher levels of education permit more people to take psychology courses and to read books and magazines on psychology. Advertising has turned to psychological campaigns to sell products and, in the process, has contributed to raising the public's level of psychological mindedness, if not sophistication. These are but a few of the many

complex factors that play into our modern psychologization. The resulting trend is clear: More people see psychotherapists today than ever before and think psychologically about more personal and social problems.

Freud's influence is strongest in the realm of fee-for-service consulting room practice. Over the years the number of private therapists and clients has grown rapidly, the kinds of issues people discuss with their therapists have expanded, and therapy has assumed a much more central place in daily life. It is not unusual to discover that a particular middle-aged, middle-class person has seen a personal therapist for individual treatment, has had an encounter-group experience, has seen a marital therapist for help with a troubled marriage, and has taken a child to still another therapist. There are sports psychologists, family therapists, pet therapists, and many other professionals available on a fee-for-service basis to help the troubled client.

Meanwhile, the limits of who a therapist can treat and what therapy can accomplish have continually expanded. For instance, Freud early declared that psychoanalysis was ineffective with narcissistic disorders, specifically schizophrenia, because the narcissist was too lost in a private world to make sufficient contact or to form a transference with the therapist. Others were to prove Freud wrong. Before Freud's death, Harry Stack Sullivan and Frieda Fromm-Reichmann began to break through the narcissistic barrier and treat schizophrenics. In more recent years, Heinz Kohut, Otto Kernberg and James

Masterson have made theoretical and technical advances that permit some successful therapy with borderline and narcissistic personalities, two types of mental disorder that were previously considered too deep-seated and irreversible to benefit much from dynamic psychotherapy.

I do not mean to imply that psychotherapy is a science with an expanding technology. On the contrary, therapy is more like an art with an accumulation of techniques that help different artists in different ways. Most therapists admit that their successes with borderline and narcissistic personalities are rare, but at least there are theories available to help therapists strategize their attempts at therapy.

There are also sex therapies for impotence, therapies for those in "midlife crisis" and for the terminally ill, assertiveness training, bioenergetics and even Tao for insufficiencies of the soul. It seems that whatever one's ailment or perceived lack, there is a therapy to suit it. The effect has been mixed. Some people are helped greatly with their personal difficulties. Others are hooked into a subculture of psychology and therapy with little or no improvement in their real condition or relationships. Still others are harmed by questionable, unethical, or incompetent practices.

Freud's legacy has not been limited to the private therapy industry. Many institutions of public welfare have turned to Freud's ideas at one time or another, hoping to find in psychoanalysis solutions for the very difficult problems they face.

And psychoanalysts have attempted to provide solutions. For instance, Franz Alexander and Hugo Staub attempted, in the late 1920s, to provide judges with an understanding of criminals:

> The majority of criminals are not different physically and grossly psychologically from the normal individual; the deviation from the normal is a matter of development, which depends more on the life history of the person than upon heredity. . . .
>
> The *neurotic criminal* we could designate as a neurotic without symptoms, who acts out his illness in real life. . . . We recommend *the abolition of all forms of punishment* and suggest that he be turned over to a special agency for psychoanalytically minded reeducation, or to a psychoanalyst for *treatment*.[14]

Similarly, August Aichorn applied psychoanalysis to the problem of juvenile delinquency in 1925:

> In remedial training we cannot be content with transient results which arise from the emotional tie of the dissocial boy or girl to the worker. We must succeed, as in psychoanalysis, in bringing the wayward youth under the influence of the transference to a definite achievement. This achievement consists in a real character change, in the setting up of a socially directed ego-ideal, that is, in the retrieving of that part of his development which is necessary for a proper adjustment to society.[15]

The impact of psychoanalysis on public institutions has been felt far beyond the criminal justice system. Christopher Lasch and Jacques Donzelot both chronicle the state's progressive intervention into ever larger aspects of family life in this century and its reliance on psychoanalytic counsel in doing so.[16] For

instance, child welfare agencies have evolved to handle children who are abandoned or abused, who run away from home, or who turn to delinquency. The courts decide on divorce settlements and child custody and even mediate disputes between children and parents. The schools take over many of the responsibilities that families once had for socialization, from the inculcation of morality to the teaching of sewing, cooking, and driving. And in each instance the public institutions have turned to psychoanalysts for professional advice.

Asylum Psychiatry after the Asylum

At the turn of the century, private therapy, or psychoanalysis, was practiced in the consulting room among the affluent, and services for the poor consisted only of asylum practice. The dichotomy was near absolute and clearly based on class. Since that time, there have been great changes within the asylum, and the public sector of psychiatry has expanded to encompass much more than asylum practice.

The asylums became state mental hospitals and veterans' hospitals. More rigorous systems of diagnosis and disease-type classification evolved. Psychological tests, brain wave studies, and biochemical measurements have enhanced the psychiatrist's ability to diagnose precisely. Straitjackets replaced chains. Ice baths remained. Insulin coma, electroconvulsive (shock) treatments and lobotomies replaced the nineteenth century's whirling chairs and blood-

letting. The dual goals of external constraint and inculcation of morality remained. And the mental hospitals generally continued to be snake pits.

Public outpatient mental health clinics and psychotropic medications have arrived on the scene relatively recently. In the late 1940s much medical research was aimed at discovering a pharmacologic cure for schizophrenia. That condition accounted for half the total number of hospital beds utilized in the United States, and the public was becoming increasingly alarmed about conditions in the state mental hospitals. A group of drugs, the phenothiazines, then used to control nausea and hypertension, was discovered, by trial and error, to decrease the severity of anxiety, hallucinations, and bizarre behaviors displayed by schizophrenics. In the early 1950s one of that group, Thorazine, was marketed widely as a miracle cure for madness. There were good effects. Many inmates who might otherwise have remained in mental institutions for the rest of their lives were discharged to return home and take pills, their psychotic symptoms having been suppressed.

A few years after the widespread introduction of Thorazine, a prominent psychiatrist recommended in the professional literature that if a little of the drug did not work, a lot might.[17] Whereas previous dosages had ranged from 25 to 100 milligrams of Thorazine several times a day, he suggested 2,400 to 3,200 milligrams per day for more difficult cases. Megadosage was invented. The first sweep of mental hospitals had turned up significant numbers of inmates who

responded to ordinary dosages. Another sweep with the more massive dosages prepared others for possible discharge. The side effects of the massive doses—sluggishness, obesity, impotence, lack of affect, mental dullness, and lack of spontaneity, for example— and the residual symptoms not touched by the medications combined to create a picture of former hospital inmates who were no longer mad but not quite normal either.

Nevertheless, this development gave hope to psychiatrists who stressed the prevention of mental illness. They believed that the potential for cure, or at least for decreasing the severity and duration of mental illness, depended on the return of the mental patient to the community, where family and friends would help provide an opportunity to work and live a quasi-normal life. Through the 1950s there had existed very few public outpatient mental health clinics. Most hospitals and psychiatry departments provided emergency, short-term, and screening services. Anyone who required longer or more intensive care was referred to state or local hospital wards. The exception was a certain number of clients who were seen in clinics for longer-term psychotherapy by trainees who needed the experience.

The public mood was right. As the political climate shifted and the time for a war on poverty approached, President Kennedy made community mental health a pet project. In 1963 the federal Community Mental Health Centers Act was passed. Mental health centers were established in communities across the country. The

goal was eventually to close down archaic state hospitals and to provide low-income clients with quality mental health services that would prevent relapses and permit them to live more full and productive lives.

For ten years community mental health was the fashion. The number of outpatient mental health facilities in urban centers mushroomed. Many of the most forward-looking and socially conscious mental health professionals poured their creative energies into the establishment of programs like day treatment, therapeutic communities, preventive consultations to institutions, self-help groups, client-run small businesses, multicultural programs, group therapies, paraprofessional training, crisis outreach teams, etc.

By the early 1970s the war on poverty had ended; the federal support that had been meant only as seed money began to dwindle; funding for community mental health centers became progressively less available in the context of budget cuts and fiscal crises; and the attention of psychiatrists and funding sources shifted from community and prevention to sex, violence, and brain chemistry. The plight of the mental patient, like that of the poor and minorities, was quickly forgotten—a disheartening indication of the 1970s social priorities.

In California, a barometer of trends in other states, the focus on community mental health always contained some built-in hazards. Less socially conscious and more “fiscally accountable” politicians and administrators formed a tenuous

alliance with progressives in mental health, because they saw in the model of community psychiatry a chance to reduce the state budget. They used the rhetoric of community mental health to diminish the budget for state hospitals, and then failed to follow through so energetically on funding the local programs. The process was gradual. Over the years, each time there was a budget cut funds were taken away from the state hospitals and no equivalent budget increases occurred in the community clinics. The exception was when scandals erupted at state hospitals and emergency funds were allocated. Funding and quality of services in the public sector were never adequate even at the height of the war on poverty, but when the federal funds were phased out, public mental health clinics were left even more underbudgeted, understaffed, and overcrowded with former mental hospital patients.

While the trend today is to close the asylums and return the inmates to the community, the life of former mental patients there is often not positively affected by the shift. The treatment they receive at public clinics rarely includes much in-depth psychotherapy, and usually involves the administration of large doses of psychotropic medications plus training in skills of daily living and appropriate behavior. In other words, the goals of treatment are more like that of the old asylum psychiatry, with its stress on external constraint and moral training, than they are like the self-discovery and selfexpansion of consulting room psychiatry. The locked doors and straitjackets of the asylum have merely been replaced by the medications prescribed in public clinics. Thus the mental patients have been

ghettoized in the community, and many people are wondering whether their plight there is any better than it was in the asylums.[18]

Meanwhile, the client population in the public clinic has expanded far beyond the group of former mental hospital patients. I mentioned psychoanalysts' presence in the courts, the schools for delinquents, the welfare agencies, and other public institutions. While psychoanalysts offered much advice about how such institutions might best proceed—for instance, offering criminals and prisoners psychoanalytic psychotherapy—carrying out their advice would have required much greater resources than those institutions were ever allotted.

Budgets of public institutions simply do not provide for the time and individual attention dynamic therapy requires. Therefore the psychoanalysts gave their advice and returned to their consulting rooms. Other less dynamically oriented psychiatrists and mental health professionals were employed to enter the courts, the schools, the prisons, and the factories to seek out the individuals presumed to be malfunctioning in each of these institutions. They discovered offenders with "antisocial personalities"; school children suffering from "minimal brain damage" or "hyperkinesis"; prisoners suffering from "impulsive dyscontrol syndrome"; and workers who were chronically absent, organized unions, or sabotaged the machinery because they were malingerers or paranoid personalities. Since mental health professionals who are asked to examine the problems of groups and institutions rarely report that they can discover no

individuals requiring their services, as more institutions seek their advice and help, more cases and conditions are discovered where treatment is indicated. The official list of known diagnostic categories expands to meet the need.

With the large number of cases thus discovered and requiring treatment, the mental health professionals tend to perform mainly diagnostic evaluation, and the individuals diagnosed—the child having difficulty in school, the troubled offender, the unproductive worker—are treated in those institutions with medications alone or join the former mental hospital patients and the smaller number of low-income people who voluntarily seek psychotherapy to form the client population of public mental health clinics.

Thus, the psychologization of modern life occurs in the public sector, too. But in contrast to the private sector, where clients voluntarily seek out therapists' help for their creative blocks and their troubled intimacies, the public client's psychologization involves more subtle or gross coercion.

The Two Psychiatries Today

Modern psychiatry ideally draws upon the lessons of both asylum psychiatry and consulting room psychiatry. As an illustration, consider a twenty-three-year-old man suffering from an acute psychotic decompensation. He is white, unemployed, a high school dropout, and just returned from two years in the army to live in his parents' home. His father reports that for four days he has been

boasting unceasingly about his ability to perform as an electrician, a doctor, a prizefighter, and a college professor; and then staying up all night pacing in the living room. Twice he left the family home at 3:00 or 4:00 A.M., wandered onto a nearby boulevard, and was nearly hit by a car. Each time a motorist stopped, found him to be dazed and incoherent, and returned him to his sleeping parents. In an interview he is guarded, withdrawn, very anxious, and irritable. He refuses to speak with the psychiatrist, laughs occasionally, and seems to grimace or mumble some words in response to hallucinatory voices. His parents are afraid he will wander off and be hit by an automobile, and they are exhausted from staying up nights watching him and worrying.

Probably this man is having difficulty readjusting to civilian life. His boasting and exaggeration of his career possibilities suggest that he is troubled about employment possibilities. But before any attempt can be made to do dynamic therapy with him, two very pressing problems must be attended to. First is to determine if his confusion is due to some physical or organic condition. Purely functional or psychological disturbances should not cause such severe disorientation. Perhaps he has suffered a head injury, has an undiagnosed case of diabetes, or has ingested a hallucinogen. In other words, a precise diagnosis must be made before psychotherapy can be initiated. Too often mental health professionals treat someone with psychotherapy only to discover too late that a brain tumor or other physical condition caused the mental turmoil.

Second, the very real risk of his self-destruction must be examined. It is useless to attempt psychotherapy if his living situation is not stable and secure. Limits must be set for his behavior. He might need to be watched by his family twenty-four hours a day until he is better able to take care of himself; he might be given medications to help him control himself and rest; or he might be hospitalized for examination and control until he can manage to survive better in the community.

Thus, two of the practices that evolved from asylum psychiatry—diagnosis by disease category and the establishment of external or medication control—must be applied before dynamic psychotherapy can even be attempted with this young man. Of course, I have drawn the line extra sharply between asylum and consulting room psychiatries for the purpose of exposition. These two practices were always known to the consulting room psychiatrist. The point is that the psychotherapist must know how to diagnose accurately and when to apply external controls if a situation is to be established wherein psychotherapy might prove useful.

I do not agree with those who wish to discard totally all lessons learned from asylum psychiatry. Technical training in precise diagnosis, proper use of psychotropic medications, and well-timed and managed hospitalization can be crucial components in the effective treatment of severely disturbed individuals. But I do believe that abuses of these components are extremely widespread and

repressive; for example, a snobbish professionalism that implies only psychiatrists know about mental life; an excessive reliance on medications that makes clients numb and dependent; and involuntary hospitalizations that serve only as incarceration.

The problem is not that the legacy of asylum psychiatry remains today. The problem is that mental health treatment for some is limited to the external constraints and moral training that derive from asylum psychiatry, while the treatment for others more resembles the self-exploration and growth that derive from consulting room psychiatry—and that the difference depends entirely on the client's socioeconomic class.

The Double Standard of Mental Health Care

Clients in the private sector are able to talk with therapists for as long as they can afford to do so, while low-income clients who must seek help in the public sector are confronted with relatively inadequate resources, less-well-trained therapists, and overcrowded facilities. The private therapist has time to listen carefully and try to understand deeper meanings. The public therapist is forced to make more rapid diagnoses and rely disproportionately on medications and involuntary hospitalization. This is the double standard of mental health care.

The dichotomy is not absolute. Many practitioners work part-time in public clinics and private practices. But even they are likely to find that they spend more

time with each client in the latter setting than in the former. And medications are certainly utilized in the private sector, but again there is a difference in the relative proportions of explorative talk before the prescription of pills.

For the sake of simplicity I have ignored third-party payments such as health insurance in this formulation of the double standard. But third-party payments do not alter the situation much. There are a certain number of people who seek personal therapy and pay for it through private insurance plans. Their therapy is essentially private. Many blue-collar workers have health insurance coverage that includes a limited amount of psychotherapy, but perhaps because they fear the stigma and do not believe long-term therapy is of any use, their utilization patterns are very similar to those of low-income people in the public sector, that is, they visit mental health professionals only at times of severe crisis and receive medications or brief therapies. Health plans that provide their own services, such as Kaiser Permanente or some health maintenance organizations, tend to limit those services to evaluation and crisis therapy. Even so, their resources are generally inadequate and the waiting rooms in their mental health sections are often overcrowded. Finally, some low- income people with public insurance plans, such as Medicaid or Medi-Cal, see private therapists. But their number is small and diminishing as these public insurance plans provide relatively lower fees to practitioners, eligibility requirements become more restrictive, and bureaucratic obstacles proliferate.

Most low-income clients are seen in public clinics. The double standard means that compared to clients in the private sector, they will not only receive less quality service, but the treatment they receive will be more oriented toward social control.

Social Control

The contrast between the enthusiasm for the notion of community mental health in the 1960s and the current low priority of public clinic funding is reminiscent of the swing Rothman describes between the enthusiasm and reforms of the asylums of the 1820s and the abuses and custody orientation forty years later. The 1960s movement, like the one of the 1820s, was built on hopes and not on actual empirical results. Even at the height of the 1960s movement, low-income people were not receiving adequate services except in a few model programs, and the double standard was very much in effect. And the relatively diminished budget priority for public mental health programs since, like the dwindling funding of asylums in the 1860s, has resulted in a greater emphasis on custody and control.

Piven and Cloward examine somewhat similar cyclical trends in the funding of all public relief and social service programs, including mental health. They concentrate on two "crises" in public relief, in the mid-1980s and the mid-1960s. At these times relief rolls expanded precipitously. Both "crises" occurred

immediately following periods of large-scale civil disorder, in the first case on the part of workers and the unemployed, in the second on the part of minorities. In both cases, the expansion of relief and social service programs served to calm the disorder, and both times the programs were cut back appreciably just after the disorder subsided. Piven and Cloward offer an interpretation:

> Relief arrangements are ancillary to economic arrangements. Their chief function is to regulate labor, and they do that in two general ways. First, when mass unemployment leads to outbreaks of turmoil. relief programs are ordinarly initiated or expanded to absorb and control enough of the unemployed to restore order; then, as turbulence subsides, the relief system contracts, expelling those who are needed to populate the labor market. Relief also performs a labor-regulating function in this shrunken state, however. Some of the aged, the disabled, the insane, and others who are of no use as workers are left on the relief rolls, and their treatment is so degrading and punitive as to instill in the laboring masses a fear of the fate that awaits them should they relax into beggary and pauperism. To demean and punish those who do not work is to exalt by contrast even the meanest labor at the meanest wages.[19]

I agree with Piven and Cloward, and I think the social dynamic they describe applies with painful accuracy to the clients of public mental health clinics. It is easy to recognize the social function of insane asylums. The picture is less clear when the patients are living in the community, receiving welfare, and taking large doses of psychotropic medications. But the social-control function remains. If the clients do not take their pills and otherwise "behave themselves," they will be locked in a hospital again. The client population

includes not only former hospital patients but also people referred to clinics

by the courts or the schools. The latter groups may not take as much medication as the former hospital patients, but they are just as aware of the consequences of noncooperation. All the clients at the public clinic are implicitly led to believe that their problems, be they chronic unemployment, trouble with the law, school failure, or personal unhappiness, result primarily from their own flaws or mental disorders, and not from any failure on the part of society to ensure social justice. Then, the example of the public clinic client's plight does serve to motivate others to hold onto even very low- paying and unsatisfying jobs so that they can at least avoid living the flattened-out, demeaning, and stigma-filled life of the mental patient.

Piven and Cloward provide a society-wide perspective from which to understand the relationship between diminishing resources and the relatively enlarged social-control aspect of public therapy, which I stated at the beginning of this chapter. This is not to say that social control is absent from the private-sector practice of therapy, or that clients who pay private fees necessarily receive competent therapy. But the problem achieves a whole different order of magnitude in the public sector.

Social control is not an abstract issue for the public therapist. Unlike the asylum psychiatrist, who was never trained to do anything but confine lunatics and classify their disease types, the public therapist is trained to practice some variety of dynamic psychotherapy. In Chapter 12, I will discuss the relationship

between the therapist's connection with social control and therapist burnout. Clients are also aware of the social-control function of public clinics. "No-shows" are frequent among clients who object, and chronicity occurs among clients who do not object enough. For many clients, concerns about social control are expressed as fear of the stigma attached to visiting a psychiatrist.

Therapists often feel that they must avoid discussing with clients the social and historical factors that make social control such a major concern. They consider such discussions to be outside the proper realm of psychotherapy. Yet these same therapists have great difficulty practicing psychotherapy in the public clinic. In the following chapters I will discuss some connections between the social and historical context of public therapy and the concrete issues involved in daily clinical practice. I will begin in the next chapter with a discussion of what I believe psychotherapy to be.

CHAPTER 2
Psychotherapy

There are books about the theory of psychotherapy and other books intended as guides to the practitioner. But practitioners in public mental health clinics often have great difficulty applying the lessons in such books to their daily work. For instance, it seems that the books on technique, particularly those on the technique of psychoanalytic psychotherapy and its briefer variations, often take it for granted that the client will actively seek the therapist's wisdom, willingly participate in verbal exchange, and appreciate the personal growth thus facilitated. The therapist's experience in the community clinic is quite different: A large percentage of clients fail to keep appointments or drop out of therapy without warning; those who appear for their sessions are often guarded or hesitant to talk about personal matters; and they much less readily express appreciation for help rendered. The therapist who reads the books on technique and then finds that his or her clients do not respond as well or improve as fast as the ones described there is likely to attribute the discrepancy to his or her own inadequacies as a therapist.

Therapists and trainees in the public clinic often bring up such feelings of inadequacy in staff sessions. When asked what criteria they use to select candidates for their therapy, inevitably there is a moment of uncertainty, even embarrassment. "You know we don't turn away anyone who seeks our services;

the clients have nowhere else to go." Of course, this is the case, and that is one big reason why outcomes in community clinics are not as impressive as those reported in the books on technique.

One way to make sure therapy will be effective is to carefully select clients who are likely to make use of the therapy and grow from it. Books on technique usually include a section on selection criteria. It is not always a simple matter of choosing the most articulate, most insightful, and most motivated—though this is the caricature of the successful private therapy client. Some discussions of selection are more sophisticated. For instance, it is recommended that the clients who are most likely to succeed are those whose problems are acute or short-lived; or those whose real-life situations, such as family and other networks, seem conducive to personal growth; or those who respond well to an interpretation during the initial interview, and thus seem willing and able to change. Those seeking therapy who do not fit this picture are often turned away in private settings. Of course, there are many therapists whose only criterion is whether or not the applicant can afford the fee. But even this criterion selects out relatively motivated candidates—that is, people who are willing to spend hard-earned money.

In this chapter, I will begin a discussion on how one might adapt what is learned from the books on psychotherapy for use in the public clinic, where many clients have nowhere else to go. First, I will discuss four elements that I feel

characterize all psychotherapies; then I will describe four principles that are more specific to psychoanalytically informed psychotherapies; and I will consider some issues that arise immediately when we talk of applying such principles in the public clinic setting. I will close with a description of a course of therapy that illustrates some of the idiosyncrasies of public therapy.

Four Elements of Therapy

There are four elements that seem to me to characterize psychotherapy as a practice: (1) therapist and client make contact; (2) they establish an overlapping language, belief system, set of rituals, or way of being together; (3) changes occur in the client and in the client's ways of relating to others; and (4) when therapist and client agree that sufficient change has occurred in the client, the therapy process is terminated. I will briefly comment on each of these four elements of psychotherapy and mention in regard to each an example of problems that arise when psychotherapy is practiced in a public clinic.

1. *Therapist and client make contact.* As a trainee, I was told by many supervisors that the task for the therapist is, in effect, to put one foot into the client's mad world in order to make contact, while keeping one foot in the world of sanity so as to be able to help the client cross back over. I use the phrase *making contact* here in the same sense as did those supervisors. In the extreme instance, the client in catatonic withdrawal is not very approachable. The therapist's every

talent and skill are taxed in the effort to enter the client's private world just enough to form a tentative relationship or, better, to begin a discussion about the value of relationships and of shared realities. In less extreme instances, the first phase of any therapy is the getting-to-know, getting-to-trust period that must precede meaningful exchange. The therapist spends a large part of the initial interview with a client trying to figure out how best to make contact. If adequate contact is not made early, the client generally will not return or not wish to continue in therapy.

Problem. The therapist and client are often at cross-purposes. For instance, the therapist wants to help but the client wants no help and is visiting the therapist only because of orders from parents or a probation officer. In the public clinic, especially when the therapist and client are of different classes and races, such cross-purposes abound and account for many "no shows," or unannounced failed appointments, as I will discuss in Chapter 3.

2. *Therapist and client establish* a *common language*, *overlapping beliefs, and a set of rituals or wag of being together.* At first, it is the therapist who dictates the rules: "You will come to my office at this particular time each week, we will meet for fifty minutes, you will share with me what goes on in your life, what you are feeling, and what is on your mind, and we will talk about all this, or do body work or psychodrama or something else." The therapist proceeds to teach the client how to fulfill these requirements, how to talk about feelings, how to talk about

inner or psychological life, how to breathe or move parts of the body, how to act, etc. But at another level, it is the client who leads and the therapist who follows. The client expresses her or his train of thoughts, life events, patterned movements, or spontaneous dramatic scripts, and the therapist takes the client's direction. The lead shifts back and forth, between therapist who dictates the format, client whose personal issues set the course within that format, therapist who interprets or directs, client who reacts compliantly or rebelliously, etc. The process is rough at the beginning, as therapist and client learn how to use words they will both understand; for example, the therapist teaches the client about identity and acting out while the client teaches the therapist about street talk. They focus on issues both agree have relevance or do things they both agree are safe. But the rough spots smooth out to a certain extent. The issues of who leads, who follows, and how trustworthy is the leader are temporarily suspended; and both therapist and client concentrate most of their energies on the task of the therapy.

Problem. If talking about oneself, self-exposure, getting in touch with feelings, or even psychological talk itself are unfamiliar to the client—and these things are less familiar to low-income and minority clients than they are to middle-class clients—then the therapy is rocky. The client might come to appointments late, refuse to discuss what the therapist wants to talk about, or fail to see the relevance of some of the therapist's rules and rituals.

3. In the process of therapy, changes occur in the client and in the client's ways of relating to others. We can speak here of structural change: alterations in attitudes, personality, thought processes, mood, psychological makeup, or styles of relating that survive the termination of the therapy. This is in contrast to changes in the client's life that depend on the therapist's actual presence on a week-to-week basis—for example, the confidence the client gets from knowing the therapist is there to support him or her—and evaporate as soon as the therapy ends. Therapy is aimed at structural change. The task is for the therapist to enter the client's life, make some interventions, and leave, fully expecting that the client will have changed or grown from the therapy and will then lead a life somehow less constricted or more full. If the client returns to earlier maladaptive ways after the therapist is gone, the therapy has failed in some important respects.

Problem. The therapist and client may not share a common perspective or set of values from which to measure and evaluate change. For instance, the therapist who believes the capacity to work is a central criterion of mental health encounters difficulties treating the low-income man who says, "Why work at a menial task beneath my dignity? No one is going to send me to college. So why shouldn't I collect disability and do what I want with my time?" The therapist who sticks to the work ethic of society at large often fails in attempts to change those members of a subpopulation who, as the last to be hired and first to be fired, may have worked out a different ethic and a different direction for change. See Chapter 9 for further discussion of this point.

4. When therapist and client agree sufficient change has occurred in the client, the therapy process is terminated. The ideal case is full agreement. The therapist is convinced that sufficient structural change has occurred for the client to continue in life without him or her, and without the excess baggage of earlier patterned distortions and maladaptations. The client is satisfied that his or her life is improved, and the improvement seems relatively permanent. Together the two experience a process of termination designed to insure that the loss of the therapist will not have the intense negative repercussions in the client's life as did earlier separations and losses. And the termination occurs on good terms—that is, the client's negative feelings toward a therapist now gone do not overwhelm the positive feelings that persist and do not cause a regression or a spiteful undoing of the gains of the therapy as if the client says, "I'll show you, evil therapist who deserted me; I'll forget all the positive things we did together and I'll go back to being as messed up and unhappy as I was before we met." Usually, spending some time discussing feelings about termination decreases the potential for such destructiveness and improves the chances of a successful therapeutic outcome.

Problem. Very often in the public clinic therapy does not end with such a termination phase. It ends earlier, cut off by a client who says, "I'm feeling better now, why should I go on with therapy?" Often nothing at all is said, and just when the therapist feels the therapy is proceeding well, the client quits. This may be because he or she feels better, the immediate stress that led him or her to seek therapy has lessened, and he or she does not share the therapist's belief that the

process should continue to deepen until a natural termination point is reached. The therapist's expectations are not met, and the therapist has no way of actually knowing if or how the therapy actually helped the client. I will discuss this problem in Chapter 11.

Though I have described these four elements largely in terms of individual insight-oriented psychotherapy, I believe they are present in all forms of psychotherapy. There are many varieties of psychotherapy, and each therapist puts her or his individual stamp on the work being done. One therapist relates entirely verbally while another advocates body work; one works with individuals, another with groups; one has clients share dreams, another does not; one looks exclusively at clients' past history, another virtually ignores it; one does long-term work, another brief; one looks at families as cybernetic systems, another looks entirely within the individual's dynamics for understanding; one therapist believes in the unconscious, another only in observable behaviors; one looks at the transference, another chooses to ignore it. Many therapists do not conceptualize these four elements precisely the way I do. For instance, some do not discuss termination with clients at all. But I believe the issues about termination are present between therapist and client, whether or not they are discussed as such.

Four Principles of Analytic Therapy

My own training as a psychotherapist has been psychoanalytic. I am not a psychoanalyst, and the reader will soon discover how far my practice diverges from the daily fifty-minute hour with the client on the couch. But many of my teachers have been psychoanalysts, and I have found that the psychoanalytic literature provides the best theoretical and technical underpinning for my work. In fact, I believe that the theory and technique gained from psychoanalysts' many years of research and treatment are a treasure chest of accumulated clinical experience and a valuable gift for the therapist in the public clinic, if that theory and technique can be adapted to meet the exigencies of clinic practice. In any case, all modern therapies owe much to psychoanalysis, if only because of the place Freud won for therapy in our culture and daily lives.

I do not mean to imply that psychoanalytic principles are better than any others, but they are the principles that largely guide my work, and thus the ones I will introduce briefly for use in this discussion about psychotherapy. I hope that practitioners with other theoretical orientations can translate the concepts I use into their own frameworks in adapting psychotherapy for the public clinic.

There is a set of principles that apply to classical psychoanalysis as well as to briefer, face-to-face, and even more supportive or directive therapeutic modalities. Of this set, I have chosen four principles to introduce here: psychic determinism, the unconscious, transference, and working through.

Freud used the phrase *psychic determinism* specifically to describe the connectedness he assumed between any two successive ideas or thought contents in his analysand's free associations.[20] In other words, it is not accidental that the analysand's thought of his father spanking him is followed by thoughts of a movie in which the hero shoots and kills the villain. The two mental contents are connected by the rage the man feels in the first and the revenge he gets through identification with the hero in the second. More broadly, psychic determinism means that no mental event is accidental. The content of dreams, accidents, slips of the tongue, jokes, and neurotic symptoms all have meaning, and are all interconnected or "psychically determined" in any particular person's mental life. It is only by assuming this psychic determinism that the therapist can hope to help the client discover this meaning.

The assumption of an *unconscious* in mental life is so familiar as to require no definition here. Freud argued that it is "necessary and legitimate" to assume the existence of the unconscious. According to him:

> It is necessary because the data of consciousness are exceedingly defective; both in healthy and in sick persons mental acts (including slips of the tongue, mislaying of objects, dreams, and everything designated a mental symptom or an obsession in the sick) are often in process which can be explained only by presupposing other acts, of which consciousness yields no evidence.. . . When, after this, it appears that the assumption of the unconscious helps us to construct a highly successful practical method, by which we are enabled to exert a useful influence upon the course of conscious processes, this success will have won us an incontrovertible proof of the existence of that which we assumed. We become obliged then

> to take up the position that it is both untenable and presumptuous to claim that whatever goes on in the mind must be known to consciousness.[21]

This assumption helped Freud read between the lines of what his analysands told him, find the deeper dynamics that underlay their experiences, and develop a strategy for their therapy.

Armed with the theoretical assumptions of psychic determinism and the unconscious Freud was ready to probe the life histories of his analysands and try to discover the roots of their neuroses. In his early cases (see *Studies on Hysteria),* Freud seemed very much the detective, hypnotizing (and even massaging) his analysands, encouraging them to tell him the stories of their lives, listening closely for clues to what they were leaving out, and then announcing his findings of "repressed memories" that he claimed explained their symptoms. This was the cathartic method of therapy. Freud explained, "Hysterical symptoms originate through the energy of a mental process being withheld from conscious influence and being diverted into bodily innervation. . . . Recovery would be the result of the liberation of the affect that had gone astray and of its discharge along a normal path (abreaction)."[22]

One common theme Freud discovered in the memories "withheld from conscious influence" in hysterical women was the "seduction scene." Freud uncovered childhood memories of seduction attempts by father or by an uncle so often that in 1896 he declared such seduction attempts to be the cause of hysteria

in 80 to 100 percent of cases.[23] He soon reversed himself on this claim,[24] because in his own self-analysis he discovered incestuous wishes toward his daughters and yet he did not act on them. He therefore began to doubt the possibility that the fathers of all his analysands, many of whom he knew personally, could be so morally corrupt as to have seduced their daughters. Perhaps in some cases these women were only fantasizing their seduction by their fathers and remembering this fantasy, and perhaps this was derived from some childhood wish of theirs and not from actual historical events. But how was Freud to know when the memory was imaginary and when it was real, and how was he to establish the validity or truth- value of any memory he uncovered in his analysands' reminiscences? Here is where the concept of transference became so important.

In those early case studies on hysteria, *transference,* or the feelings the analysand displaced from earlier relationships (for example, with father) onto the analyst, was treated as a distraction from the work of uncovering hidden memories. Or the transference was seen as merely another symptom of the neurosis, a resistance to the progress of the therapy. The sooner the transference could be circumvented, the sooner the real work of analyzing historical facts could proceed. Or, if the transference could not be circumvented— for instance, if the analysand fell madly in love with the analyst, as Fraulein Anna 0. did with Freud's colleague Dr. Josef Breuer—the analysis had to be terminated.

When Freud discovered his inability to tell fact from fancy in hearing stories of childhood seductions, he was forced to turn his scientific gaze away from the analysand's reported history and to focus it more on the here-and-now process of the therapeutic relationship. While he could not judge whether reported memories were of actual events or of imaginary wishes, he often could tell if what his analysand said about him was accurate or distorted. If an analysand talked as if Freud were interested only in romancing her, and he knew this not to be the case (he soon discovered he required a personal analysis in order to be certain about such things), then he was able to recognize his analysand's distortions and base his interpretations on that. Transference was no longer viewed as an unfortunate distraction from the therapeutic process. It became the central focus of the therapy. Freud developed a newer theory: that the analysand in relating to the analyst reproduced all the interpersonal difficulties that characterized the neurosis, and this reproduction he termed the "transference neurosis." By analyzing and altering the transference neurosis, the analyst would be able to effect structural changes in the analysand's mental life. James Strachey summarized this development:

> The original conflicts, which had led to the onset of neurosis, began to be reenacted in the relation to the analyst. Now this unexpected event is far from being the misfortune that at first sight it might seem to be. In fact, it gives us our great opportunity. Instead of having to deal as best we may with conflicts of the remote past, which are concerned with dead circumstances and mummified personalities and whose outcome is already determined, we find ourselves involved in an actual and immediate situation in which we and the patient are the principal

> characters and the development of which is to some extent at least under our control. But if we bring it about that in this revivified *transference* conflict the patient chooses a new solution instead of the old one, a solution in which the primitive and unadaptable method of repression is replaced by behavior more in contact with reality, then, even after his detachment from the analysis, he will never be able to fall back into his former neurosis.[25]

Like Freud, more contemporary psychoanalysts have turned their attention increasingly to the here-and-now process of the therapeutic relationship, particularly to the transference neurosis and the related resistances the analysand throws up to the progress of the therapy. Resistances are the elements and forces within the client that obstruct the process of therapy. Psychoanalysts have not forgotten about the history, for instance, of childhood events. But they have found that to actually be in touch with past memories, to connect the "affect" with the "idea," the analysand must experience something in the present—and that something is the transference. Thus, an interpretation should not aim merely to give insight into past events—such insight is often only intellectual and not useful—but must somehow connect current conflicts and distortions to that past. An effective way to do this is to interpret an aspect of the relationship between the analysand and analyst here and now, to relate this to other events and relationships in the analysand's daily life, and to demonstrate how this reproduces patterns of past relationships.

An illustration of this point may prove useful. A young woman was seeing a woman therapist because she feared she was incapable of deep and lasting

intimacy. As she described a series of friendships with other women that had ended abruptly, the therapist detected a pattern: Each time the client became close to another woman, she began to fear that her new friend was mocking her behind her back, and she cut off the relationship without even checking whether her fear had any basis in reality. The therapist also knew that this woman's mother had a habit of shaming her in front of relatives and friends. For instance, the client remembered from the age of seven or eight her mother pulling up her dress, roughly grabbing hold of the fat that insulated her abdomen, and saying to a friend, “See how fat my daughter is.” The therapist tried on several occasions to point out to this woman that her seemingly exaggerated fear of betrayal by friends might be related to the way her envious mother had humiliated her as a child. The client each time said, “Maybe so,” but seemed untouched by the insight.

In one session, the woman seemed very upset and could not quite say why. The therapist suggested that she might be angry. The woman denied this, but then later blurted out, “I am angry at you—you listen to all my troubles and seem sympathetic, but then I know you go have drinks with other therapists and you laugh about how miserable all your clients are.” The therapist knew this was not true—she was very careful to protect her clients’ confidentiality—so she was able to explore this distortion. It emerged that the woman had overheard a group of therapists at a restaurant talking about clients and laughing, and assumed that her therapist did the same. When the therapist confronted her on this and demanded to know if she believed that this therapist would ever do such a thing, the client

broke into tears and talked of her problem trusting another woman. It was at this point, after the therapist had established enough trust for the client to correct her distorted assumption, and in the midst of tears and confusion, that the interpretation could be effective. In fact, the therapist did not even need to make the full interpretation. She merely pointed out how easily the client could be led to lose faith in her therapist, and the client connected this to the way her mother was untrustworthy, and to the possibility that she had been unfair to women friends and prematurely jumped to the conclusion that they were untrustworthy. This was the point at which she first noticed the therapy becoming effective and began to change her pattern with women friends.

Change in therapy does not occur all at once. Freud wrote:

> I have often been asked to advise upon cases in which the physician complained that he had pointed out his resistance to the patient and that all the same no change had set in; in fact, the resistance had only then become really pronounced and the whole situation had become more obscure than ever. . .. The analyst had forgotten that naming the resistance could not result in its immediate suspension. One must allow the patient time to get to know this resistance of which he is ignorant, to "work through" it, to overcome it. . . . This *working through* of the resistances may in practice amount to an arduous task for the patient and a trial of patience for the analyst. Nevertheless, it is the part of the work that effects the greatest changes in the patient and that distinguishes analytic treatment from every kind of suggestive treatment.[26]

As the client is working through the particular material the therapist interprets, the therapy process itself becomes what one analyst has described as a

"corrective emotional experience."[27] A relationship has been formed within which the client relives some of the issues and conflicts of growing up, but this time with an adult's skills and ability to separate fantasy from reality, and in the presence of a therapist who holds a steadier course than parents did earlier and helps the client straighten out some of the distortions of previously lived experiences.

I can think of an incident that might help illustrate all four of these principles. A young, unemployed black man came to see me and said, "Doc, you gotta help me control my temper. My wife's pregnant and I've got to provide for her and the baby. I've been out of the Joint (state prison) for two years and no one will give me a job. Every time I get turned down after a job interview, I go out and drink, get nasty, and get into a fight. If I get caught, or go off on [hit] a cop, they'll violate my parole and send me up for a good long time. I can't go back there. I'd kill someone first—or do myself in."

I felt there was a serious depression and feeling of low self-esteem underlying this man's anger, and I began to talk with him about it: "Why do you assume it is something wrong with you that prevents your finding a job? Do you know that the actual unemployment rate in the black community (including people who give up and do not even apply for unemployment benefits and are thus not included in government statistics) is 25 to 30 percent?[28] That means 30 percent of young black men are unable to find work, and I'll bet many of them are

blaming themselves for their failure, just like you are." As we talked about this in our first three weekly individual sessions, he seemed to respond, seemed less critical of himself and more confident he would be able to control his rage.

In our fourth session, just after telling me how frightened he was that he would do something wrong and end up back in prison, he told me about a run-in he had had with a police officer three days prior. "This cop pulled me over and hassled me about dope. I told him I knew my rights, and he couldn't search my car without a good reason. He pulled out his gun, pointed it right at my face, and said, 'Buddy, you know I could blow your head off and no one would ask any questions.' Then I figured I'd better keep quiet, play along, and let him do anything he wanted to me. I just shined him on, thinking to myself he was only a punk needing a gun to be tough. He seemed satisfied he'd put me in my place, he didn't even search my car, and he let me go." (laugh)

Why did this man tell me this particular story at this particular moment in a therapy session? The incident with the police officer had occurred three days earlier. There were plenty of other incidents intervening in his life. Why did he choose to tell about that one? The principle of psychic determinism holds that such things are not accidental, that there was some psychological or symbolic meaning in his selecting that incident just then, and that it was well worth the therapist's effort to uncover that reason.

My immediate hypothesis was that for this man, a relationship between men always involves domination—one man is dominant, the other dominated. Whether it is between father and son, employer and job applicant, or police officer and driver, domination and cruelty characterize the interaction. Though this man would readily admit that this was his belief, he was not consciously aware of why he mentioned the incident at that moment. His reason was *unconscious.* I hypothesized his unconscious concern to be that in his trusting me and entering a therapist/client relationship in which I was in a powerful position, he might be setting himself up for further domination and cruelty. I might be like that police officer, nicer perhaps, but just as likely to turn against him, and he might be making a mistake by trusting me. His unconscious thought was that he would be better off "shining me on" in order to survive our encounter with the least pain.

If my hypothesis were to prove correct, then this particular unconscious concern on the part of this man would be part of his *transference* toward me. In other words, he would be transferring onto me suspicions and feelings he had experienced toward a father who beat him (1 later learned this had been the case), teachers who constantly derided him, police, judges, and prison guards who treated him harshly, and employers who refused him jobs. Up until this point in his therapy, I was not aware of how I had consciously dominated or been cruel to him—though I do not mean to disallow the reality factor that I represented a county institution that included courts, jails, and so forth.

This man's working through of his unconscious concern began with my sharing my hypothesis: "I wonder if there are ways you think of me as similar to that policeman. I, too, am in a position of power." His immediate response was adamant: "Oh no, you're very different, you wouldn't do anything like that." But then he thought about it, and thought about his conflict in being straight with me: "If I tell you some mean things I've done, will you tell my parole officer?" There began a working through of his distrust of all men. We discussed confidentiality, and what I would or would not write in the clinic chart. I write very little precisely to protect confidentiality—but this creates problems when charts are audited for clinic accreditation. He did not immediately open up his private thoughts to me, but very gradually over the ensuing weeks and months he began to trust me more and tell me ever deeper secrets. He was discovering that all men are not the same, and that there are ways to discover whom to trust and whom not.

Therapy and Play

No amount of theory and technique can help a therapist who is unable to make contact with a client, understand his experience, and develop a common language to talk about that experience. At its core, therapy is a shared experience of two or more people who relate to each other in a particular way. When the therapist uses theory and technique in the service of this human encounter—that is, when the therapist's self is as present and important in the therapy as are the theories and techniques, and that self is very real—then the theory and technique

enlarge the therapist's capacities to help the client. But when theory and technique become the therapist's entire mode of relating to the client, something more mechanical and less human occurs.

Therapy is not designed for one person to tell another how to live his or her life. That can be done rapidly. Rather, it is an attempt on the part of one person, the therapist, to help the other, the client, to find his or her own path. This takes more time, especially if the client and therapist differ in racial, class, and cultural backgrounds. The client comes in broken down, stalled, or in pieces. The therapist cannot function like an auto mechanic, simply identifying the pieces, whether they be pistons and valves or egos and split-off parts, and knowing how they fit together. People are more complicated, more changing, that is, they are alive. The pieces do not fit together in any predesigned plan. The therapist must be content to see in the client the potential for wholeness and growth, and to foster this potential. The client might then come together and grow in a particular direction the therapist had never actually envisioned. The therapist must be continually open to such possibility. Whenever the therapist loses this openness and starts to prescribe what the direction will be, what is occurring is not therapy.

I think psychoanalyst D. W. Winnicott is discussing this distinction when he writes:

> It is not the moment of my clever interpretation that is significant. Interpretation outside the ripeness of the material is indoctrination and produces compliance. A corollary is that resistance arises out of

> interpretation given outside the area of the overlap of the patient's and the analyst's playing together. Interpretation when the patient has no capacity to play is simply not useful, or causes confusion. When there is mutual playing, then interpretation according to accepted psychoanalytic principles can carry the therapeutic work forward. *This playing has to be spontaneous, and not compliant or acquiescent*, if psychotherapy is to be done.[29]

Winnicott is making a technical point about interpretation. No matter how correct or meaningful the therapist's interpretation, it is wasted if the client is not fully ready to hear it. The art of psychotherapy includes a developed sense of timing, dosage, and tact in the dispensing of interpretations.

But Winnicott's point goes far beyond technical considerations. His distinction between indoctrination and compliance, on the one hand, and playing and psychotherapy, on the other, touches on what I believe to be the central conflict for the therapist in the public clinic. It is difficult enough in private practice to stay on the therapy side of the line and avoid indoctrination. The task is made all the more difficult in the public clinic setting. There the clients are low-income or unemployed and have problems with their very survival—food, shelter, etc.—so that the pursuit of therapy in itself is lower on their priority list. Also, the class and racial backgrounds of the therapist and client can differ to such an extent that communication problems, insufficient empathy, and even value clashes arise. In addition, when public agencies suffer budget and staff cuts, each staff therapist's caseload swells, and the time, space, and energy are not as available for quality therapy. As public agencies increasingly rely on less playful modalities to

handle the overload—for example, employing large doses of psychotropic medication or involuntary hospitalization—the staff therapist's complicity compromises his or her credibility as a noncoercive therapist. Finally, the agency within which the therapist works—county mental health, for example—is actually part of the system that the client population views as repressive. All of these factors must be considered by anyone who wishes to do therapy in such a setting.

MY THERAPY WITH EMMA

Though the principles learned from psychoanalytic psychotherapies are applicable once adapted, the format of the therapy is quite varied, and the therapist must be prepared for the variations. In order to illustrate some of the variations, I will close this chapter with a brief synopsis of my therapy with Emma. I saw her sixteen times over a span of one year. Three sessions lasted fifteen minutes each and were designed primarily for medication review. Ten sessions were in group therapy. Three sessions were in family therapy. Interspersed were twenty occasions when Emma failed appointments, and of the group meetings she attended she appeared significantly late for half. Hers is not the ideal motivation for psychotherapy, nor are these the ideal conditions. But this is the public clinic.

Emma lived half of her sixty-two years believing she was totally crazy. Her husband convinced her of that. He was a career soldier, hated his work, drank every night, ignored their four children, and beat her severely once or twice a

week. “You bitch! If it weren’t for you and these kids I’d leave the army, go out and have a good time.” Then when she began to cry and become overwhelmed by her pain and sadness, he would say, “You cry too much. You must be out of your mind.” He took her to see a psychiatrist. This was thirty years ago, when her children were very young. The psychiatrist offered a diagnosis: depression. He administered ECT— electroconvulsive therapy, or shock treatments. He gave her three courses, or about thirty shocks, over the next three years. Her depression continued. She developed gaps in her memory. Her husband continued to drink, beat her, force her to have intercourse when he wanted, and yell at her when she complained: “You’re crazy!” Her depression worsened. When her husband was about to leave for a tour of duty in Panama, her psychiatrist decided she was too sick to go with him and admitted her to a state mental hospital, where she remained for a year. Meanwhile, her husband took the children to the Canal Zone. Emma had no friends or relatives visit her in the hospital. She assumed her treatment was due to her madness. She withdrew, became immobile, her face frozen in a frown. Her doctors were not certain about her diagnosis: retarded depression versus schizophrenia, schizo-affective type. More shock therapy.

Then her family returned home. She was discharged, went home, and tried to be a good wife and mother. Her three boys were teenagers and beginning to have problems. One began to fail at school, get sent home by the principal, drink alcohol, and get into trouble with the law. Another was married, but began to drink and beat his wife. The third son was very shy, expressed little feeling, and

developed severe diarrhea, which turned out to be ulcerative colitis. Emma blamed herself for each boy's problems. And she never was able to really talk to her daughter, now sixteen and uninterested in being home with the family. Emma went in and out of deep depressions, and was usually treated with progressively higher doses of tranquilizers and antidepressant medications.

It was years later that I saw Emma. When I began to work in a community mental health center, I took over the treatment of a large number of people from the psychiatrist who was leaving. He had been prescribing large doses of medication for Emma—Triavil 4-25, half Thorazine-type tranquilizer and half antidepressant—two of which she was to take four times a day. She appeared withdrawn and sluggish. But she was working in a factory, as she had done for the past ten years, whenever she was not in a psychiatric hospital. I began to lower Emma's drug dosages. She became more disturbed. She believed she talked in her sleep, the neighbors overheard her, told others where she worked, and then everyone at work talked behind her back about her. She stopped going to work. She was by this time in group therapy with me, where these issues were discussed. She insisted she could not work because other workers would talk about her behind her back. She wanted me to increase her medication dosages. I refused. Instead, we agreed she would go on disability for a few months and continue to attend the group. This she did sporadically, missing two sessions out of three, and appearing late to the others.

She did seem to relax—perhaps she felt safer not working. In the group she was silent, obviously depressed, almost immobile, and frowning most of the time. When the group was able to encourage her to speak, she exposed her concern: "Last week when no one showed up for the group session but me and Tom, I was sure you all had stayed away because you knew I would be here." As we discussed her concern, the group members were supportive but challenging. One said, "I stayed away because I'd just received my disability check and I was drunk at group time." Another: "I stayed away because I had another doctor's appointment." And another added, "Emma, what you are saying is impossible—I didn't know you were here. I wasn't here. So how could I have known to stay away because you were here?" After some more such feedback, Emma demanded to know: "Do you all think I'm crazy?" The group immediately reassured her they did not think so. Some even chided: "How could I accuse anyone else of being crazy? Look at me!" Emma finally seemed reassured, perhaps merely by the amount of attention she was receiving.

It was several sessions later that Emma asked again, "Do you think I'm crazy?" She did not need too much feedback before she broke down and cried (I had never seen her cry until then). She sobbed: "When Fred [her husband, who died three years before I met Emma] was beating me and telling me how much he hated me and the kids... I believed him. ... I thought I was a terrible mother... I was crazy . . . how could anyone love me?" When the group responded with, "You did a great job raising your kids, considering the circumstances," and "We love you," all

Emma could do was to continue crying.

Group therapy continued. Family sessions were added, where Emma appeared with her daughter and one son, the only children still living in the area, their spouses, and a total of six lovely grandchildren. She asked questions: “Am I crazy? Was I a good mother? Am I lovable?” What emerged in the course of three family sessions spread over three months was much hatred toward a father now dead, much expression of concern about Emma, and very moving statements from both children about what she had given them, and how they had passed through teenage phases of hatred, but now were able to have relatively happy family lives, and how much they appreciated Emma’s buffering them from their father’s abuse.

The family cried together, sharing their hatred of Fred, their guilt about it, the childrens’ concern about Emma’s mental health, and all of their wishes to be a closer family now and to be more able to express their feelings. During all this time Emma took gradually lowered doses of medication. She began to talk more in group, to be more lively, to express openly how she hated her work (she received a lot of support on that), and then, after a few months, returned to work while continuing in the group.

CHAPTER 3
The No-Show

The no-show, or unannounced failed appointment, is a big problem in the public mental health clinic.[30] There, the expression is used as a verb: the client "no-shows," and the frustrated therapist who is left with an unfilled hour views the act as willfully vengeful on the client's part.

There are many ways to no-show. Sometimes the client merely fails to appear for a first, second or later appointment and does not call to cancel; when the therapist phones to inquire, the client might say, "I forgot" or "I was busy"; and then when the therapist offers another appointment, the client accepts but goes on to no-show again.[31] Alternatively, the client misses the appointment but then shows up later that day or two days later saying, "I forgot what time our appointment was"; or the client arrives forty-five minutes late knowing the therapist can then see him or her for only a few minutes; or the client comes on time, rushes in and says, "1 can only stay a few minutes, a friend gave me a lift and he's double-parked outside."

No-shows are more frequent in the public clinic than in private practice. At least the private client is generally courteous enough to call and cancel when unable to keep an appointment. (Of course, the private therapist would otherwise be likely to charge for the missed session.) There are many other contrasts in

practices between the public and private sectors that might help explain the differing no-show rates. An example is the waiting room experience.

The doors and hallways of a private therapist's consulting rooms are generally arranged so that the client leaving is not likely to meet the next client arriving. Each can sit alone while waiting. The waiting room becomes a decompression chamber, where, in those private moments before the session, among tasteful decor, sweet-smelling flowers, or evocative works of art, the client can separate from the social transactions, frantic pace, pressing concerns and commotion of everyday life. Therapy occurs in a separate space where the commotion is momentarily calmed and the private self permitted to emerge.

How different is the waiting room of the public mental health clinic. Generally located in a shabby sterile-looking building, it is a public place. First, there is the secretary who registers the client and calls the therapist. A nervous client may wonder, "What does she know about my problems or think about my coming to such a place?" Then there is the endless wait in a room full of clients of other therapists—and the wondering whenever someone walks through the waiting room to leave, "Is that my therapist's other client? Does he like her better?" Many clients tell me of their fear that, while they are waiting, some crazy person will accost them for a handout, make sexual advances, or merely be loud and abusive, ruining their chance to collect their thoughts before entering the therapy session. Others report their nervousness in being among other clients

who seem so obviously disturbed and wondering if they appear similarly disturbed to others. Always there is the fear that they will meet someone they know who will "put it out on the street" that they are crazy enough to need to seek help in such a place.

Whether it is because of their inability to pay the fees, their reluctance to submit to these waiting room experiences, or any of a large number of other possible factors, the rate of no-shows is alarmingly high in the public clinic. I will suggest here an interpretation of many no-shows and offer some thoughts about how therapists might approach the problem.

An Explanatory Hypothesis

Many no-shows are indirect expressions of clients' feelings of powerlessness and anger. A no-show is an indirect act. There are more direct ways to refuse treatment. For example, a client might refuse an appointment, or appear for an interview and state directly that he or she does not wish to share personal matters with the therapist, or call to cancel and decline further appointments.

There are many reasons for a client to feel powerless before a therapist in a public mental health clinic. The institution that runs the clinic—for instance, the county—also runs the welfare department, the sheriff's office, the courts and jails, and the probation department. The therapist might decide that the client is crazy and lock him or her up in the county psychiatric hospital, or might report

something the client says to a social worker, who can suspend welfare payments, or to a probation officer, who can revoke probation and order incarceration. Even if the therapist believes that he or she would never do such a thing, the client might not be convinced—and for good reason. The therapist's notes might be subpoenaed, and how is the client to know what is written there? Even though there are laws that protect clients' confidentiality, public clinic clients who cannot afford legal services do not always demand their rights, or do not know them. And public clinic charts are more susceptible to subpoena than are a private therapist's notes.[32]

Then, the client might also feel powerless being on the therapist's turf, where verbal and psychological expressiveness are at a premium. For instance, the client is asked to "talk about feelings," a level of abstraction with which the therapist and the private client, who has more likely attended the same colleges and read the same books as the therapist, are very comfortable, but which is further removed from the more concrete ways the public client usually expresses feelings. The client feels one down in the encounter.

When any client, public or private, shares inner secrets with a therapist and begins to trust the therapist's feedback enough to make changes in personal patterns, the therapist becomes a very powerful person in relation to that very vulnerable client. If, as is likely in the public clinic, the client's problems include a feeling of powerlessness, whether from a sense of personal inadequacy or from

being poor, and if the county institution and the therapist's turf are viewed as unfamiliar and potentially harmful, then the client has great difficulty accepting the one-down position of being the therapist's client.

Then there is the anger. The therapist symbolizes the kind of success and power in the system that are denied to the client. And the therapist represents that system, at least the public institution that runs the clinic, and thus at least potentially wields all the power of that institution. Thus the therapist *could* arrange to have welfare payments cut off or probation declared violated. Besides, because the client is less able to express anger toward welfare workers, police, and probation officers—the risk is greater with these other public agents—the therapist receives the brunt of the client's rage. Probably the indirectness of the client's act—the no-show—is due to his or her perception that the powerlessness is so complete (the therapist holds all the cards) that direct action or expression of anger would be useless and possibly dangerous.

This interpretation, of course, is a hypothesis, but one that can rarely be tested. Therapists might hypothesize that the no-show means they missed something or said the wrong thing to the client in the last session or over the phone, or they can assume the client was poorly motivated for therapy in the first place. The former hypothesis tends to make the therapist feel inadequate, the latter places the blame on the client's pathology. But the client is no longer present to react. The therapist has no feedback to help improve his or her practice.

There are those clients who do not completely no-show. They come late, leave early, or otherwise let the therapist know they can be only partially involved. We might say that a part of such a client wants to see the therapist and a part does not. A compromise is worked out by the client's controlling the time frame for the appointment and making sure it is cut short. It is possible in many such instances to discuss this dynamic with the client while it is going on, or in retrospect if the client later comes to attend therapy sessions promptly and regularly. From such discussions come tests of hypotheses about no-shows.

One young, unemployed black man came to his first appointment with me forty-five minutes late, answered my questions in monosyllables, and seemed less than spontaneous. I said, "It seems like you don't really want to be here."

"Oh no, nothing like that. I'm just rushed. I've got other things I've got to do."

"That's okay, but I could also understand your being hesitant to even come to a place like this."

"What do you mean?"

"Well, we're sort of on my turf here: a county building; you're supposed to tell me what's on your mind; and you don't even know me, or what I'm likely to do with what I learn about you."

"Yeah. I'm only here because my social worker said I had to come."

The client proceeded to ask me a series of questions—for instance, Was I going to write what he told me in his chart? What was I going to tell his social worker? There began a discussion about the issue of confidentiality. He was not likely to talk much about his personal life until the topic had been aired. By the end of that first session he let me know how angry he was that he had to come. But he returned on time for his next appointment.

A young white man attended his first two or three appointments for only a few minutes each, raised similar questions, and then abruptly left, saying that the friend who had driven him to the center was waiting for him outside. After several such abbreviated encounters in which I tried my best to insert the kind of discussion quoted above, this man too began to attend sessions regularly (many outcomes are less successful), and we talked about his behavior in the first three sessions. He explained that he was not sure he could trust me, he needed the friend outside so he could venture in to see the "shrink," and he did not want to spend too much time with me for fear that I would read his mind, think he was crazy, and lock him up. These types of revelations generally come out very gradually, over many sessions, if at all.

A black single mother of four was on probation, and her probation officer "suggested" but did not "order" her to seek therapy. She saw a woman therapist in

a clinic for about one month and seemed to be enjoying the therapy and growing from it. One day she complained to her therapist: “I thought my probation officer was my friend. I told her I snorted coke [cocainel that my old man gave me. She got angry and told me I’d have to stop living with him or she’d send me back to jail to do time. Some friend she turned out to be!”

The therapist said nothing and the client went on to ask the therapist what she wrote in the chart. The therapist made some vague response and announced their time was up, she would see her again next week. The client failed to keep the next three appointments. Since this client had never missed appointments before, the therapist phoned her and insisted she come back to the clinic at least once more. During the interview that followed, the client admitted she had failed to keep the appointments because she had felt betrayed by her therapist.

The client had actually given her therapist this message in the previous session, and perhaps because the session was coming to an end, the therapist missed it. She had discussed her resentment toward a probation officer who she thought was her friend and who then turned against her. If we assume it was no accident that this client told her therapist about such resentments at that particular moment (psychic determinism) and that her choosing to do so might have been related to the transference, then a tenable hypothesis would be that the client was feeling some equivalent resentment toward her therapist.

In fact, this turned out to be very much the case. Over the years, this woman had experienced betrayal by several women employees of the county. A social worker had discontinued her welfare benefits when she admitted living with a man. A policewoman had acted kindly toward her and seemed to offer protection against a brutal male partner—the good cop/bad cop routine—so she had confided in the policewoman some secrets that she later discovered were used in prosecuting her. Then the probation officer whom she had trusted turned against her. Why should she trust a woman therapist employed by the same county? Perhaps her therapist was acting like a friend only to uncover information that she would then turn over to the probation officer.

The working through of such distrust is not easy. Generally, the therapist must first give up her personal investment in seeing herself as a totally trustworthy friend to her clients. There is at least a kernel of truth in the client's fears that her therapist might say something to her probation officer. Certainly the therapist might tell the probation officer that the client had failed to keep several appointments—if, that is, the client had agreed in advance that the therapist should do so and had signed an informed consent—and the client's chart might be subpoenaed. Clients are legally entitled to refuse consent for probation officers to see their psychiatric record—but there is a subtle and unstated coercion involved. Will the probation officer be tougher if consent is refused? Until the therapist can recognize and even validate the reality basis of part of the client's concerns, the initial distrust cannot be worked through.[33]

In this particular case, there followed a rather frank discussion of trust and a detailed exploration of the issue of confidentiality. The therapist told the client what kinds of things she would write in the chart, explained under what circumstances the chart could be subpoenaed, discussed informed consent and what she would and would not tell the probation officer, etc. In the process, the client again began to trust the therapist, at least enough to appear regularly for ensuing appointments. Meanwhile, the therapist had demonstrated her trustworthiness by being open to the client's questions, and soon the client was able to vent a great deal of the rage she felt toward the therapist, the probation officer, and actually against all women, beginning with her mother, who had continually betrayed her. The therapist had been permitted access to these deep-seated feelings only after she proved she would honestly and dependably negotiate the more current reality-based issues.

The Therapist and the Client

The therapist's reactions to no-shows can be intense. It is as if the client were trying to give the therapist a taste of what it feels like to be so powerless and angry. The therapist feels powerless: "Why couldn't she call to cancel? Now I'm left with a free hour and I can't do anything because I don't even know if she'll appear late." The therapist becomes angry: "Damn it! Why can't she show any respect for my busy schedule, or appreciation for my efforts to help her?" When the therapist does not transcend this dynamic and remains angry, and this is all

the more likely the more no-shows any given therapist suffers, opportunities are lost to break through deadlocks. For instance, the client who no-shows for a morning appointment may appear at the clinic in the afternoon to see if the therapist "has any spare time to see me." Then the therapist's response might be indirect, too. Still upset about the wasted hour that morning, the therapist might refuse to see the client even though he or she does have free time, or he or she might see the client but be particularly unempathetic in the session. The client likely leaves the clinic, not to return.

The therapist can react by invoking selection criteria: "This client is not motivated enough to benefit from psychotherapy"; or "Psychotherapy requires a commitment to meet regularly and talk about feelings rather than acting them out; this client's no-shows express his need to act out, and thus he is not a good candidate for psychotherapy." Or, what amounts to the same thing, the therapist might make a diagnosis, of severe character disorder, for instance—borderline, antisocial, or "chronic breakdown syndrome" are likely choices in public clinics—and decide that the client's condition carries with it a poor prognosis so that therapy is not appropriate, and medication alone is indicated.

Such therapist reactions are valid to a degree. As mentioned in the last chapter, when the therapist utilizes no selection criteria at all and undertakes therapy with every client who comes in, an alarmingly high failure rate ensues, as does rapid therapist burnout. On the other hand, I believe a too-rigid and too-early

judgment about who is likely to benefit from psychotherapy in the public clinic precludes our reaching a population who might benefit greatly from therapy—that is, if therapy can be adapted to their particular needs. As a first step in this adaptation, I recommend waiving any rigorous selection criteria for at least the first several sessions and offering a trial of psychotherapy.

I have found repeatedly that during such trial periods I am able to differentiate between two levels of the client's resistance to the therapy. The first level, containing a high concentration of feelings of powerlessness and anger, seems to have very little to do with the therapist and much to do with the setting—the public institution, the whole idea of "seeing a shrink," distrust of the system, and, in the case of a black client and white therapist, fears about the racial configuration (see Chapter 8). This level of resistance is shared by a large number of clients who no-show, and the themes that characterize it—the fear of being diagnosed crazy or locked up, the concern about confidentiality, the doubts about being listened to and "given a fair shake"—are voiced by clients with wide-ranging personal histories, motivation levels, and diagnostic categories. The other level of resistance, more linked to personal issues for each unique client, usually involves more deep-seated conflicts and more tightly guarded secrets, focuses more on the therapist as a person rather than as a representative of an institution, and is more similar to the wide range of resistances any client might present in any therapy.

I thought of calling the first level the *institutional transference* and the

second level the *personal transference*, but I am not satisfied with these terms. The word *transference* refers to distortions of the current relationship that arise when the client unconsciously projects or transfers onto the therapist feelings and fantasies actually connected to people and relationships of the past. But the feelings the client has toward the therapist in the public clinic are not entirely distortions. There are very large reality factors in the client's concerns about being diagnosed, being locked up, being one down, and being betrayed. A black psychiatrist pointed out to me that the difference between "paranoia" and "protective awareness" has much to do with the color of one's skin. The fact that a white man has trouble understanding why a black man feels he is being watched has something to do with the fact that a black man is more likely to be stopped by police and frisked while walking at night than is a white man walking down the same street. The white man might assume the black man is paranoid about police harassment, whereas the black man might be adopting a protective awareness toward a reality that is unfamiliar to the white man. Likewise with that first level of resistance to therapy. The therapist should not declare wariness to be distortion until the reality basis is explored. But nothing can be explored when the client no-shows.

Whatever we call the two levels of resistance, it is clear that until the therapist and client work through the first level, little progress can be made with the second. The example mentioned involving a woman client and woman therapist is illustrative. Until they worked through the client's concerns about

confidentiality and her fear that the therapist would act like all the other county employees she had encountered, her more deep-seated conflicts about trusting women in general and her mother in particular could not surface.

It is as if the singular client and the singular therapist must first find each other in the midst of a crowd. For the client the process involves distinguishing the therapist as a unique person who may or may not be trustworthy, but whose trustworthiness is not entirely determined by his or her job in a system already known to be hostile. And for the therapist the process involves seeing the client as a unique person with certain strengths and problems, and separate from that large pool of potentially unappreciative and frustrating clients. Only after the therapist and client have recognized each other and the potential in their unique encounter can therapy proceed.

"Do You Think I'm Crazy?"

Many clients ask this question, and repeatedly, in various forms. Student and veteran therapists alike are careful about their responses. When students ask me how such questions should be answered, I first recommend caution. Not infrequently a client will ask if the therapist thinks he or she is crazy, hear the therapist's reassurance that he or she is not, and then proceed to exhibit progressively more chaotic thoughts, intense affects, and bizarre behaviors. It is almost as if the client is saying, "Oh yeah, so you don't think I'm crazy—I'll show

you how crazy I can get!" Perhaps such clients are worried that the therapist is not aware of the seriousness of their problems, or they want to test the therapist's reactions to see if he or she can control the craziness they fear within themselves, or perhaps it is just a matter of their trusting the therapist more and dropping their everyday politeness and inhibitions. Whatever the particular case, the question hardly lacks meaning.

I want to focus here on two specific meanings related to the two levels of resistance I have just described. One possible meaning has to do with the realities of the public mental health system. The client asks, "Do you think I'm crazy?" More often he or she jokes about it: "You're probably going to think I'm crazy, but I have to tell you . . . ," or "if they knew about this, the men in white coats would come and take me away." This is because the client fears that if he or she is honest about himself or herself, he or she will be diagnosed and then either locked up in a psychiatric ward or forced to take strong tranquilizers. There is good reason for this fear. It is likely that most people the client knows, being poor, do not voluntarily seek out therapists to help with everyday problems, and have contact with the mental health system only when forced to do so by extreme circumstances. A friend or relative may have been hospitalized or given Thorazine in the past, and the client is stating the very real fear that the same thing will happen to him or her. This first, reality- based level of general apprehension about seeing a therapist who is part of the mental health institution must be confronted early and very frankly. Rather than immediately saying, "Oh, no, you are not crazy,

and I would never lock you up," the therapist must search deeper into the truth, discuss the validity of the client's concerns, take responsibility for the fact that this client probably would be locked up if he or she behaved in certain ways, and that, even if the therapist personally shuns involuntary hospitalization, the clinic is part of a mental health system that does practice involuntary hospitalization and utilizes very strong tranquilizers. The truth and the therapist's honesty are the client's reassurance; superficial and false denials only heighten distrust.

There is a second level to the question "Am I crazy?" The client is in the process of baring deeper and deeper layers of secrets to the therapist as the level of trust deepens. The process involves a delicate balance. These secrets likely have not been offered to anyone before or, if they were, betrayed. When the therapist seems to betray the client's trust, perhaps by seeming to be disinterested in what the client is saying or even by laughing at the wrong time, the client closes off access to more strongly guarded secrets. In the context of this balance, the question "Am I crazy?" can really contain the client's concern that "When I tell you this about myself, you'll finally think I'm crazy." And the question is then not so much about craziness but about the client's acceptability as a person—that is, "Am I lovable?" The client is checking to see whether or not the therapist will still find the client lovable once this new level of secret is out between them, as if to say, "If you really knew what I'm like inside, you'd reject me just as all important others have in my life." Every therapy contains the potential for this kind of intimate questioning. Often no verbal exchange about it need occur, the therapist's

sensitivity being proof enough for the client that it is safe to deepen the trust and the secret-baring. But obviously no such communication occurs if the client no-shows.

Some Recommendations

Any recommendation about the therapist's handling of no-shows must relate to that first level of largely reality-based client concerns. My first recommendation has already been presented: The therapist should attempt to delay whatever diagnostic, prognostic, or selection processes are in order for several weeks or even months so that a trial therapy period can occur. During these initial sessions, the therapist can try to help the client work through some of these first-level concerns, demonstrate honesty and trustworthiness, and perhaps resolve some of the client's need to be indirect in her or his expressions of powerlessness and anger. Not all clients will respond to this approach, and some will no-show anyway. Others will continue to act out in various ways. But at least a certain number who do respond to the therapist's approach in the initial sessions will be able to make better use of therapy. The therapist will be permitted a better look at their mental life, and at least will then be able to make better formulations and prognoses.

My second recommendation has been illustrated in the clinical scenarios: The therapist should attempt to uncover the most pressing first-level realities or

resistances very quickly in the first few sessions, be they matters of confidentiality, fears about meeting a therapist on his or her own turf, or whatever other issues intensify client feelings of powerlessness and anger. Needless to say, the therapist must meanwhile permit the client to express these feelings directly. Some clients no-show after a session in which they have directly expressed anger toward the therapist—precisely because they were afraid of the anger that emerged. This eventuality needs to be discussed too.

My third recommendation is that the therapist encourage a certain *play* in the realm of power. For example, the client, a young unemployed black man, no-shows for a morning appointment. Then he appears at the clinic that afternoon asking to see the therapist. The therapist is busy. As a matter of courtesy, the therapist might take five or ten minutes, perhaps at the next break, to greet the client, find out something about how he is and why he missed the morning appointment, and set up another appointment time. Beyond courtesy, though, this brief unscheduled meeting serves another purpose. If I am correct that feelings of powerlessness play a large part in the client's no-show, then it is likely that the client is indirectly attempting to gain some power in this interaction. The therapist took control of their meeting by insisting on an appointment time in the first place. The client is unemployed. His day is not structured by the clock. He does not work from nine to five, nor does he go to bed at a set hour and awake at another. His schedule is not crowded by other appointments. When he no-shows for his appointment and then appears unexpectedly, he is taking back the control of

meeting time that he originally gave up to the therapist when they made the appointment. He insists that they meet on his time, not the therapist's. This might partly offset his fears about meeting on the therapist's turf.

The client's attempt to equalize power relations here is not very impressive. The therapist is well within his or her rights to tell the secretary that he or she cannot see the client now and to have the client phone for another appointment time. This is precisely why the therapist's willingness to greet and meet briefly with the client is so important. The therapist shows he or she is willing to engage the client around an issue, time, that seems to have some importance for the client. The therapist who is not willing to do so is effectively telling the client that the time frame of their interactions is entirely controlled by the therapist's needs. The therapist becomes another in a long list of uncaring "public servants" who make the client wait for hours in uncomfortable waiting rooms and seem unconcerned about the client's pains and needs. The therapist's minor unresponsiveness can become a major betrayal in that delicate balance between trust and the baring of secrets. The client has risked making a demand for power —"We meet on *my* time!"—and the therapist's ignoring of that demand, or dismissal by relaying a message through the secretary, can be taken by the client as a betrayal, a premature exposure of his feeling so inadequate behind that mask of bravado.

Of course, the busy therapist cannot always respond, even with a brief

meeting. And the client might easily be taking advantage—manipulating just to manipulate, not really wanting therapy. This is the gamble the therapist must take. Therapists quickly learn to spot good risks. In the cases where it pays off, a level of sensitivity can be established between client and therapist that allows therapy to proceed. The therapist momentarily bows to the client's need to take control or gain power vis-à-vis time, communication is established in the interplay, a space is created in the midst of an intimidating institution where client and therapist can meet and have a heart-to- heart talk. Then when the therapist explains he or she has a busy schedule, and in order to be fair to this client and others would like to arrange a full hour's meeting another day, the client is more likely to accept and appear on time for that appointment.

This play around power between client and therapist is not limited to the issue of time. Place is important—the therapist's willingness to make a home visit occasionally breaks through a seemingly deadlocked therapy process. Language is important too—the client often confounds the therapist with "street talk," seemingly in direct response to the therapist's insistence on using college-learned conceptual and technical language. Demands for medications (see Chapter 4) and for letters and other paperwork (see Chapter 6) can be the terrain for similar interplays. Whatever the issue or the terrain, the recommendation I am making here is that the therapist be willing at certain moments to accede to the client's demands for control and power, go one down for that moment, and thereby validate the client's need to feel powerful and establish a space in which the client

can talk about such issues. This does not mean that the therapist must allow himself or herself to be taken for granted, nor does it mean that therapy can proceed when the therapist remains one down. But the play around power provides the client an opportunity to express feelings like powerlessness, to know the therapist responds, and then eventually to permit the therapist to occupy that rather powerful position of knowing about the client's inner mental life.

It is not at all certain that my recommendations will decrease no-show rates. This is not my intent. Generally, a more efficient way to do that would be to improve the clinic's public relations in the community, provide public education about mental health, and even institute in the clinic a policy of phoning to remind every client of scheduled appointments. My recommendations are meant to help therapists look at some dynamics involved in no-shows, to cope with feelings no-shows bring out in them, and then, in a certain number of cases, to proceed with psychotherapy.

CHAPTER 4
Medications: Alternative or Adjunct to Psychotherapy?

Psychoanalyst Michael Balint has applied principles such as psychic determinism, transference, and the unconscious to the exchange between general practitioners and their patients—for instance, in examining the meaning of prescribing drugs like penicillin or codeine:

> For some years now we have organized research seminars at the Tavistock Clinic to study the psychological implications of general medical practice. In one of these seminars the first topic discussed was the drugs usually prescribed by the practitioners. In a very short time the discussion revealed—certainly not for the first time in the history of medicine—that by far the most frequently used drug in general practice was *the doctor himself.* It was not only the medicine in the bottle or the pills in the box that mattered, but the way the doctor gave them to his patient—in fact the whole atmosphere in which the drug was given and taken.[34]

General practitioners who have attended the Tavistock seminars report much improved rapport with patients and gains in their clinical efficacy. If a psychoanalyst can helpfully explore the meaning of the general practitioner's ministrations, why do psychiatrists concern themselves as little as they do about the meaning of prescribing psychotropic medications in the public clinic?

One reason is the splitting up of areas of expertise among subspecialists. Thus, those who are most interested in uncovering meanings—for example,

psychoanalysts and nonmedical therapists—utilize medications relatively little, while the psychiatrists who rely most on medications tend to focus least on uncovering psychological meanings. The more biologically or pharmacologically oriented psychiatrists are interested in biochemical pathways, genetic links, and pharmacologic cures. These are important. But too often they are examined in total isolation from psychological and social considerations. Of course, the relationships between biological, psychological, and sociological levels of explanation of human behavior are quite complex. These complexities will not be discussed here. Rather, the focus will be on understanding the act of prescribing medications in the public mental health clinic.

Another reason so little attention is paid to this issue is that public clients are divided into categories: those who undergo therapy and those who are treated primarily with psychotropic medications. Too little time is spent talking with the latter group to even begin to explore meanings. In Chapter 1 I discussed the double standard of mental health services and the evolution of a public sector in which relatively inadequate resources guarantee an imbalance: too many clients with too massive problems for too few therapists.

Typically public clinics cope with excessive client demand by assigning a select minority, those with the most acute difficulties or the best motivation for change, to therapists, and consigning the majority of clients, including the more chronic cases, to “medication clinics.” There physicians might spend a few minutes

once a month with each client assessing progress and side effects, reevaluating treatment plans, and refilling prescriptions. In this way, it becomes possible for some psychotherapy to occur—therapists spend full fifty-minute hours with the select clientele, and physicians handle the overload by prescribing medications. Then, the clients who are in therapy with nonphysician staff can also see a physician periodically and receive medications. The psychiatrist may see some clients in therapy, too. and prescribe medications during the course of therapy.

Thus, there are three groups of clients: one group is in psychotherapy; one group receives only medications; and one group is in therapy and receiving medications. The practice of psychotherapy with the first group of clients can be difficult, and some of the more common difficulties are discussed in other chapters. I will discuss here the second group, those clients who receive medications as an *alternative* to therapy, and the third group, who receive medications as an *adjunct* to psychotherapy.

Medications as an Alternative to Psychotherapy

This arrangement seems appropriate enough—certainly not all clients are good candidates for dynamic psychotherapy. But problems arise when contingencies like inadequate budgets and understaffing determine the choice of utilizing medications as adjunct or alternative; in other words, when financial considerations and not clinical judgment are the determinants. The basic message

given to the group of clients receiving medications as an alternative to psychotherapy is clear: “You are second-class clients. Because you cannot afford private therapy, or because we do not deem your case interesting enough, and because our budget does not permit us to provide therapy to all clients, you will be given medications instead of the therapy we offer to others.” Then, the social-control aspect of the treatment is magnified, and the therapeutic diminished.

Low-income clients are very attuned to such messages. When the client asks for more time with the therapist, and the therapist refuses because there are not enough hours in the day, the client knows without anything being said that a therapist would be more available to a client who could afford private fees, or who seemed a more “interesting case.” Such things are rarely discussed, however. There is no opportunity for client and doctor to really talk during their brief monthly appointments; and if the client did complain about the inequities inherent in the arrangement, there is always the chance that the doctor would react angrily and refuse to prescribe the medications. The client is left feeling very much one down.

There are other ways clients feel powerless. Therapists and clients too easily collude in the assumption that the therapist has all the answers and the client none. The client population in public clinics, particularly those clients receiving medications, tend, as a group, to feel powerless, to feel they have failed, to give up, and then to blame themselves for their failure and powerlessness in the world.

Michael Lerner has termed this self-deprecation "surplus powerlessness." He states: "There is real powerlessness (the objective reality of poverty and inequity in society). But over and above that there is 'surplus powerlessness,' a powerlessness that is not simply a reflection of reality, but rather an internalized sense of futility and frustration that takes on a life of its own, becomes an independent reality, and becomes a causal factor in why people fail to engage in actions that are objectively in their own self-interest."[35] The young black man who totally blames himself for his inability to find work in spite of a 30 percent unemployment rate for young men in urban ghettos is suffering from this surplus powerlessness.

It is not surprising that clients who feel they have failed so totally with their lives assume that their therapists, seeming paragons of success, have all the answers. Such clients devalue their own achievements and wisdom, and assume the therapist will tell them how better to live their lives. The devaluation of self and idealization of therapist is a fruitful topic for discussion in the early phases of any psychotherapy. But when the client devalues self severely and medications are prescribed as an *alternative* to therapy, the topic is not discussed, the notion that the doctor has the powerful remedies is reinforced, and the dynamic is intensified.

There is not very much a physician can offer a person in a few minutes of contact once a month. Whether the client complains "I can't sleep," "I'm nervous,"

"I'm bored," "I'm having trouble with my wife," "I'm hearing voices," "1 can't control my temper," or "I'm thinking of suicide," all the psychiatrist can offer is a few minutes of warmth and reassurance and adjustment of the medication dosages. The adjustment is rarely downward, given the recurring troubles in clients' daily lives. So, over the years, the regular consumers of these medication clinics tend to ingest increasingly more psychotropic drugs, and tend to rely on these drugs to handle their pains and dilemmas.

To illustrate this problem, I will mention an extreme case, which, unfortunately, is not rare. A certain number of former mental hospital patients—those who cannot find family members to live with and who do not get the help and support they need to learn to live alone—end up living in Board and Care Homes. The proprietors of these homes, usually community residents with little or no professional training but with spare rooms in their homes or garages, receive state or federal funds, such as SSI or Social Security (disability) Insurance, to house and feed disabled former mental hospital patients. The funds are not very plentiful, so the proprietor does well to keep the bed linens clean and the guests fed. When funds for local service projects, activity centers, and rehabilitation programs are minimal, the Board and Care residents often occupy themselves between visits to their therapist by watching television for most of their waking hours. This keeps them out of trouble and allows their house proprietors to change the linens and prepare the meals. Of course, I am describing one kind of home to make a point—there are many other proprietors who make fairly

energetic attempts to encourage their residents to be active. But progressively higher doses of tranquilizers and antidepressants are required to maintain people in such sedentary and unproductive ways without their becoming restless or angry. More medications are required to help them sleep at the end of monotonous days. Thus evolves the caricature of the chronic mental patient, heavily medicated and vegetating, a product of the massive utilization of psychotropic medications.

As many critics of such programs have pointed out, this is no great improvement over the state mental hospitals. At least there the patients had ward community meetings plus occupational therapy or planned recreation.

In the full-blown case, it is not difficult to recognize the effect. The client is lethargic, obese, lacking any spontaneity, stiff in posture and movements, and almost devoid of any expression of affect. There are less extreme cases. Many clients watch TV only part of the day, do so in family homes, and receive somewhat smaller doses of medications. But the fact remains that a very large number of clients at public clinics are maintained on long-term psychotropic medications, often in progressively higher doses, and receive very little, if any, psychotherapy or rehabilitation. The client is given pills for sleep, more pills for depression, more for anxiety, more to help control aggression, etc., until the inner capacity to handle any stress or emotion is so diminished that he or she becomes totally reliant on doctors and medications.

One of the best ways to demonstrate this effect in practice is to describe the struggle of a client to end his reliance on pills. Jim's struggle began when he and his wife, Leslie, came to my monthly medication clinic. I noticed that they came to all appointments together, preferred to see me together rather than separately, and took large doses of the same medication: Stelazine, a phenothiazine, or major tranquilizer, similar to Thorazine. I suggested that they begin seeing me weekly so we could spend more time talking.

Jim came from a family of white sharecroppers in Arkansas. At age twenty-three he had left home to join the hippie life of 1960s San Francisco—and to partake of frequent acid (LSD) trips. Leslie grew up in a southern California ghetto family, lost in the middle of nine sisters and brothers. She was shy and felt very much unnoticed, but related easily to white youth, and eventually decided to try acid too. They met while both were tripping at a mutual friend's San Francisco apartment. They found comfort in holding on to each other through the worst moments of their trip. Each found with the other a warmth and peace not known before. Later I discovered that both had been repeatedly beaten by parents and neither recalled pleasant relationships at home.

They began to see a lot of each other. She became pregnant and they decided to have the child together. Soon after their baby was born, they began to experience hard times. Neither worked. Money was scarce. Their acid trips became more terrifying. Within the year following the child's birth, each of them

landed in mental hospitals, she massively depressed and suicidal, he hallucinating and screaming for someone to help him. Their hospitalizations convinced them to stop taking acid. Instead they took the Thorazine and Stelazine doctors prescribed at the hospital. They were able to survive on her welfare checks and his governmental disability payments, and they rented a small house where they lived with their daughter in relative seclusion.

When I first saw them, they both seemed bored—with life and each other. They were somewhat stiff and inhibited in speech, affect, and body movement. Both seemed depressed, exaggerated perhaps by drug-induced sluggishness. Jim had been impotent for some time—another common side effect of psychotropic drugs— but had not known that this was related to the medication. Physicians often fail to alert patients to this. Imagine the turmoil the sudden occurrence of impotence causes anyone who is the slightest bit paranoid. Jim thought he was a total failure, "even as a man." Leslie felt she was unattractive, and Jim's apparent lack of sexual interest confirmed this for her. Life was no fun for either of them. They experienced joy only around raising their daughter, who at ten was a lovely human being, a credit to their capacity to parent, especially considering their own childhood experiences.

Jim and Leslie were afraid to face the world outside their home. Jim had experienced only failure there, and with no skills and the unemployment rate rising, he was unlikely to find gratifying work. Leslie was trained in key punch and

could find work, which she did periodically, only to quit very soon and return home. “He gets too threatened when I’m working and he’s not. Then it’s even more depressing at home, and it’s just not worth it.” I tried very tentatively to convince them to reduce their drug doses. But each time they did so, insomnia, a frequent concomitant of reducing long-term tranquilizer doses, and new anxieties would crop up. They began to no-show often, appearing at the clinic only when their prescriptions needed refilling.

Once they found themselves in difficulty financially, having nothing in reserve to buy groceries for the last few days of the month. I loaned Jim a few dollars when he came in to have his prescription refilled. Most books on therapy technique advise against money lending, but most therapists I have talked to in public clinics admit they do lend to clients on occasion. Jim was touched. The next week he called to tell me he thought his wife was suicidal and asked if they could see me together. Meanwhile, Jim had found a part-time, 8 hours per week job. When I saw them he seemed less depressed than usual, and she more so. They reported being constantly together, she sobbing or holding back tears, he hovering over her, concerned about her mood. She was gaining weight—these medications can also cause obesity, as can depression—and he was still impotent. Her thoughts of suicide were more compelling.

Gambling that they were ready to make some changes, I advised: “Stop your pills. Take a risk and let yourselves feel! Leslie, you have things to cry about. Jim,

you take care of your daughter for a few hours and leave Leslie to herself. Leslie, you go in your room and have a good cry. As long as you keep holding back the tears, you'll go on being stuck and suicidal forever." With a bit more encouragement, they went home and followed my instructions. It began to work. They both seemed to have realized that their continued clinging could lead only to death. Jim, with a part-time job to his credit, had initiated the change. They began again to attend appointments regularly and to report proudly how they were following instructions. I made more suggestions—for instance, that they should stop attempting sexual intercourse for a while.

Soon Leslie stopped taking medicine altogether, went to work, and quit visiting the clinic. Jim came in alone, and the first issue to arise in his individual therapy was his feeling of inadequacy over Leslie's bringing home more money. He tried to stop taking the medicine but would have anxiety attacks whenever his prescription ran out. He became angry at me for pushing him to stop taking pills. Though he experienced anxiety and rage, he did not demonstrate any signs of a psychotic decompensation, and it became clear to me that whatever his mental state when he was hospitalized ten years earlier, his main problem now was an intolerance for any strong emotion.

He began to report arguments with his wife. First, it was little things, like where they would go out to eat. Then it involved philosophies of childrearing—something they had never argued about before. He began to direct his anger

toward me and then to no-show after expressing anger. I confronted him, insisted he come in to talk about it, and he discovered I could tolerate his anger, as could our relationship. Likewise, anxiety. He was learning a small step at a time that strong emotion was not the same as madness. And he had to give up the secure but depressing state of numbness his medications had induced. A legitimate mourning process occurs at such times. He told me: "It's like coming out of jail. I feel like every experience off pills is new and scary, and I keep wanting to turn around and go back to my jail cell where it's safe." He began to accept the fact that if he and Leslie were to be two autonomous people, they would periodically argue, and this would not necessarily lead to the kind of brutalities he had experienced as a child.

When he started thinking about going to college he became anxious. He had been coping with his failure by giving up. That is, as long as he considered himself a total failure, a chronic mental case, he did not have to look at the envy and rivalry he felt with his wife or with others more successful than he. As soon as he started thinking about college and career, competitive feelings overwhelmed him. "I'm thirty-five. Everyone else who's going to has finished school already and is halfway up their career ladder. I'll always be behind." As I started to show him this was not necessarily true, he turned on me: "How do you know? You're a success. I'm just your charity case!" He had begun to value his own potential enough to feel competitive with me. Our therapy sessions became charged. He slowly began to risk more. He stopped taking medications. His sexual performance gradually

improved. He and Leslie tolerated progressively more separation from each other as he filled his life with other activities, including classes at the local junior college. He began considering a professional career. Their daughter seemed to like the changes, achieving grade-level in school for the first time. Jim's therapy continued but medications were no longer an important issue. Eleven months had elapsed from the time I first suggested weekly sessions.

I do not know how severe were Jim and Leslie's original acute decompensations. This is difficult to reconstruct from memories and hospital records ten years past, especially when LSD is involved. But certainly when I first saw them they had not worked through important issues of individuation, identity formation, and autonomy. They were merged, nearly symbiotic, both being immature and directionless. Their reliance on medications had prevented them from looking at these issues for ten years, and mental health clinics had provided the medication for all those years as an alternative to psychotherapy. The list of feelings and conflicts that emerged as Jim quit taking pills—anxiety, rage, marital disputes, insomnia, fear of breakdown, sexual performance anxiety, envy and insecurity—are precisely the complaints for which many clients are given medications in the first place.

Problems and Side Effects

Few therapists in public clinics are proud of the fact that clients' lives are

constricted by the medications prescribed. Why is so little done to remedy the situation? In the first place, there are not enough hours in therapists' days to offer to all clients the services Jim and Leslie received—an hour a week for a year or more. Yet this is considered relatively little time to do therapy by many private practitioners.

Secondly, there are resistances built into the whole public mental health system that make change difficult. For instance, I attempt systematically to reduce medication dosages, advising many long-term users to take drug-free "holidays." Since the staff who do therapy at the clinic where I work are already overbooked with appointments, the day-treatment program in the county has a long waiting list, and the vocational rehabilitation counselors are backlogged six months; this means that a certain number of my clients will be taking less medication and receiving no more therapy. Of course, given that arrangement, a certain number of them will suffer relapses and will have to be readmitted to the already overcrowded county or state hospital. The staff there will become annoyed with me for reducing medication dosages—readmissions reflect negatively on my competence as a psychiatrist. And the client will probably be discharged from the hospital with another supply of high-dosage medications. Meanwhile, I will spend sleepless nights worrying that one client or another, whom I barely know from fifteen-minute visits once a month, will commit suicide or go out of control and harm someone else. At times like these, I begin to understand why psychiatrists keep raising those dosages, numbing themselves to the plight of clients, or leaving

the public sector altogether.

A third reason why it is so hard to end the practice of prescribing high doses of medications as an alternative to psychotherapy is that clients themselves often strongly resist the change. Anna did.

Anna was forty-two when she came to the public mental health clinic where I worked. The mother of a thirteen-year-old boy and a three-year-old girl, she received some welfare assistance during the frequent periods when her husband, an unskilled construction worker, was laid off. She was somewhat overweight, dressed in shapeless homemade clothes, and seemed quiet, withdrawn, even timid. But a good look into her eyes gave one the hint of strong feelings she was keeping carefully locked up inside.

In very matter-of-fact terms she told the story of being committed to a state hospital fifteen years earlier because of a "mental breakdown." She told of having "lost her mind" and "acting crazy," but she could not be more specific about the experience. She was discharged from that hospital after several months, and told she would have to take Thorazine pills for the rest of her life to avoid another breakdown. She had done so religiously, in fact increasing the dosage on several occasions and asking doctors over the intervening years to add other strong tranquilizers when she was feeling "out of control."

She told me how she had for fifteen years visited mental health clinics every

month or two, sat an hour or more in the waiting room, and then saw the psychiatrist for five or ten minutes. Each time she would complain, “Doctor, I’m so nervous I can’t sleep,” or “I’m snapping at my husband,” or “I don’t have enough energy to get out of bed and get the house clean”; the busy psychiatrist, who might be seeing twenty patients with similar complaints in a morning medication clinic, would have little recourse but to increase her medication dosage. Thus Anna was taking massive doses of Thorazine (400 milligrams per day) and Stelazine (60 milligrams per day).

I was convinced that her rigid posture, lack of facial expressiveness, and general lack of spontaneity were side effects of these medications and were not due to any psychopathology. So I decided it would be better for her to take less medication and to talk more about what was troubling her. I asked her to join in group psychotherapy.

She was generally very silent in the group but attended regularly. She mentioned a few times her fear of her own rage, and over several months I began to piece together a picture of that “breakdown” fifteen years earlier. It seemed to me that she never really had experienced delusions, hallucinations, or other symptoms characteristic of a psychotic break. Rather, she had been a little drunk and had demonstrated an explosive rage that frightened her husband so much that he carted her off to the hospital, where the psychiatrist explained her rage as “madness” and began the Thorazine treatment.

When I explained to Anna that I felt her rage might not be madness and suggested we lower her medication dosages, she balked. I began to recognize significant anxiety, even terror, in her previously expressionless face. Then I met her husband, who had come to the clinic to pick up Anna after group. He was a muscular man who held himself stiffly and glared intensely. I noticed that the clinic secretary was unusually stiff and polite with him. Something about him caused people to stand back and restrain their exuberance in his presence. When I briefly chatted with him, I sensed a short fuse to his tenuously controlled explosive rage.

I asked Anna the next week about his behavior when he was unemployed, and she described how he would drink, get angry, and beat her at the slightest provocation. That was why she insisted on taking so many tranquilizers—she was terrified that she might otherwise express her dissatisfaction and anger and thus provoke his rage and further beatings. This woman lived in constant terror and numbed her pain only at the expense of any spontaneity and strong feeling.

My immediate response was to tell her, “get in touch with your feelings, stop being so numb. If he can’t handle your appropriate resistance to his tyranny, you’d be better off without him.” And here is where Anna stood up to me: “That’s fine for you to say. You don’t know what it’s like to be poor and alone raising two kids. Who will teach my son to be a man? I’d rather take the pills, swallow my resentment, and keep my family together than suffer what other women do to

raise their kids alone."

I had never heard Anna be so articulate. I was prepared to give her other suggestions: "You could develop a support network with other single mothers; you would feel so much more energy without the pills that you could raise your kids and still be able to do things for yourself." But Anna's statement cut me off. I realized I was trying to indoctrinate her, albeit an indoctrination with the best ideas of equality between the sexes and freedom for self-expression. It was unlikely that Anna would join a women's group at that time or even see the value in doing so. She had to cut off her ties with other women precisely because she feared their challenging the course she had chosen in life. Anna soon thereafter quit attending group and had her prescriptions renewed elsewhere.

Therapists write too little about their failures. Mine with Anna taught me about the depth of the medication problem, about the stark reality of social inequity that is expressed in the lack of alternative paths to follow.

I have not yet mentioned the side effects of psychotropic medications. All pills have side effects, many that we do not yet recognize. I will not attempt a comprehensive listing but will mention as examples two very dangerous and not-too-rare side effects of currently popular psychotropic drugs: tardive dyskinesia with Thorazine-type drugs, and renal (kidney) failure with Lithium.

Tardive dyskinesia, the result of medication-induced permanent brain

damage, has been reported to occur in many mental patients. Tardive (mouth) dyskinesia (involuntary movements) is a syndrome that begins with incessant movements of the mouth (lip smacking, tongue tapping, or cheek puffing) and then progresses to involuntary rhythmic (chorea or dancelike) movements of the head, neck, arms, hands, feet, and eventually the whole body. It is a side effect of long-term use of Thorazine or other major tranquilizers. But unlike other side effects, this one does not diminish when the drug is withdrawn—it becomes worse! And the drugs usually given along with the major tranquilizers to diminish some other side effects—Artane or Cogentin, for example—are ineffective in halting the progression of this effect. The tranquilizers that cause this progressive brain damage also mask the symptoms, such as the mouth movements, so it is only after the drug is discontinued that the symptoms appear. If the client then takes more of the drug, the symptoms will likely be masked again, but the brain damage effect will continue until the symptoms become severe enough to break through the masking, or until the drug is eventually discontinued and the more severe symptoms become apparent. No effective treatment is available once actual brain damage has occurred. Here is another medical horror story in the tradition of Thalidomide—another torture for the forgotten chronic mental patient to bear in the closeted isolation of the Board and Care Home.[36]

The story of Lithium, widely prescribed for manic-depressive disorders since the early 1970s, and renal damage is similar. Heart disease and heart failure also occur. Once the drug was found to be effective in some cases to dampen the

wide mood swings that characterize this condition, its use rapidly spread, and many clients were told: “You will have to take this medicine for the rest of your life.” There began to appear reports of severe and irreversible kidney damage from long-term use of Lithium.[37] Currently there is much debate about the incidence and severity of the damage. But once again, the side effects were not discovered until years after the widespread prescription of the drug, and once again the low-income client who was prescribed medications as an alternative to psychotherapy tended to be more subject to the damage. In addition, clients at public clinics tend to be given less frequent physical examinations and fewer screening blood tests than clients on comparable medication regimens in private practice or at university clinics, so that side effects are detected later, only after more obvious damage has occurred.

How are we to obtain truly informed consent from clients who might benefit from such potentially dangerous drugs? How do we weigh the risks of further mental decompensation against the risk of permanent brain or kidney damage? How do we effectively educate the client to make choices between such risks? I do not know the answers. Nothing in my medical or psychiatric education prepared me to face such issues, while advances in technology continually confront clients and therapists alike with more challenging dilemmas. But I can say with certainty that the double standard of mental health services guarantees that low-income people will suffer most from the eventual damages. They are more likely to be treated with medications as an alternative to psychotherapy, they are less likely to

be educated about the risk of side effects, and they are monitored less closely to detect the early signs of eventually serious damages.

In summary, when medications are used as an alternative to psychotherapy, the clients are not receiving the best care available; they are taught to constrict their experience in order to remain in control; their feelings of powerlessness are intensified as they become dependent on doctors and pills; they are at risk of serious side effects; and they have little opportunity to discuss all this or to reverse the whole process.

Medications as an Adjunct to Psychotherapy

Medications can more positively serve as an *adjunct* to psychotherapy. For instance, there is an optimal range of affect, chaos, and distress within which a client can be expected to work on improving his or her situation. If a client is not sufficiently anxious about his or her present condition, the client will not be motivated to change. If he or she is too anxious or too chaotic, the client will not be able to focus on the task of therapy. And if the client is too distressed, he or she will lack the optimism and hope the therapeutic venture requires. Medications can usefully be employed to maintain the client within such an optimal range. For many clients, no medication will be necessary. Others will suffer acute severe emotional crises—psychotic, depressive, etc.—and require medications to calm down and face the task of understanding and healing the wounds that resulted in

their crisis. Still others will become too anxious or too depressed during the course of therapy to continue. Tranqulilizers or antidepressants may then be indicated, as a time-limited *adjunct*, to be discontinued when the client can go on in therapy without them.

Whenever possible, the client may profitably monitor and control the use of these medications. Thus, instead of the physician prescribing a set daily dose schedule, the dosages might vary with the client's immediate needs. For instance, tranquilizers can be prescribed "as needed," up to a set maximum. The client decides to take several during a stressful day and none on a better day. Particularly with psychotic clients concerned about control by external forces, putting the client in charge of dose schedules can encourage trust and self-reliance and tends to diminish the risk of long-term dependency. Of course there are exceptions: Some clients need the therapist to impose the structure; some medications such as (tricyclic) antidepressants are effective only when administered in a consistent dosage over several weeks; and others, such as Lithium, require close monitoring of blood levels or side effects and thus require strict control by the physician. But generally, the more education the client is given about effects and side effects, the more time-limited is medication use, and the more the client fits the use of pills to specific daily needs, the less likelihood that abuse will occur.

As part of the accompanying psychotherapy, the issue of medications must

be continually open to discussion in psychodynamic terms. For instance, the client might feel that the therapist has magic answers or that pills are a substitute for therapy; or the client might feel that the therapist is lowering dosages to punish, or prescribing higher doses to control. Whatever the client's fantasy, the meaning of the particular prescribing practice must be uncovered in the therapy.

The search for such meaning is easiest when the same practitioner does therapy and prescribes. Only psychiatrists can do this. If a therapist of another discipline refers a client to an M.D. for medication, close collaboration is necessary. For instance, it is not uncommon to find that a client who attends sessions with a nonmedical therapist, seems resistant to therapy, and periodically sees a physician for medication refills, is actually thinking: "I don't know why they want me to see the therapist. It's really the doctor who understands my condition —and the pills that help me. I'll keep playing their game and sitting through those therapy sessions. That way I can keep getting the pills." Unless the therapist and prescribing physician collaborate closely, such assumptions cannot be uncovered and the resistance is never worked through. Where close collaboration occurs and the meaning of prescribing medications is constantly open to discussion, medications can be very useful.

Valium and a Difficult Psychotherapy

There are three main categories of psychotropic medications. In one

category are the major tranquilizers: Thorazine, Stelazine, Mellaril, Haldol, Prolixin, etc. Jim and Leslie are representative of clients taking these drugs for many years. Antidepressants are another category—for example, Elavil, Tofranil, Sinequan. Emma (Chapter 2) used these medications. The minor tranquilizers are another category frequently prescribed in public clinics and private practice. They include Valium, Librium, and Miltown, among others. The terms *major* and *minor tranquilizers* are actually deceptive. Thorazine and Valium are not simply stronger and weaker agents of the same effect. If we call the Thorazine effect (including awkwardness, sluggishness, constraint, and numbness) tranquilization, then we cannot call the Valium effect (including relaxation and a pleasant mellowness) a minor version of the same thing.[38] The two categories are comparable in one respect, however. When the private physician (general practitioner or psychiatrist) is too busy to play the good listener and wise adviser and relies heavily on Valium to fill the gap, the prescribing of Valium begins to serve the same purpose in private practice that prescribing Thorazine does in public clinics. In fact, Valium is among the fastest selling drugs in the United States.

In the public clinic it is possible to generalize about at least two levels of meaning in the long-term prescription of Valium. On one level Valium is prescribed to help people dampen feelings when they seem on the verge of losing control. On another level, the pleasant effects of Valium seem to satisfy certain needs, for example, the need to feel content, that the client's current life and relationships fail to provide. Every case is different, but these two levels of

meaning are apparent in Tim's use of Valium. As is often the case, addiction was an issue, too.

For years Tim, a twenty-six-year-old black man, had kept control of his temper only by taking large doses of Valium (10 milligrams) four to six times a day. He had dozens of scars from knife fights, which he readily displayed by lifting his shirt or pant leg. And he had a long jail record from the times he had done some damage in such fights. He lived with his wife and child, received general relief (welfare), and spent his days in a drowsy state listening to music or watching TV. When he did not take Valium, he tended to drink and beat his wife. This because he could not beat his father, who continually harassed him. His father, a minister, had beaten him all his life on the slightest provocation. His mother never protested or stood up for him. Tim was married and had a family of his own, yet he still lived in a garage apartment behind his parents' house, for which he paid his father exorbitant rent. Tim knew he could easily have found an apartment with more rooms for less money. His father showed no mercy. Even if it meant that Tim's whole family had to go without food or warm clothing during difficult times, Tim's father demanded the full rent on the first day of the month. In addition, his father demanded that he do chores such as mowing the law. Tim went along with his father's demands, meanwhile consuming large amounts of Valium, remaining paralyzed in terms of career or personal growth, and periodically beating his wife or getting into a street fight.

Tim was not motivated for psychotherapy. He had been going to various public clinics for several years, demanding high doses of Valium, and intimidating one psychiatrist after another with his explosive rage. Each psychiatrist he saw would give in to his demands for a while and then refuse to see him anymore. At my clinic we adopted an alternative stance: He was to be seen regularly by one psychiatrist, and any time he appeared to see anyone else, he was to be referred back to the psychiatrist assigned. I was selected.

At first I saw Tim once a month, prescribing slightly less Valium each time, and telling him he needed psychotherapy to help him work through his troubled relationships with his father and other authority figures. Several times he tried dropping in at the clinic before his appointment date, saying he had lost his pills and requesting more. I refused to give him any more, made it clear that he would receive only the amount I prescribed, and told him he must keep his appointments. His rage reaction showed in his eyes and in a momentary tensing of his body. But he controlled himself. He could have left the clinic and gone elsewhere, but he kept returning. I knew from his wife that he did not seek pills elsewhere. He seemed to value continuing his relationship with me and began to tell me more about his life each time he came in to have his prescription refilled.

Tim, small physically, seemed to have to restrain himself whenever I refused his requests for more medication. But he would end up telling me a story; for instance, “Some dude hassled me and I pulled out my knife and held it to his

throat, just to let him know he couldn't mess with me." Then he would matter-of-factly pull out a four-inch switchblade, making it clear he was just showing it to me and would never use it unless attacked. The transference was very clear. But how was I to get the meaning across to him? I have found that confrontation or even verbal interpretation at a time like this often results in the client no-showing or unilaterally ending the therapy. This may be because the client is expressing a sense of inadequacy by pulling out the knife, and the therapist's interpretation only makes him feel more inadequate.

I believed Tim would not harm me—he never raised a hand against his father—and he let me know in nonverbal ways he appreciated my patience with him and my concern. In spite of his talk of violence, he seemed starved for real caring, and very responsive to any warmth or reassurance, like a little boy having a tantrum and wishing someone would come and take away the hurt. But I always worried that Tim would pull his knife out at the wrong time, get himself killed, or harm someone and go to prison. I began to question the wisdom of his remaining in his father's place. This turned out to be the right foothold. He returned a few times to ask me what I meant. I explained that I was perplexed about his hating his father so, feeling so abused by him, and still tolerating the situation. A month later he returned and reported that he and his family had moved—to a larger apartment. He was very proud of himself and did not even argue about the dosage of Valium I was prescribing— by now down to 5 milligrams three times a day. He wanted to see me more often, and very soon he started asking about regular

psychotherapy.

In Chapter 3 I mentioned that medications, like appointment times and requests for letters, can be used to negotiate the delicate balance between trust and self-exposure in psychotherapy. Tim has not yet agreed to engage in dynamic therapy and has seen me only to have his Valium prescriptions refilled. Yet he has stopped beating his wife, moved away from his father, stopped carrying the knife, and cut down his consumption of Valium and alcohol. Now he is ready to talk about ongoing psychotherapy. I believe a symbolic exchange of knives and pills has occurred, with very little actually verbalized. He talked of knives to express his rage and powerlessness. I offered pills to help him contain his rage, meanwhile showing my concern and my confidence that he would eventually be able to control himself without pills. When he was certain enough of my concern—that is, when he began to trust me enough to tell me more about his life (after about six months)—I was able to decrease the medication dosage significantly. He found in his talk of knives a way to tell me he was upset. Unlike his father, I was willing to talk about it—and we bargained. I gently but firmly withdrew the Valium; and he told me more directly about his rage. He began to tolerate more talk of rage (his own and his father's), and thus became capable of moving away from his father (after twelve months). The pills and knives gradually became less important, and the exchange began to take the form of words.

Tim did not stay in therapy long. He attended group therapy sporadically for

a few months, no-showed often, and then dropped out. Who knows what kind of progress he might have made had I been in a position to see him two or three times a week in individual therapy? But he continued to take the lowered doses of Valium, and continued (followup only one year) to refrain from violence. I have to admit that I was more successful with Tim than I have been with some other young unemployed men who control the rage they feel about their lack of education and employment by consuming large amounts of Valium. I must assume that he was ready to change, and this is why his growth became possible.

Whether the medication is a major tranquilizer or a minor one, Lithium or another antidepressant, questions arise regarding prescription practices. Is this medication being prescribed as an adjunct or alternative to psychotherapy? If as an alternative, is it because the client cannot afford private fees, and does its prescription effect therapeutic goals or merely social control? Of course, it can be very irresponsible to withhold medications when other therapeutic modalities are not available to help clients through troubled times. But unless these questions are approached seriously, as resources for mental health services are further diminished, current abuses of medications will intensify.

CHAPTER 5
Dependency and Group Psychotherapy

If, instead of offering therapy to a minority of clients and medications to the majority, a public clinic staff were to decide to offer psychotherapy to everyone who might benefit, there would be two options available to serve the excessive client demand. Either the clients could be seen individually in brief therapy, or they could be offered longer-term group therapy. Brief therapy is appropriate in some cases—for instance, when there is an identifiable dynamic focus or time-limited crisis, or when a small number of family sessions might accomplish more than lengthy individual therapy. But, in general, I prefer to see clients for a longer time, and this is possible only if I see them in groups.

This is not to say that groups are an inferior or second-rate form of therapy. But I would like to be able to offer all clients the option of individual or group therapy and to be able to extend the therapy or offer more sessions each week if the client's condition calls for it. Given the resources in the public clinic, this is not possible. If more than a handful of clients are to be offered psychotherapy, group psychotherapy must be the main modality. For this reason, I have for some time concentrated significant energy on encouraging, training, and supervising public therapists in the practice of group psychotherapy.

In this chapter I will present one dynamic that commonly occurs in group

therapy at the public clinic and will discuss the utilization of this dynamic in advancing the therapy. The dynamic involves clients who feel powerless and become dependent on the group leader. Of course, this dynamic occurs in private therapy groups as well, and the private group therapist or member will find many of the illustrations very familiar. But, as I will demonstrate, it is particularly noteworthy in the public clinic setting.

Some Theory

Just after World War II psychoanalysts in England and the United States began to experiment with group psychotherapy. They would sit with a small group, focus on each member in turn, and spend some time analyzing that individual member's symptoms, dreams, neurosis, or transference. Other members would await their turns while observing fragments of one another's analyses. Essentially, individual psychotherapy was practiced with each group member in rotation. To this day, some group therapies retain this approach; for instance, in Gestalt therapy the therapist takes a turn with each individual member who is "ready to work."

Wilfred Bion pioneered a crucial shift in the object of the group therapist's attention. Instead of focusing in turn on the individual members and their psychodynamics, he devoted his attention to the dynamics of the group as a whole. For instance, when the therapist spoke to one woman in the group about her

personal conflicts, several other women in the group might become disruptive by beginning side conversations or moving around noisily. The therapist might then comment that his attention to one woman in the group provoked jealousy in other members, and that the disruptive behavior represented their angry attempt to interrupt his interaction with the first woman.

Once the focus was shifted from the individuals to the whole group, the interpretations of group process became more complex. Stated very simply, Bion believed that group meetings aroused strong anxieties in the members present. "What is expected of me in this group?" "Will others like me?" "Who is the most valued group member?" "Who is the leader's favorite?" Sexual feelings, competitiveness, rage, jealousy, and envy all emerge. In order to quell the strongest of these feelings—for instance, the competition for the leader's approval, the envy of the leader, various sexual rivalries and jealousies, or the rage when the leader does not provide magic cures—the group adopts a series of defensive postures.

Bion termed these defensive postures basic assumptions. In other words, the group colludes in operating as if a certain illusion were actually reality, and does this in order to avoid the most threatening aspects of the group experience. I will not review here all the various types of basic assumption groups Bion described. But I will mention one type as an illustration and as the basic assumption that seems most prevalent in groups at the public clinic. The *dependency basic*

assumption is in play when the whole group colludes in acting as if a leader is available to make everything right and assure all members security and satisfaction:

> The basic assumption in this group culture seems to be that an external object exists whose function it is to provide security for the immature organism. This means that one person is always felt to be in a position to supply the needs of the group, and the rest in a position in which their needs are supplied. . . .
>
> If the psychiatrist himself feels impelled to help restore the sophisticated structure by claiming authority as psychiatrist, it shows that it is not the patient only who feels the need of a familiar situation. . . .
>
> Benefit is felt no longer to come from the group but from the leader of the group alone, with the result that individuals feel they are being treated only when talking to the leader of the group... .
>
> There is a marked inability on the part of the individuals in the group to believe that they can possibly learn anything of value from each other.[39]

Bion reported that this dependency basic assumption occurs in all groups at certain times, and is one major mechanism groups use to avoid looking at difficult questions and feelings within their midst. Thus, the basic assumption prevents the group from doing their real work. The task of the therapist is to identify basic assumptions as they arise, to point out to the group how they interfere with the group's work, and thus to help the group face the underlying feelings against which they erect defenses in the form of basic assumptions.

In the public clinic there is a stronger tendency toward the dependency basic

assumption than is found in other settings, and this tendency seems linked to the very problems that cause the clients to seek help at the clinic.

An Illustration

For the purposes of this exposition, imagine a therapy group composed of Emma (Chapter 2); Chris and Tim (Chapter 4); Roscoe, Betty, and Sam (Chapter 6); three other clients; plus a black paraprofessional and me as cotherapists. Not all these clients were actually in the same group, and several were not in groups at all. But including these clients in a hypothetical group will give the reader some feeling for the composition of a group in a public clinic. Imagine further that in the first six sessions of the group, the following patterns are observed:

> one member looks at me whenever she talks, does not look at anyone else, and waits expectantly for my response.
>
> another member rarely talks in the group but waits until after a session ends and then approaches me to say she is very depressed, even suicidal, and asks that I prescribe some medications to help her.
>
> another member repeatedly asks technical medical questions in group, for instance, about the advisability of her seeking electroencephalogram (EEG) studies to discover the cause of her headaches, knowing that only a physician could answer such questions.
>
> all group members treat me with great deference, listening very hard

whenever I speak, and asking many questions about what I might mean.

meanwhile, the comments of the cotherapist are practically ignored and various members refer to the group as “Dr. Kupers’s group.”

In short, this group is functioning with the dependency basic assumption, as if I am the only one with anything of value to say, and members can only hope to please me and thus receive the benefits of my attention and advice. A similar illusion is maintained at certain moments in groups meeting in the most luxurious private settings, but in the public clinic the dependency assumption takes on a specific meaning and requires the therapist’s special attention.

As I discuss the distortion of group dependency, I do not want to deny the reality-based aspect of the assumption. The group leader does have more power than the members in many ways, inside the group as well as in the system, and often the leader must overrule a member who would lead the group astray. Then, too, there is an appropriate amount of dependency that is required if therapy is to proceed. And in the areas of therapeutic technique and medical science at least, the physician coleader does have more knowledge than the paraprofessional coleader. When the group leader, out of some personal need to be seen as equal with everyone in all regards, denies this reality or criticizes this appropriate dependency, and thereby “deskills” himself or herself in the group’s eyes, the group and the cotherapist might become confused, anxious or angry at the leader

who is not taking sufficient control of the group. The group therapist must confront and interpret the dependency basic assumption only if and when it becomes a distortion or an obstruction to the group's progress. That will also be the moment when it blocks the members' path toward personal autonomy.

There are clients in public clinics who are able to regulate their own self-esteem and function confidently in the world; there are others with a grandiose sense of self; and there are still others who display euphoric or manic moods. But these are not the majority. Most clients who attend public clinics in low-income communities suffer from too little self-esteem, too little confidence in their own powers, a fundamental belief that they are not lovable, too much isolation, and a feeling that they have little of value to offer others. I do not mean to imply that these are characteristics of the community at large. Rather, given the stigma attached to mental illness and the presence of a criminal justice system to siphon off the most aggressive of those who come to the attention of public institutions, it is generally the less assertive people who are forced by circumstances to seek help at mental health clinics.

The pattern of dependency in the hypothetical group I described implies a set of assumptions. The group assumes that I am the source of wisdom and power. When one group member talks, the others do not really listen, assuming that one poor client is as valueless as another, and that they have little to learn from each other. The group listens to me but not to my cotherapist. They must assume that

because I am white and professional, my words have more power, and because he is black and paraprofessional, his are less valuable. In their valuation of the white professional and their devaluation of each other and the black paraprofessional, the group members display their extreme devaluation of self. Anyone who is like them—another client, black, a poor person, someone without a degree—is useless. Anyone who has the attributes of success and power according to the societal ideal—a professional white male—is worthy of attention and capable of providing great benefits. These clients cannot adjust their self-esteem upward and function better until their extreme self-devaluation is confronted, and this group setting offers an excellent opportunity for such a confrontation.

On Technique

The point of Bion's search for the basic assumption that characterizes a group at any particular moment is that the assumption is illusory, and the group process progresses healthily only when the group discovers the illusion and evolves a more realistic perception of people and events. The illustion of the dependency basic assumption is that group members are powerless while the leader is all-powerful and all-giving, so responsibility for change rests entirely with the leader. Bion suggests various techniques for the group therapist to facilitate the group's growth beyond such an assumption:

> In the groups in which I am psychiatrist I am the most obvious person, by virtue of my position, in whom to vest a right to establish rules of

> procedure. I take advantage of this position to establish no rules of procedure and to put forward no agenda. . . .
>
> Thus a woman who starts off with a personal difficulty that she feels the psychiatrist could relieve, if he would respond by analysing her associations, finds, if the psychiatrist does not do this, that a totally unexpected situation has developed, and it will be surprising if the psychiatrist is not then able to demonstrate difficulties of the group, which will include difficulties of the patient in question, that the patient may think quite unimportant, but that turn out in the end not to be so. . . .
>
> We must recognize now that a crisis has been reached, in that members may well have discovered that membership in a group in which I am a member happens to be an experience that they do not wish to have. In that way we have to face frankly that members of our group may need to leave, in exactly the same way as a person might wish to leave a room which he had entered under a mistaken impression.[40]

Bion recommends that the therapist proceed with further interpretations of group dynamics, and thus avert a mass resignation

by group members. This approach works when the motivation for group therapy is great and tolerance for frustration and delayed gratification is assured. For instance, Bion's approach, known as the Tavistock model, is the approach used at the A. K. Rice Institute in the United States and works well as an experiential training technique for mental health professionals or for middle-level managers or business executives who want to study group dynamics. The approach has been applied with some success on inpatient psychiatric wards, where group attendance is guaranteed by the staff's encouraging each patient to attend group. But in the public clinic, the approach often fails.

Groups in public clinics are plagued by no-shows, especially during the early sessions, before real group cohesiveness has developed. Unlike the settings I have just mentioned, where high member motivation or a closed ward setting guarantees full attendance long enough for cohesiveness to evolve, in the public clinic the client is likely to be ambivalent about attending a group, anxious about meeting strangers and exposing personal secrets, and attends the first group sessions only in response to the therapist's coaxing. The therapist in the public clinic is faced with the dual task of motivating the group members to return enough times to become self-motivated—that is, to see that their attendance is rewarding— and to utilize the pattern of dependency that emerges to help the group members correct problems that arise from their lowered self-esteem.

The therapist can accomplish this dual task only by mixing support and reassurance with well-timed interpretations of the group's process and the individual members' personal needs to collude in that process. If the therapist, with the intention of permitting the group's anxieties and confusion to mount until the members are ready to work on understanding their illusion, sits back, remains silent, and provides no support for dependent group members, then the group is likely to flounder for a while until dissipated by no-shows. If, on the other hand, the therapist accedes to all the members' demands for reassurance and advice, then the group continues to function as if the therapist were the only one with any power. The group evolves a friendly ambience, but little actual therapy occurs. The key is timing.

In the beginning the therapist must play to the members' dependency needs. He or she might respond to a member who continually questions only the leader; might answer technical medical questions or admit "I don't know"; might spend a few minutes after group or arrange an individual session with a member who says he or she cannot talk in a group about suicidal ideas; and might prescribe medications when appropriate. The therapist might even manipulate the members' needs to have a leader by directing the group—for instance, by suggesting everyone take a turn in introducing himself or herself, or in sharing a reaction to a particular member's dilemma, or by turning to one or another member who remains silent and supportively asking that the person share something with the group about his or her life. In this way, the leader takes advantage of the power granted by the group, smoothes out the process in the first few sessions, and guarantees that all members get enough of what they thought they came for to come back again. Then, after several sessions or after several months, when the therapists are confident that there is enough group cohesiveness to hold the group together and the patterns of dependency are fairly obvious, the therapists can begin to interpret.

"I notice that everyone waits for me to say something about Jim's dilemma. Doesn't anyone want to share his or her own reactions?" Someone does share a personal reaction, but it is clear that this is only after I suggest they do so, and meanwhile other group members pay little attention. I say, "I think it is time we talk about a pattern that has developed. Everyone seems to want me to deal with

all the difficult questions here."

"Well, you're the doctor, you know how to handle the situation." Other group members plead that they are overwhelmed. Or when one member shares a reaction with another, the group still listens more carefully to what the therapist says next. Or when the paraprofessional cotherapist comments, group members fidget or engage in side conversations. Gradually, both cotherapists encourage the group to focus on the hierarchy thus established. What does this mean in terms of self-valuation and how does devaluing oneself relate to the problems and disorders for which the clients have sought therapy? If the therapists' timing is correct, the group members will be able to confront these issues in themselves and each other.

A change in the group dynamics will occur. Perhaps group members will listen more closely to one another, value one another's contributions more, and in the process notice an improvement in their own self-esteem. This process occurs gradually, in bits and pieces, each time the therapists or the group find themselves operating as if all valuable contributions emanate from the therapist alone.

A recent group therapy session is illustrative. A black paraprofessional woman and I are cotherapists. My cotherapist asks a black underemployed and severely depressed construction worker how he feels about another group member's sporadic attendance. The man turns to me and responds: "1 guess it's a

matter of commitment. I come every week and I expect him to do the same." The group discusses commitment. Another member says: "He doesn't like us very much and that's why he doesn't show up for meetings." My cotherapist asks the construction worker: "How can you tell whether he stays away because he doesn't like you or whether there is some other reason he's not here?" Again, he turns to me and responds: "I guess I just always assume it's because he doesn't like me—maybe that's just my depression talking." We discuss depression, low self-esteem, and how seeming rejections make matters worse.

After the construction worker seems to have resolved something for himself about that issue, I turn to him and ask: "Why, when the other therapist asks you a question, do you turn to me to respond?" He seems shocked by my question, as are other members of the group. He turns to the other therapist and apologizes profusely, stating he did not mean to insult her. Then he tells me: "I guess I figure that you're the doctor and you know more about my condition." I ask whether that is really true. After all, the other therapist did the initial interview with this man. I ask whether he feels I make most of the important comments and interpretations in group, or whether both cotherapists contribute equally. He hesitates, and then responds: "You know, I think you're right—1 just assume that because you're the doctor, you know what's going on."

"Does the fact that I'm white and she's black have anything to do with this? Or that I'm a man and she's a woman?"

"What do you mean?"

"You know what I mean." There is an uncomfortable silence, and several group members awkwardly shift posture.

"You mean you think I don't listen as hard to a black person as I do to a white? I don't think it's that. It's just that you're the doctor."

"Okay, let's talk about that. Is a doctor the only one who knows about feelings and personal problems?" The discussion shifts to the construction worker's assumption that, whatever is causing his depression, he is not capable of talking about it or changing it.

He interjects: "And neither is a nonprofessional!" We proceed to talk about the ways in which certain group members devalue their own insight into their problems, how this leads them to the assumption that a black paraprofessional cannot have much insight either, and how they devalue their own resources for helping themselves and each other. Before the session ends, the group is in agreement that this self-devaluation is connected to the depression various group members experience.

Beneath the dependency and self-devaluation there often lies deep ambivalence toward the therapist. The client who values the therapist's attentions inordinately is also likely to be suppressing the rage he or she feels when rebuffed

or disappointed. Whenever a person depends upon a loved one or important other and then is disappointed, the love turns into its antithesis: resentment, envy, or hate. This applies to the child's ambivalence toward a parent as well as the adult's ambivalence toward a mate. In groups, the ambivalence of members toward the leader or leaders can be extreme. The more the members depend on the leader, the more likely that feelings of envy and resentment toward that leader will erupt. Groups tend to set up leaders whom they then attack. Either the leader does not do well enough at calming the members' anxieties or, if the leader is relatively successful, the members envy the leader for his or her accomplishments.

The dynamic is exaggerated when a white therapist leads a group of low-income and minority clients. The therapist can never alleviate members' pains and anxieties sufficiently, and the successful therapist symbolizes all the privileges and accomplishments the clients envy most. This is often the dynamic that underlies seemingly irrational outbursts of anger against the group leader. It is crucial that the therapist help the group members discover and verbalize the negative feelings in the group. Otherwise, the resentment, envy, and rage are denied and the clients act out what is not spoken. The acting out might take the form of hostile silences, no shows, side conversations and other disruptions, or clients' failure to progress in therapy. It is as if the clients were thinking to themselves: "I'll defeat the therapist after all. I'll disrupt the group and refuse to improve." For many clients, inability to express negative feelings plays a large part in the evolution of emotional disorder. When the therapists successfully interpret that the group is

acting out discomforting feelings and everyone sees that the therapists and the group survive the experience, the group is likely to begin to work very hard at therapy, and individual members are likely to notice improvements in their personal lives and relationships.

The initial phase of group therapy that centers on dependency and acting out can last many months. Often, the professional therapist who first attempts work with groups in the public clinic is disheartened. More "psychologically sophisticated" groups in private or university settings seem more intense, often because many more intellectual ideas about group process are shared, and the abundance of such ideas reassures the participants that rapid progress is being made. In fact, once the group in the public clinic has attained cohesiveness and begins to hook up members' valuation of self with more spontaneous and assertive expressions of self, very rapid progress occurs.

"Putting It Out on the Street"

Often, during the early phase of a group's formation, a client will rationalize exclusive dependency on the therapist by saying: "I don't trust the others. As soon as I say something they'll be putting it out on the street. I don't want anything coming back in my face after I leave here." Usually there will be some reality base for this concern—an incident from the past when this client was betrayed by an intimate. "I told Sally, who I thought was my friend, that I'd been cheating on Ben

and seeing Larry. Sally told Ben and then all hell broke loose."

The client does not say all this in group. There she sits quietly and, when questioned about her silence, says only that she does not want her business put out on the street. She asks to see me alone to explain why. I suggest that she continue to attend group sessions, and even if she cannot share her secrets, perhaps she can talk about her difficulty trusting the others.

There is a class and cultural issue here. In the community of psychologically minded therapy providers and private consumers, the capacity for openness and self-exposure is highly valued and socially useful. On the street, it is often more useful not to show your cards. Many low-income clients come to the clinic believing it is fine to expose feelings and secrets to the doctor or therapist, but it is dangerous to do so in front of anyone else. Sometimes this belief evolved out of betrayals of early childhood, when a mother said she would keep a child's secret from father and then did not. Sometimes romantic triangles and jealousies have been fought out via betrayed secrets. And sometimes it is the class- or culture-based distrust of self-exposure that causes the shyness. Whatever its origin, a client's concern about confidentiality in group must be respected from the start.

Once the client discovers that the group respects his or her unwillingness to fully participate, the client's trust in the group is heightened. He or she gradually contributes more to group sessions and experiments with sharing more personal

secrets. Meanwhile, the group begins to negotiate its boundaries. Members check out with one another how much confidentiality they can expect, and accordingly decide what it is safe to discuss.

Then it is no longer a question of whether or not one client can trust another with secrets. It becomes a question of whom a client can trust with what secret, and how far can such trust go? The capacity to make such discriminations is a prerequisite to a client's learning how to be safe on the street and still develop certain intimacies that permit of sharing deep secrets.

When group members are not able to develop enough trust in one another to share feelings and secrets in group, and continue to trust only the therapists, then it is not possible to work through the dependency basic assumption.

A Parallel Process

Another obstacle to progress in group therapy arises from the relationships among the staff of the clinic, as reflected in the relationship between cotherapists whenever professional and paraprofessional work together. If the professional as therapist derives too much personal gratification from being placed on a pedestal, if that gratification prevents the therapist from interpreting illusory group assumptions as they arise, and if the relationship between cotherapists is shaped significantly by the professional's need for gratification, then problems arise. In other words, if the professional and paraprofessional cotherapists collude with

the group in the assumption of a value hierarchy and implicitly agree that the professional's words are much more valuable than the paraprofessional's, then both cotherapists have great difficulty helping the group transcend the dependency basic assumption. On the other hand, if both cotherapists notice that the group values the contributions of one much more than the other and the cotherapists collaborate closely on the timing of an interpretation of this discrimination, then the therapists can successfully utilize the group's attitudes toward them to help the group members change their attitudes toward themselves and one another.

Here is a parallel process.[41] The relationship between white professional and black paraprofessional has parallels in the relationship between therapists and clients in the group. If the cotherapists treat each other with respect as equals —though their expertises may lie in different areas—then there is hope for the group's realization that clients are valuable people and have contributions to make, too. If the cotherapists collude in the assumption the white professional is the only one whose contributions are valuable, the group will continue in its dependency basic assumption.

Not all groups have cotherapists, and not all cotherapists are pairings of professional and paraprofessional. But I use this particular constellation as an example to point out a larger parallel process between staff attitudes and client attitudes in the public clinic. I have observed that in clinics where white male

psychiatrists dictate protocol, make all decisions, and devise treatment approaches, a hierarchy is established with M.D.s on top, and Ph.D.s, M.S.W.s, psychiatric technicians, and community aides occupying successively lower rungs on the ladder. Certainly the salary differentials fit this hierarchy.

In the context of such hierarchies, clients are the least valued contributors to the evolution of therapeutic modalities and are seen as somewhat passive recipients of services designed by professionals. In such a setting, when white professional and black paraprofessional are group cotherapists, the clinic staff hierarchy is obvious and nonnegotiable, and the clients are presented with concrete evidence that their dependency assumption is valid, because they see their cotherapists model the inequality.

Alternatively, if there is an atmosphere of more equal exchange among the staff of the clinic, and if the white professional listens as closely to the black paraprofessional's contributions as does the paraprofessional when the professional talks, then the clients are presented with a model in which everyone's contributions are valued. Of course, the psychiatrist might have a particular expertise about therapy technique. But the black paraprofessional has an expertise, too, about daily life in the community or about the street talk occurring in the group. The specifics of staff hierarchies are not always the same. Sometimes the top rung is occupied by black or women professionals. Sometimes it is a paraprofessional who is most expert about therapy technique. But the point is that

unless the staff of the clinic are able to exchange ideas and expertises and value one another's contributions, the group therapies occurring in the clinic will encounter great difficulty transcending the dependency basic assumption.

One Client's Gain from the Group Experience

An objection is frequently raised by students and staff when I talk about group therapy: "It may be fun to be in a group and learn about group process, but how does that help the clients with their real-life problems?" The question relates to another about the usefulness of group therapy altogether: "Isn't it really a holding operation for clients who can't be seen in individual therapy?" My response is: "Not necessarily—not if group therapy works as it should." But how does the individual client gain from the group experience? I will describe briefly the problem of one group member, a process that occurred in the group, and the effect of that process on the member's life.

Ken is a forty-eight-year-old white man who has worked for ten years doing maintenance at a small factory. Prior to that he drank heavily. He has been married four times and has children by two of his former wives. Up to ten years ago he lived a cyclic pattern: love at first sight, precipitous marriage, divorce within a year or two, heavy drinking and skid row existence, and then another new love. Each time he fell in love he went to work, and each time his marriage ended he went back to skid row. There were a few periods in jail in between—for

minor burglaries—and a few visits to psychiatric hospitals—probably alcohol-related psychotic episodes. Just after his last psychiatric hospitalization ten years ago, he met his current wife, found his current job, and settled down. He attended Alcoholics Anonymous for a while and has not had a drink during the entire ten years. In addition, he took Thorazine in moderate doses for nine of those ten years, or until he joined group therapy one year ago.

At the time he joined the group Ken was severely depressed. He worked at a boring janitorial job, he had no interest in sex, he had no desire to participate in any entertainment or recreation, he took his pills before going to bed, and his life was "just not any fun." His wife was domineering and rejecting. She took his pay checks and ran the household. She put all her energy and attention into her three children from prior marriages, their mates, and her eight grandchildren. Ken and she lived by themselves in a large house, and she often invited her family there or visited their homes. Ken felt left out and did not relate well to any of her family. He did not love his wife but remained with her because he was afraid of returning to skid row without her.

Ken never stood up for himself with his wife, and during the first year in the group, never stood up for himself there. He was polite, listened to others attentively, and said little about himself. He seemed sad, shy, and meek. He attended regularly, seemed attentive, and obviously enjoyed the meetings. I gradually reduced his medications, until by the end of the year he was taking only

occasional minor tranquilizers.

Meanwhile the group, of which he was a charter member, had passed through an initial phase of dependency on me, compliant politeness, and negotiations about confidentiality. Two women in the group had early tended to no-show whenever they were angered by something that was said. By the end of that first year they were beginning to express anger and to attend more regularly. One man would challenge statements I made, or insist the group do exactly the opposite of what I suggested. The group meetings were becoming more spontaneous, louder, and punctuated by laughter as well as angry accusations.

One day a new client appeared at the group meeting and said I had told him to join the group. It was an awkward moment. The young black man had expected to be warmly received, but instead he was practically ignored. Everyone, including my cotherapist, was angry that I had not informed them a new member was coming. I asked the new client to step outside with me, explained to him that a mistake had been made, and asked him to return to see me the next day. That client was supposed to enter another group I was leading, on another day; the secretary had given him the wrong appointment time. But the mistake set the stage for an important discussion.

When I stepped back into the room it was Ken who led the attack. “You should have told us you were asking someone to join the group. Maybe we

wouldn't go along with it." He was angry. So were the others. I did not immediately explain, and the group seemed to delight in my cotherapist's disappointment in me. Ken led the discussion, which expanded into the first serious criticism of my style that the group had ever presented. Ken even yelled at me that I should have discontinued his Thorazine sooner, since it was the Thorazine that was ruining his sex life. By the end of that session I did explain that the new client's arrival was due to an error and that I agreed the group should discuss the prospect of adding members before any were invited to join. Meanwhile, the group had become more comfortable challenging my authority, expressing overt hostility, and proclaiming the members' collective will.

In the sessions that followed Ken spoke more. He reported that he was standing up to his wife more, demanding sexual encounters, and putting his foot down about how often her family could visit. At first he feared that his anger represented an early sign of another mental breakdown. Other group members phoned him to find out how he was or to offer support between sessions. He did not suffer a mental breakdown, his wife began to respond to his demands, and he reported a lightening of his depression.

Some Other Issues

I am suggesting that group therapists first play on the group members' initial dependency, in order to heighten motivation and foster group cohesiveness. Only

after this cohesiveness evolves should the therapists energetically explore the defensive nature of the dependency. Meanwhile, there are some less constructive ways that the public clinic setting itself fosters client dependency. I will mention some of these ways and suggest some approaches therapists might utilize to alter them.

Clients generally come to the clinic, sit uneasily in the waiting room hoping they will see no one they know, and interact as little as possible with one another and with clerical staff. They see their therapists and leave. In the interaction with the therapist, clients often feel they contribute little except problems and that the therapist supplies all the strength, wisdom, and remedies. The client may leave feeling stronger or more relaxed, but little has occurred to alter the isolation and feeling of having contributed little to the process. A predominant feeling is that the therapist is giving the client charity.

Books on technique advise the therapist to discourage contacts between clients outside of group therapy sessions. They reason that such contacts encourage clients to divert energy from the group encounter, or to act out conflicts the group should be discussing. This is often the case in relation to sexual liaisons. A pair of group members might get together outside the clinic and try to satisfy physically with each other the needs for specialness, warmth, and affection that the group does not satisfy. If this precludes the group's talking about such needs, or if the couple rushes into a premature intimacy that eventually proves

destructive, the traditional caution is warranted. But these are the exceptional cases.

More often the members of the group benefit greatly from offering one another rides to and from the clinic, from calling one another between sessions when they need someone to talk to, or from occasionally visiting one another at home. For instance, two very depressed middle-aged women in a group might discover that they both sew all their own clothes and get together outside to shop for materials or to exchange patterns.

Group members at first tend to limit their social interactions outside the clinic because they fear the stigma of associating with other "mental patients." When this stigma is examined in group, another step is taken on the path toward appropriate self-esteem, and the group member is able to risk more in relating to another group member, and eventually to others outside the group.

The psychiatric hospitalization of a group member is a major event. Other members might express anxiety about their own potential to "break down." Or they might be upset that their care and concern for one another, plus their therapists' expertise, were not enough to prevent the hospitalization of a member. Or the event might represent for some a reenactment, complete with feelings of powerlessness or guilt, of an earlier scenario involving the breakdown and hospitalization of a parent, relative, or close friend. Whatever the group's fantasies

and anxieties, it is important that they maintain contact with the hospitalized member.

Group members might usefully visit the hospitalized member. The therapists certainly should, meanwhile improving the continuity of care by meeting with the staff at the hospital. Therapists in public clinics generally do not treat clients when they are admitted to inpatient wards. Usually the therapists feel discouraged that they have failed to prevent hospitalization. When they can transcend this feeling and actively participate in treatment planning with hospital staff, more rapid recovery and discharge are likely. Even when hospitalization occurs outside the county or public system, therapists are welcomed by hospital staff to visit and collaborate in treatment planning and sessions. If the group members and therapists visit the hospitalized member, that member feels the support, and at the intervening meetings the group is able to discuss their fantasies as well as the realities involved in the member's need for hospitalization.

Clients' feelings that they contribute nothing and merely receive charity at the public clinic are closely tied to the dependency basic assumption and to their massive devaluation of self. As excessive dependency on the group leader is worked through, clients feel less like recipients of charity and more like contributing members of the group. There are some supplementary approaches to this issue that are often useful. In Chapter 6 I will discuss advocacy and the group's sense of power in winning battles for themselves and one another. I think

it will be useful if I mention here a ritual that developed in one group and that seems to me to be a symbolic working through of the members' feelings about receiving charity.

A middle-aged black woman in this group battled through three appeals to the Social Security Administration to win her disability claim. She had been doing domestic work in spite of suffering from a severe lower back condition and massive depression. Her husband was an invalid, paralyzed below the waist since an accident on the job six years earlier. He received very little workman's compensation, and they lived on her income. She came home from work barely able to stand, her back bothering her so much. Then she had to fix dinner, take care of her husband and two teenage children, and try to get to bed early enough to be able to get up and take a long bus ride to work.

Her back condition and her depression were each serious enough to warrant disability benefits. But the Social Security Administration rejected her application and first appeal. She could barely read and write, so group members helped her fill out the appeal forms. I wrote letters to support her claim. The group asked her weekly if she had heard anything. They expressed anger when she reported that she had been sent to another psychiatrist for an examination, that after waiting an hour to see him, he spent only five minutes with her, and then on the basis of his report, her application was refused. Group members accompanied her to a hearing on her appeal. Finally, after ten months, she was awarded total disability benefits.

This woman then invited the group to her home for dinner at the time of the next group meeting. Everyone went. The meal was a feast. This usually timid and downward-glancing woman beamed proudly when someone complimented her on the roast beef or rich chocolate cake. She spoke more at the following group sessions and began to lose some of the excess sixty pounds she had been carrying around.

The group evolved a ritual in which any member who won a battle in court or in a hearing with the support of the group would host a celebration feast. The meaning of these events was thoroughly discussed, including some members' statements that previously they felt empty and unable to give anything to anyone, and now they felt totally at home hosting and thanking the whole group.

The Lessons Are Generalized

Group therapy is useful only to the extent that clients' gains are generalizable outside and beyond the group experience. The fact that members grow to trust, open up with, and depend on one another is important. But the test of the group's success is in the members' capacity to function in their own lives, activities, and intimacies.

I have been describing various aspects of what I consider the optimal progression of stages in public group therapy. I will schematize and complete that progression here:

1. Whatever their other symptoms, clients come to the clinic feeling isolated, worthless, powerless, and dependent on doctors and therapists to help them.

2. Group therapists play on the group's dependency basic assumption in order to motivate clients to return and in order to foster group cohesiveness. Meanwhile, clients develop more trust and self-esteem.

3. While the therapists confront and interpret the dependency basic assumption, group members begin to value one another's contributions and support, and come to value their own in the process.

4. The cohesive group of increasingly interdependent clients becomes a place where members can risk, expose, and test their self-worth, trustworthiness, and lovableness. They find out how safe it is to express their feelings spontaneously, to confront other group members, or to ask others to satisfy some of their needs. Telephone contact, visits to hospitalized members, advocacy, and other forms of support occur between members outside of actual group meetings. The therapists help by making explicit the testing and risk taking, and by interpreting underlying anxieties, such as fears of rejection.

5. The group members generalize lessons learned among themselves. They trust, support, and take risks in relationships outside the group. Then they return to group and discuss their independent activities and relationships. They risk the group members' feelings of envy or feelings that they are becoming too

independent and deserting the group. The therapists must help the group members stand up for themselves and branch out from the group; and they must facilitate the group's mourning of their earlier exclusiveness and more total interdependence.

This progression of stages may require several years. During that time, each of the members will probably undergo structural change, and will be ready to struggle with the issues of termination. Other chapters will discuss various groups and group members at various stages, structural change, and issues that arise in the termination phase of all therapy modalities.

CHAPTER 6
Advocacy as a Therapeutic Intervention

Psychoanalysis occurs within a certain framework, or frame. Sessions last fifty minutes. A certain fee is paid. The analysand sits or lies on the couch and talks. The analyst listens and interprets. The analysand knows little of the analyst's personal life. The analyst refuses to answer certain questions or respond to certain requests. The two do not meet socially.

The frame is important because within it certain variables are held constant, and beginning with these constants, variations and distortions can be interpreted. Thus, if the analysand comes late, wants to meet the analyst somewhere outside the office, resents paying the analyst's fee, wants to talk about the analyst's personal life, or asks the analyst to do him a favor that is not part of the contracted frame, then the analyst can interpret the analysand's need to alter or overstep the frame. "Perhaps you came late because you wanted to make sure we had less time to talk about some disturbing things." "You seem to ask me a lot of questions about my personal life. Is it because you want to know if I experience the same kinds of pain and conflict as you do?" "Do you think my fee is too high because you can't afford it or because you don't think the work I do with you is worth it?" The analyst keeps the frame constant, and lets the analysand know only a limited amount about the analyst, in order to be able to observe and interpret the analysand's unique experience of a relatively standardized therapeutic situation.

Within this frame, analysts speak of their own neutrality. They claim to be neutral, or to act as a blank screen upon which the analysand projects fantasies, conflicts, and anxieties from his or her inner mental life. This is the model. Few analysts today actually maintain a rigid frame, and few claim to be absolutely neutral. Analysts might chat with analysands between interpretations, might share a personal anecdote or political belief, or might agree to do a favor for an analysand. But these are idiosyncratic relaxations of the rules. The analyst still bases interpretations on the assumptions of a constant frame and of a certain neutrality on the analyst's part.

I believe this standardized frame is very valuable, although I do not believe that within this frame the analyst is neutral. But the constant frame has permitted analysts to accumulate important knowledge about how very diverse people behave and change within a certain set of circumstances.

The various forms of psychotherapy that derive from psychoanalysis have altered the classical frame while retaining many of its features. Therapist and client might sit face to face, and more conversation might occur. But still the therapist tells the client little about his or her own personal life, and still the fifty-minute hour is the rule.

When the public therapist adheres to the traditional frame, it works very well for certain clients. But in many other cases the therapy fails. The client no-

shows, or the client needs help with external stresses, such as an impending trial, and thus is not able to make use of a therapy that is bounded by the traditional therapist's definition of frame. If the therapist insists on maintaining too much of that frame, such clients decide therapy is irrelevant to their needs and lose the potential benefits it might offer them. It is mainly in order to extend the population who might benefit from psychotherapy that I suggest the therapist violate some aspects of the traditional frame.

Generally, the therapists who are most successful in low-income communities are the ones who are willing to get up from their chairs and leave their consulting rooms. This might be to talk with a client in the waiting room who appears at the wrong time, to make a home visit to a client who cannot come to the clinic, to visit a client in the hospital, or to appear in court on a client's behalf.

These therapists are willing to violate the traditional frame to a certain extent, while at the same time taking a somewhat modified frame with them as they leave the consulting room. They leave the fifty-minute appointment schedule behind as they sit with a client in a courtroom. But they can still listen carefully, assume there is unconscious meaning in every interaction with the client, remain alert to signs of resistance, and plan to explore and interpret all these phenomena in the next regularly scheduled therapy session. The fact that the therapist is or is not willing to leave the consulting room to do a favor for the client becomes an issue for later exploration.

I do not believe a therapist is ever entirely neutral. A therapist's refusal to leave the office has meaning too. A therapist might decide that therapy can occur only within the consulting room, refuse a client's request for support or for a home visit, and plan to explore the client's disappointment or resistance in the next session. But the client may not show up for that next session. The client might feel that he or she needs the therapist's help with immediate pressing problems before being capable of attending regular sessions at the clinic. Or the client might need to know that the therapist can be trusted before sharing personal secrets. Often, it is the therapist's very willingness to violate aspects of the traditional frame that makes it possible for therapy to proceed.

The therapist who refuses to violate the frame ends up treating only a small proportion of potential clients—the ones who are prepared to fit into the traditional frame. Many low-income clients would thus be excluded, and not because they are incapable of benefiting from psychotherapy. The therapist claims to be neutral while he or she in fact practices in such a way as to make psychotherapy unattainable for the majority of low-income clients. Then, this "neutral" therapist rationalizes the skewed population of clients who benefit from therapy by explaining that the others are "unmotivated."

I have no basic criticism of the use of a traditional frame with clients who can benefit within it. But I also believe it is the therapist's responsibility to make sure therapy is available to everyone who needs it, regardless of class or race. In

order to maximize these benefits for the population of clients in the public clinic, therapists must be flexible about the frame.

Of course, if the frame is entirely abandoned therapy cannot occur. The therapist becomes a service provider, an advocate or a friend—roles that have value in themselves. But the specific practice of psychotherapy is not possible. Additionally, with certain clients— for instance, very seductive, manipulative or chronically dependent ones—a more traditional frame is essential to create boundaries for the work of therapy and to permit the therapist to confront the client's tendency to act out by seducing or manipulating the therapist to do favors. Thus, the therapist who violates the traditional frame must work out a therapeutic strategy for doing so and must be certain that the particular client involved will be helped and not merely appeased by the therapist's alteration of frame.

Advocacy is an example of a potentially constructive violation of the traditional frame. According to *Webster's Dictionary*, the advocate is "one who pleads the cause of another." Therapists can be effective advocates for clients. I will present several illustrative cases, and then discuss the relevance of these advocacies to the therapeutic process.

ROSCOE

Roscoe had worked for twenty of his fifty years in a factory, lifting heavy crates. Then he suffered a serious back injury on the job. Believing he could not

afford a lawyer, he settled with the company for six months of disability payments and no workman's compensation. After the disability payments ran out, his back was still hurt and he could not return to manual labor or to any work that required standing or sitting for prolonged periods. Being black and having no high school diploma, he knew his chances for employment were slim. He could not adequately support his wife and two teenage children and consequently felt guilty and inadequate. He became increasingly depressed.

When, two years after his injury, he came to the clinic for treatment, he was immobilized by depression. He castigated himself for not supporting his family, he saw no hope for the future, and he was seriously considering suicide. He entered group therapy. The group immediately became interested in his workman's compensation settlement, and several members pointed out how he had settled for next to nothing. They encouraged him to apply for SSI. When his depression lifted enough for him to do so, he filed an application.

During times when funds are scarce, for instance, under conservative administrations, public welfare and disability agencies reduce their budgets by reducing the number of people to whom they grant benefits—for instance, by making the application procedure more difficult. Thus, if a local office of a disability program were to systematically deny all initial applications, while assuring the disappointed applicants that there was a procedure for an appeal, that agency would successfully screen out a large proportion of applicants—those

who, for whatever reason, were unwilling or unable to proceed with the appeal after an initial failure. The agency would then have a far smaller number of appealed applications to consider seriously. Unfortunately, the group of people most disabled by their mental condition are the least likely to appeal and eventually win benefits. For instance, someone who is very depressed and receives an initial rejection notice would be likely to think, "Another rejection—further proof I'm no good for anything," and not have the confidence to proceed with an appeal.

Roscoe's initial application for SSI was denied, in spite of a letter from an orthopedic surgeon who reported that his back injury was very severe and a letter from me stating that his depression was severe and disabling, too. Roscoe was depressed when he heard his application had been denied and wanted to drop the whole matter. But the group would not permit this. "This is the way they do you if you let them," said one member. Another added: "You gotta fight back—it took me three appeals before I got my disability."

Roscoe listened and said he would appeal, but weeks passed and he did nothing. The subject came up again in group, and one member said, "How about if I go with you to the SSI office to appeal?" Others volunteered to do the same. It turned out that Roscoe could not read and write well enough to fill out the appeal application. So several group members stayed an hour after group time to help him fill it out. Then, on the following day, the whole group met at the Social

Security office to accompany Roscoe.

There were four benches seating twenty to thirty people in the Social Security waiting area. Behind the counter were the four or five desks where interviewers met with the disability applicants in turn. The waiting room was packed with people standing three deep around the benches and milling around on the street outside. Our group waited an hour and a half before Roscoe's name was called. We noticed that many applicants left in disgust before they were called —another part of the implicit elimination process. We all accompanied Roscoe to the interviewer's desk. He seemed to delight in her having to gather chairs from adjoining offices for all of us to be seated. He spoke much more forcefully than I had yet heard him. And when the interviewer said she would notify him of the date for his appeal hearing, one of the group members took out a copy of the agency's appeal regulations and told the woman she would have to be sure to do so by a certain date. The interviewer seemed flustered, and Roscoe seemed all the more confident. He left the office beaming, and he did follow through with his appeal, eventually receiving benefits. Meanwhile he continued to attend the group, and his depression gradually lessened.

Here is an example of advocacy. I can take credit only for acting as a facilitator of the whole group's advocacy of Roscoe's cause. As I mentioned in the introduction, advocacy stands on its own as a valuable service and admirable group effort. But, in addition, in a community setting where the professional's talk

is cheap and the client's everyday hardships are overwhelming, a well-timed act of advocacy can be much more valuable than a verbal interpretation in breaking through a difficult resistance. The group's advocacy of Roscoe's cause helped him in a very concrete way—he needed our support to go through the application and appeal process. His success lifted his spirits some. But there is a much more specific way in which this advocacy fit into Roscoe's therapy.

Beginning therapists, having some idea that depression results from anger turned inward upon the self, often advise their depressed clients to "get in touch with your anger!" This seldom works. The reason is that depression arises from a very low self-esteem, and a person with such low self-esteem is hardly ready to express anger toward others. One depressed man stated: "What right do I have to be angry? I don't deserve any better treatment than I'm getting." Others become even more depressed as angry feelings emerge, believing that it is wrong to be so angry. The most effective therapeutic strategy with someone this depressed is to first challenge the distortions in the lowered self-esteem, and then, as the person corrects his or her valuation of self, he or she starts to feel, "How dare they treat me like this—I deserve better!" Then the rage erupts spontaneously, without any suggestion on the part of the therapist. The therapist's task is to validate the appropriateness of anger and to help the client integrate the feeling without losing control.

The therapist's challenge of distortions in the client's self-esteem cannot

consist of false praise—clients too readily feel patronized, and often rightly so. The challenge must be a confrontation with facts. For instance, a very depressed single mother came to see me and complained that she had "made a mess" of her life and was "incapable of doing anything right." While we talked, she nonchalantly intervened in a fight between the two young children who accompanied her and immediately returned to the conversation with me. I was impressed with the children, the way they related to me and to each other, their warmth, exuberance, and their obvious precociousness. I was also impressed with their mother's way of being with them, and her way of being with me while periodically turning just enough of her attention to their needs. After listening to her describe her sadness and ineffectualness, I pointed out that my impressions of her obvious capacity to mother did not fit the image she presented of a useless woman who failed at everything. We talked about her feelings as a single mother, how hard was her burden, and how well she was doing. This led us to the subject of her tendency to judge herself harshly, and we began to explore the issue of her own parents' expectations and her feelings that she "never quite measured up." Several sessions later, while still feeling significant sadness, she began to express some anger, too —toward a male friend who did not give her enough support in raising her children, toward her father who did not give her enough credit for raising the children alone, and toward me because I did not sufficiently understand her sadness. Meanwhile, her depression and self-castigation lessened.

Basically, I challenged the distortions in this woman's lowered self-esteem

by making verbal interpretations—for example, pointing out the discrepancy between her claim that she was useless and her obvious capacity to mother. I could have accomplished the same purpose by substituting an act of advocacy for the interpretation. This is what occurred in Roscoe's case. At the moment when his total self-castigation robbed him of the will to fight for his deserved disability benefits, the group's forceful advocacy challenged his image of himself. Their support, and his eventual feeling that he was worthy of others' support, permitted him to switch from castigating himself to making angry demands for what was rightfully his.

BETTY

Betty was immobilized by depression, too. It seemed to me that her depression and obesity were linked, and if there were some way to alter one, the other would be affected at the same time. She had spent the first half of her thirty-five years in Tennessee with her mother and stepfather, a poor, alcoholic, and abusive black man. She moved to California in her late teens but remained fat and depressed. For eight years she attended the mental health clinic to have her prescriptions for Thorazine refilled. When asked how she was managing, she would respond curtly:

"Fine."

"Any problems we should talk about?"

"No Doctor, I just need my prescriptions refilled, and I don't have much time."

She would smile—it was actually a self-satisfied grin—as if to say, "I put a stop to your nosy prying." But at the same time, her eyes pleaded, "Do you really want to stop at that? Don't you want to know more about my pain?" So one day I confronted Betty and insisted she take the time to tell me more about herself. It was like pulling teeth, but after she challenged me several times with "You don't really want to hear this," she told me that she had been depressed ever since she was eight and her stepfather began to abuse her sexually. It happened repeatedly. She tried to tell her mother about it, but her mother would accuse her of lying or would just plain ignore her and drink some more from the whiskey bottle she carried in her purse. Betty interrupted her story with a burst of tears. Still sobbing, she said, "He did me that way so often he tore my insides up." She had three younger brothers whom she loved and helped to rear, particularly at times when her parents were drunk or sick. At sixteen she left home to get away from her stepfather, but lost touch with her brothers in the process. She came to California, became more depressed, and started putting on weight. When at twenty she complained of severe menstrual cramps, her physician decided her "internal damage" was irreparable and performed a total hysterectomy.

I asked Betty if she had ever told this story to anyone before, and she said, "I don't trust anyone to keep a secret." I encouraged her to attend group therapy and

assured her she would not have to talk about anything she did not feel comfortable sharing.

The group Betty attended sat at a round table. She would periodically lean down under the table to get something out of her purse. While still leaning down, she would take out a piece of hard candy and slip it into her mouth. Then she would sit up, suck on the candy, and all the while try very hard not to let on to anyone that it was in her mouth. Meanwhile, she remained silent in the group or, when she was prodded by others to talk, would state her fears that someone would "put my business out on the street." I knew this because one day I sat next to her in group and saw her put the candy in her mouth. She did not know I was watching. When she turned our eyes met. She smiled, clearly embarrassed. Then again, maybe she did know I was watching and wanted me to know.

Betty was unable to have children of her own. But six years earlier, a woman whom she had met at a state mental hospital, whose difficulties precluded her from raising her own children, had asked Betty to care for the children. Betty accepted responsibility for the two children, received a letter from the friend declaring Betty was to raise the kids, and proceeded to raise them as her own. Betty applied for and received welfare benefits for two dependents.

Soon after she entered the group, trouble erupted. The children were by now eight and ten years old and had known Betty as "Mommy" for six years. But now

the childrens' maternal grandparents decided they wanted custody.

Betty's position was not very strong. The letter she held from the childrens' mother, still in a state mental hospital, had no legal value. Her own mental hospitalization eight years earlier disqualified her as a foster parent. And although she had applied for "aid to families with dependent children" in good faith (she considered herself a mother to them) the court would consider it welfare fraud for her to accept financial assistance for children who were not legally her own. Betty's worst fears were realized: A social worker removed the children from her home and placed them with the grandparents; her application to become a foster parent was turned down; and she was charged with welfare fraud and ordered to return the several thousand dollars she had collected over the years and spent for food and clothes for the children.

Needless to say, Betty's depression worsened. She did not even attend group. A social worker phoned me and reported these developments, and I had to phone Betty and insist she attend group and share her plight with the others. She seemed to be gaining weight. In a rare moment of spontaneity, she confessed to the group that she regularly baked two or three chocolate cakes, ate them all by herself, and became so sick (she suffered from diabetes) that she had to spend the next day in bed.

I had plenty of hypotheses about the psychodynamics of Betty's depression:

She ate to fill a gaping hole inside her that was opened by the poor mothering she had received; her sexual trauma reinforced her suspicion that she was a "bad girl," and that this was why she was treated so badly; the early loss of her womb confirmed her fantasy that everything inside her was bad; she compensated by being a Supermom, first with her younger brothers and then with her adopted children, making sure the children she was raising received better treatment than she had; and the loss of her two children accentuated the whole constellation of bad feelings. But Betty seemed incapable of hearing any such interpretations, so absorbed was she in her own depression and so convinced that she was receiving the very treatment she deserved. She began to attend group less regularly, eat more sweets, and take more Thorazine.

The group worried that she might be suicidal. When she no-showed, various members would call her, visit her home, and insist she attend sessions. She seemed depressed almost to the point of stupor. The group was outraged. They insisted that Betty complain to the county protective services agency, and the whole group volunteered to accompany her. The unanimity and intensity of the group's outrage reached Betty. For the first time since I had known her, she did express her rage. I suspect that she had been taking Thorazine precisely to control this anger. (She later mentioned that in a rage she once hit her rather ineffectual and emotionally removed husband and broke his jaw.) She did go to the agency with the group and confronted the protective services worker there.

Regrettably, I have no storybook ending to report here. Custody of the children was eventually awarded to the grandparents. But Betty was granted liberal visiting privileges. And with the group's support, Betty enlisted the help of a poverty lawyer and fought the charge of welfare fraud. A hearing was held and Betty, accompanied by me and several group members, explained that she had received money only for the children, had spent the money for their food and clothing, and had filled out the application in good faith, believing herself to be their actual guardian. The charge was dropped, and Betty was not forced to pay back the money she had received. Meanwhile, Betty remained severely depressed for many months. She was mourning the loss of her children, and all that caring for them had represented.

Though she was depressed, something did change after the group's advocacy. She no longer no-showed or sat silently in group or withheld her feelings. She exposed her sadness in the group and seemed more empathetic with other members, often making very perceptive and nurturing comments when others talked of their pain. She no longer indulged her sweet tooth so perversely and she kept her diabetes in control. About a year after losing the custody fight, she began to lose weight and report weekly to the group how many pounds she had lost since the last meeting. When she had lost about twenty-five pounds, she announced that she would no longer take any Thorazine and returned the last of her pills to me in front of the whole group.

SAM

I do not want to give the impression that one intervention, be it an interpretation or an act of group advocacy, can change the course of a therapy or of a person's life. Roscoe and Betty both improved gradually, and only in the context of incessant group pressure and support to readjust their self-esteem and stand up for themselves. In Sam's case, repeated acts of advocacy were required before he could trust me enough to proceed in therapy.

Sam had sad eyes. They seemed out of place in a round dark brown face that otherwise looked as though it should be smiling. Sam did not smile. He was depressed. He told me that since he had left Arkansas a year before, he had not been able to find work. He was now in California, "the land of golden opportunity"—or at least that was what he had believed a year before when he left his parents and four younger sisters and brothers.

Sam was twenty-six and unable to read or write. He left school in the fifth grade, when his teachers told him he was too dumb to learn. He believed them. He decided that if he was so dumb, he would never get very far in school, so he might as well quit and go to work in the cotton fields. Then he would have money to contribute to the family. His parents believed he was dumb, too. He did not get good grades in school, he was very quiet and so did not seem quick-witted, and it seemed appropriate for their oldest son to help make ends meet.

Sam had some money when he moved to California but it was soon gone. He applied for welfare and lived most of the year in a skid row hotel room, the welfare payments stretching almost enough to pay for food. Luckily he made friends with some people who periodically invited him to dinner. He went to a vocational rehabilitation counselor who told him he would not find work until he learned to read and write and enrolled Sam in a state-financed tutorial program.

Sam told me he was too depressed and lonely to study—and his failure to attain literacy made him more depressed. We began to talk about this. Several months passed. He was beginning to attend tutorial sessions regularly. Some weeks he would study, others he would sit around feeling sad and lethargic. Then he skipped three of his weekly sessions with me, and the next time I heard from him was at the time of his discharge from a mental hospital. He had become increasingly paranoid, began roaming the streets aimlessly, got into a fight, was arrested and was referred from the police station to the mental hospital because he seemed to be acting in a bizarre manner. As often happens, the hospital notified me that he had been admitted only after he had been there a few days and was ready to be discharged. I gave Sam an appointment for the next day.

I know some psychodynamics and some therapy techniques that are relevant in many cases of paranoia, such as with clients who are untrusting, secretive, hostile, very anxious, and convinced they are in great danger from all fronts. Lowered self-esteem is likely to be present, as in depression, but there is no

way the client can expose his or her inner ruminations and self-devaluing beliefs if he or she does not trust the therapist enough to confide such things. Beyond that, even if the paranoid client does expose his or her fantasies and fears to the therapist, he or she is not able to accept what is potentially helpful in the therapist's interventions until he or she determines that the therapist is not one of the enemy. In other words, the client cannot make use of the therapist's help with reality testing until he or she is certain the therapist can be trusted to tell the truth.

I began discussing this issue with Sam, and he gradually relaxed and began to tell me what had happened. At the same time, he seemed very anxious, uncentered, and distressed by paranoid ideas. I decided to prescribe Haldol, a strong Thorazinelike tranquilizer that is often helpful when paranoid ideas and anxieties are prominent in the client's turmoil. I do not think I would have prescribed anything if I had been able to see Sam several times a week or if he had been living with his family. It was arranged that he would live in a Board and Care Home instead of the hotel, and he applied for SSI on the basis of his mental impairment.

Sam believed that the hotel manager who was mean to him, the policeman who arrested him, the woman who he believed slipped angel dust (PCP—a powerful hallucinogen) into his drink and thereby caused his mental breakdown, and the doctor on the ward who made him take medicine were all collaborating on

a scheme to destroy him. One day I was thirty minutes late for our appointment. He glared at me, causing me to feel a little of the terror I imagine he was feeling much of his waking life. “Why’d you do me like that, Terry? I thought you were my friend. Doesn’t it matter to you that I’m sitting and waiting? Sometimes I think you’re one of them!”

I explained that I was at a meeting and had tried to reach him by phone to change our time, but he was not home. He settled down and we examined why he had jumped to the conclusion that I was one of his enemies. We discussed his perception that everyone was against him; he began to admit he might be exaggerating. I suggested that even though some others do treat him badly, it is still possible to form relationships and that even when a relationship is disrupted and he feels betrayed, he can communicate disappointment and rage, and proceed in the relationship.

It seemed to me that Sam had bought into the line his teachers and his parents had fed him: “You’re too dumb.” He had meekly accepted that his own inadequacies were the cause of his unhappiness. He even blamed himself for his inability to find work, felt that if he was brighter and able to read he could find work, and disregarded the fact that there were many literate black men on the streets unemployed. Then, when his external polite mask was weakened—in response to stress or as a result of ingesting angel dust, I cannot determine the relative weight of each—a rageful inner voice emerged proclaiming: “How dare

you all treat me this way!" I asked myself why Sam had to lose touch with reality and go to a mental hospital to express the rage he must have felt all along about his mistreatment. Why had he not been able to stand up to his fifth-grade teacher and say: "I know I'm not dumb. This school must not be very good at teaching reading and writing!"? The self-devaluation that made such a stance impossible must have evolved from a very early sense of low self-esteem and vulnerability.

As it happened, and the therapist can rarely plan such eventualities, several opportunities for my advocacy with Sam appeared. He was due to appear in court to answer charges stemming from the fight and arrest, he was dropped from the tutorial program because of his poor attendance, and his application for disability was refused. Remember, a key issue for Sam was whether or not I could be trusted. We talked about this repeatedly, for instance, after I was late for that appointment. These three acts of advocacy presented an opportunity for Sam to evaluate how much I could be trusted. Within a span of four weeks, he asked me to write a letter to the judge, talk to the vocational rehabilitation counselor to see if his money for tutoring could be extended, and write a letter in support of his appeal of the denied disability. Luckily, in all three instances Sam was rewarded. The judge dismissed charges saying that Sam was too distressed at the time to be legally responsible, the counselor renewed Sam's grant for the tutorial program, and the disability was eventually approved. Sam began to smile more. He continued to become transiently paranoid, and depressions recurred. But he had learned to discriminate more accurately between people he could and could not

trust, and he had learned to continue his studies in spite of anxiety and sadness.

When paranoia is a problem, change is rarely rapid. The problem originates in the person's very early, even infantile lack of trust in his or her environment and loved ones. The resulting sense of low self-esteem and vulnerability, the rage at the unfairness of it all, the projection of that rage onto others who are viewed as enemies, the constant fear of real or imagined dangers, and the inability to trust and test the reality of the feared dangers combine in many cases to form a very rigid personality, and a client who is extremely difficult to treat. Sam's therapy continued for several years. At this writing, he continues to have conflicts about trust and self-esteem, and when stressed, he still tends to project his rage and anxiety. But he does continue in therapy and is reading and writing much better. I present his case not as an example of any kind of cure but rather to illustrate the way advocacy helped therapist and client get past a particularly difficult, early obstacle involving trust.

The focus in Sam's therapy alternated repeatedly between the issues of trust and self-esteem. Just when Sam would begin to accept my feedback that he was a lovable human being, he would suddenly begin to distrust me and believe I was no different from his fifth-grade teacher and that I was saying nice things to him only in order to trick him. The three acts of advocacy I have described each occurred at a moment of Sam's heightened distrust, and each preceded a renewed confidence that I was trustworthy and an improvement in Sam's mood and ability to study

and relate to others. I do not believe that advocacy was the only potentially successful choice of intervention. But it is remarkable that after these three acts, Sam's trust in me became somewhat more constant, his need for reassurance less intense, his anxiety attacks less frequent, and his attendance and motivation in therapy more regular.

A Rationale for Advocacy

I acted as an advocate for Roscoe, Betty, and Sam because I believed that their causes were just. Low-income clients have all too few advocates. They are unlikely to hire lawyers to fight for them in court, or at welfare or disability hearings. They cannot afford attorneys' fees, and even if they could, the whole legal apparatus seems to them very alien and intimidating. They are more likely to drop an appeal or accept a penalty than they are to fight their own cause in court or in a hearing. The presence of an advocate allows them to stand up for themselves better.

Beyond this just-cause rationale, it is useful to conceive of advocacy as a therapeutic intervention. While the therapist's knowledge of therapeutic principles and understanding of the client's psychodynamics might determine the type of message the therapist wants to give the client at a particular moment, the act of advocacy can offer the perfect opportunity to get that message across to a client who is otherwise incapable of really hearing it. Thus, Roscoe and Betty were

so depressed that they were incapable of hearing that others found them lovable. Only when those others, the group members, insisted on acting as their advocates did they get the message, start to value themselves more, become active in their own interest, and become less depressed. For Sam, the issue was trust. I was unable to help him differentiate between me and others who had persecuted him. If I failed to help him with this differentiation, I was certain he would be unable to use my services, would have no-showed or discontinued the therapy, and would have deteriorated further. At a time when my words were ineffectual, my acts of advocacy convinced him. After three such acts, he developed enough trust in me to be able to continue therapy and engage in further reality testing in the transference.

What I am suggesting does not differ in form from what I believe to be a common practice among therapists—the substitution of one or another active intervention for a verbal interpretation at a moment when psychodynamic understanding dictates an intervention but the verbal interpretation seems less useful. Thus, even therapists who remain close to the psychoanalytic tradition occasionally insert a technique borrowed from Gestalt, psychodramatic, or bioenergetic therapies to demonstrate a point. The therapist might ask the client to tense his or her body, to breathe in a certain way, to "Pretend I'm your brother and tell me what you would have liked to tell him then," or to "Close your eyes, take a few deep breaths, imagine you are back in grade school, and tell me what you see." When the therapist's interventions are haphazard, little progress is made

—one gimmick follows another in an interesting but unfocused interaction. But when the therapist's approach is guided by a thorough understanding of the client and the process of therapy, the insertion of one or another active maneuver at certain moments can be a creative and valuable supplement to dynamic psychotherapy. This is the context in which advocacy is useful.

The first question that arises when I discuss this use of advocacy with colleagues is: "Yes, that's nice, but what does that have to do with therapy? Doesn't it just foster the client's continued dependence on the therapist?" The answer to this question depends on how the remainder of the therapy unfolds. If, in the ensuing therapeutic sessions, the act of advocacy is never discussed or examined, then the meaning of the experience will be left to the client's private fantasies. The client might feel that he or she is actually unworthy of the therapist's attention, that the therapist helped only "because it's his job," and that the benefits gained "are only charity"—further proof to the client that all he or she is is a charity case. Alternatively, the client might fantasize that in order to continue receiving the therapist's attention, he or she must continue to act needy and compliant. Then, even if the depression lifts, the client is unable to grow beyond dependency. Or the client might win disability benefits, and then in order to avoid seeming unappreciative, never mention the resulting feelings—for instance, the guilt and depression that are connected with his or her belief that he or she never really earned the money.

Whatever the client's fantasy or the meaning to him or her of the act of advocacy, the next phase of the therapy must focus on that meaning and aim to help the client integrate the whole experience into a more developed and confident sense of self.

Sam could not figure out why I did all those things to help him. "It's just your job. You do this for everyone who comes here."

I responded, "Why do you assume I wouldn't do it just because I like you and want to do it for you?"

Tears welled up in Sam's eyes, and then he mentioned something he had not told me before: "I cry a lot, I don't know why. And sometimes in tutoring school the teacher comes over and asks me what's wrong. I say, 'Oh, nuthin'. She must think I'm crazy."

We discussed crying, and he seemed relieved when I said, "I don't think there's anything wrong with crying. But a lot of men feel ashamed when they cry —and that's too bad." He laughed when I mentioned that former professional footballer Roosevelt Grier sings "It's all right to cry" on the children's record, *Free to Be You and Me*. Then we explored together some reasons he might feel sad. I reminded him he was far from home. Did he miss anyone?

He talked about his parents and how he missed them. "But there's nothing I

can do about it so I just try to forget about them." He told me about a girlfriend he had left behind when he came to California. He said it was the first time he had connected his tears with the people he had left behind. We talked about the way he needs to assume he does not matter to me and to pretend that others do not really matter to him—at least not enough to cry over. The session ended with his telling me how he struggles to read the newspaper each morning at his Board and Care Home. "I can't really read a whole article, but I copy down the words I don't know and take them to my teacher the same day."

Of course, the client must become dependent on the therapist to a certain extent if the therapy is to proceed. Dependency is necessary if the client is to experience feelings intense enough in the transference and to have the opportunity to examine the whole issue of dependency with the therapist while it is a living reality in the consulting room. But if the client becomes too dependent on the therapist, he or she tends not to accept sufficient responsibility to make the therapy a success—he or she relies on the therapist to do all the work. The art of psychotherapy includes the capacity to gauge the amount of dependency the therapist should expect in the client at each moment in order to foster maximal progress in therapy.

When the client is immobilized by depression, paranoid fears, or diminished self-esteem, it is very difficult for him or her to talk about the issue of dependency, or even to put into words the feelings of powerlessness. The advocacy situation

contains the potential for client and therapist to act out what they cannot yet communicate in words. Later the words will more easily flow to examine the drama that has been enacted. For example, the client is confronted by a threatening reality in the form of a court or welfare institution. Feelings of powerlessness are exaggerated. A relatively powerful therapist intervenes and helps diminish the danger. The scene activates memories of childhood events in which a strong parent intervened or failed to intervene to help a weak child cope with a stark reality.

Betty was very nervous just before her hearing on the welfare fraud charge. She was relieved to hear that I was nervous, too. She noticed that the hearing officer treated me with great respect. During a break in the proceedings, we discussed this, and along with several other members of the group, agreed that the disrespect she was shown when unaccompanied was unfair discrimination and not a reflection of Betty's inadequacy. She spoke with more confidence after the break, and even winked at a friend from the group as if to say, "I have some rights, too."

Betty's attitude had been that she was totally powerless to fight against a monolithic institution, and that all she could do was give up. The support she received from me and the group permitted her to see that the institution was fallible, though still very powerful. But she had some power, too! Of course, her victory was a small one, and once won, her life would still be hard and her poverty

painful. But at least she realized she could effect some change, however minimal, in her circumstances, and thus could face the world with a little more self-assurance. In other words, what may have seemed objectively a small victory was a very large one in her inner reality.

Roscoe, Betty, and Sam were all given the opportunity to reassess their ability to affect their circumstances. At first it was the advocates' powers that made the difference—the crowd at the disability office, the group's insistence that Betty fight back, or my persuading Sam's rehabilitation counselor to extend his tutoring. The client in each case was dependent on me or the group. But at least the institutions no longer seemed immovable.

Meanwhile, the issue of power moved into the center of the material examined in therapy. Why did the agency accord such respect to the therapist and so much less to the unaccompanied client? How much of this was due to the client's presentation of self—dress, manner, and assertiveness—and how much to unfair discrimination inherent in society and in the agency's procedures? Is it shameful that the client required help from the therapist or group? Or is it admirable that the client was able to enlist support in the struggle for what is rightfully his or hers? Even if results are minimal or disappointing, the previously unassertive client was able to hope for some results from attempts to affect his or her own plight. Thus occurs an opening for meaningful discussion in therapy about assertiveness, pride, and self-respect.

I will close by mentioning two related issues that will be explored in other chapters. One is the issue of assertiveness and anger; the other involves the therapist's conscious and unconscious feelings about being the advocate.

Clients who feel powerless to affect their plight and who suffer from very diminished self-esteem have great difficulty demanding their due and expressing anger when denied. A dynamic that is often observed in clients who experience severe breakdowns is that they suppress anger for long periods, and then it erupts in some kind of violent explosion which lands the client in the hospital. The client then is likely to take Thorazine or some other drug in order to prevent further outbreaks. This dynamic has much to do with the "chronic" problem, and will be discussed in Chapter 9. Here I will mention only that until the feelings of powerlessness and low self-esteem are confronted, therapy cannot help the client very much in the areas of assertiveness and aggressivity.

Finally, the therapist who has great personal need to be seen as a powerful healer and advocate has difficulty stepping down from that position and permitting the client to move on to the next level of self-sufficiency. This can be a big problem when the therapist finds too little validation and reward for most of his other work in the public clinic, whereas he feels needed and appreciated as an advocate. Unless the therapist can master this tendency, excessive client dependency ensues. Only when the therapist is able to help the client examine the distortions behind his or her feelings of shame and timidity will dependency

gradually be transcended. In other words, the therapist must work through the countertransference brought on by his or her assuming the role of advocate. More on this subject in Chapter 8.

CHAPTER 7
Depression

Angel dust (also known as PCP) is an antidepressant, or so says the user who returns from a "trip" and cares to talk about it. Other users die in violent ways while "high on dust," and still others have such horrifying trips that they do not want to talk about them.

The many young men I know who use angel dust seem to fit a pattern. They dropped out of school early and had great difficulties finding work that they considered worthwhile. They want to be cheerful and yet frequently find themselves feeling sad or lethargic. They take angel dust literally to "get high." Like speed (amphetamines), angel dust stimulates the user to peaks of ecstasy. Better than speed, angel dust causes the user to imagine visions never before imagined while peaking, and bodily sensations that make him or her want to remain at the peak forever. Thus, many users of angel dust are, in effect, attempting to treat their own feelings of sadness, lethargy, boredom, and hopelessness.

Many mothers worry about their children's use of angel dust. It is hard for mothers not to notice, as the user might seem strange for days. I treated a mother for depression while her children were destroying themselves with angel dust. I will tell part of that woman's story here. As I worked with her, I intermittently felt

overwhelmed listening to her stories of grief. I tried to counter these feelings by rigorous attention to the theory and technique of therapy. I will interrupt Velma's story from time to time in order to share with the reader some of the theoretical and technical issues that arose in my mind as I responded to her unfolding story.

VELMA

On the street, many young black people smoke Shermans. Not the packaged kind from France. The Shermans smoked most often in the ghetto begin with a marijuana joint. This is laced (sprinkled) with angel dust, and the laced joint is then dipped in "embalming fluid"—one young man told me it is actually formaldehyde. I do not know if in fact it is formaldehyde, but for the purpose of this discussion, the important thing is that the people who smoke Shermans believe it is formaldehyde. They are embalming themselves while still alive!

The effects of angel dust are varied. One young man smoked a Sherman and later that day entered a Rolls-Royce showroom. He chose an automobile, handed the salesman his life savings of two hundred dollars, and said, "I want that one." When refused the keys, he became vociferous and demanding. The police were called. He was taken to a nearby hospital, protesting all the while that he deserved a Rolls-Royce as much as anyone else.

This man merely spent a few days on a psychiatric ward. Another man, thinking he could fly, jumped from a second-floor window. He crashed on the

cement and broke an arm and a leg. Still another man on angel dust saw a police officer harassing a motorist. He stopped his car, went over and grabbed the officer, throwing him to the ground. The officer's partner shot and killed the man on angel dust.

Even when such disasters do not occur, "dust" causes brain damage. I have seen many depressed young people who have stopped using the drug but complain that their memory is not very good, or that they cannot add and subtract as well as they once could. Some people continue to consume "dust" while controlling repercussions by constantly sitting glued to their TV screens.

When someone seems dangerously out of control "on dust," relatives or friends in the community sometimes give him or her warm milk to drink. It seems to have a calming effect. They say cocaine works as well.

Velma often had to calm two of her three sons down to keep them from doing "something crazy" while toxic on angel dust. But she never had to take care of her son Bill this way. He never even let her catch him smoking marijuana. He was the "good one" of her three boys. At twenty-two, he was working, had completed a year of college and planned to return to get his degree as soon as he had saved enough money. Bill had a baby who was eighteen months old. The baby's mother, Pam, was the woman Bill loved, and though they were not married, he considered her his "ol' lady."

Since Bill was never in the kind of trouble his two brothers seemed to constantly find themselves in, Velma was particularly stunned to hear the news of what had happened to him. He had smashed his car into a large truck at such high speed—perhaps 90 miles per hour—that the fire department had had to cut his body out of the accordioned wreckage. He had been instantly killed and incinerated. Pam had been thrown free of the car at the instant of collision and was alive, although she had suffered head trauma, several broken bones, and some treatable burns.

No one can prove it, but police and friends say that Bill was under the influence of angel dust at the time of the accident. What is known for certain is that Pam stayed in the hospital for several days and then, within two weeks of her discharge, was admitted to the county psychiatric ward with a diagnosis of "acute paranoid toxic psychosis secondary to the ingestion of PCP." Velma had to take care of her grandchild while preparing for her son's funeral.

The burial of a twenty-two-year-old black man is a particularly disheartening event. The family was well known and liked in the community. Hundreds of people attended the funeral, almost all black, and a very large proportion young. Everyone was well dressed. A young woman Bill had grown up with sang gospel songs, and Bill's best friend, a tearful but controlled young man, read the eulogy. Mourners filled the seats of the church and stood three deep around the walls. Everyone was very serious, as if they knew how to conduct the

task at hand, and most had attended other funerals for other young men. Velma cried through most of the service. Various babies cried and young children had to be quieted. I spoke with Pam's father. She was still in the hospital having her fractures and burns treated. I knew he was disabled by a back injury, not working, and quite depressed even before the accident. He said, "I guess she was lucky," and he stood up straight to shake my hand.

Velma appreciated my interrupting my "busy schedule" to attend the funeral. I had been seeing her in individual psychotherapy for over a year. Rather, I had been seeing her off and on over that period. She first came to see me because of depression, and each time her mood lightened a little she dropped out of therapy, thanking me for all I had done for her. Over the previous year, I would see her for four to six weeks in a row, then she would stop keeping appointments for a few months, then she would call me during a crisis and start seeing me again. I was not seeing her at the time of Bill's death, but she called the day before the funeral, told me what had happened, and said she wanted to see me after the funeral.

Velma had first come to see me only at the insistence of her family doctor. Dr. Smith, a woman, was the only person in whom Velma felt she could safely confide. Velma suffered from hypertension and recurring headaches. She had never complained of depression, but her physician felt there was a significant psychological component to Velma's condition and referred her to me. I

immediately concurred with Dr. Smith.

Depression is often masked so that sadness is not apparent, but bodily symptoms, or "depressive equivalents," are obvious. Headaches, backaches, and abdominal complaints often contain an element of depressive equivalence. Low-income people may find it easier to complain to doctors about body aches than to therapists about psychological or emotional pains. This is partly because their life experiences are more concrete and they have read less about psychology than have middle-class or college-educated people. And for them the doctor is someone they trust, someone they hope will cure their physical pains. They are less trusting and less hopeful with the therapist. Velma complained about her headaches and her "high blood." When I asked her about sadness, she said, "I've cried out all that's in me. There ain't no use being depressed anymore."

A common scenario that occurs when a depressed person goes to see a physician about physical pains begins with the physician taking a history, doing an examination, and perhaps some laboratory tests. "I can't find anything the matter with your head, Mrs. Jones, perhaps there's a psychological problem. Are you worried about anything?" The patient hears that the pain is not real, it is psychological or psychosomatic. Then the patient is referred to see a therapist. Too often therapists brush aside the effects of the pain itself on their new client, and rush to uncover the meaning of the pain. For instance, one therapist said to a client who complained of headaches, "Headaches generally mean you are

suppressing your anger, holding it inside, and it builds up like pressure in your head until you feel the pain as a headache." This interpretation is fine for many people, but the timing must be right so it will have meaning for the client.

Mrs. Jones, who just heard from her physician that her pain was "all in her head," is unlikely to be helped much by a therapist giving her the above interpretation on the occasion of their first meeting. She more than likely needs her therapist to be concerned and supportive, to validate and empathize, to hear about her pain in all the detail she wants to describe it, and to say something reassuring such as, "It sounds like those headaches really make your days unpleasant." She needs the therapist to hear that she is hurting. Later there will be time to discuss whether the pain is physical or emotional and what it means.

Velma's doctor had listened to her tales of pain. And I made clear to her I did not think she imagined her pain. Still, she was insulted she had been sent to see me. It took us several sessions to clarify that I did not think she was crazy and her pain imaginary. After that she began to tell me about her sadness.

The first crisis that brought Velma to see me involved her oldest son, Jesse. He was twenty-five at the time, had been sent to prison three years earlier for what he claimed was a "bum rap," and had just been accused of attacking a prison guard with a homemade knife. No one was hurt, but he was about to go back on trial for the attack, and could receive a life sentence for assaulting an officer with a

deadly weapon. “He was always a little wild. I figured he was just getting it out of his system. He’d steal cars, smoke that angel dust, and get into trouble. His father wanted him to get a job and settle down, but Jesse kept saying he wouldn’t work for such awful wages, he was going to make something of himself. He was just a kid when they threw him in prison. He didn’t have a chance in there with all that violence. He doesn’t belong in prison.”

Velma drove several hours each way to visit Jesse every Sunday, whether she was well or sick. She complained that her husband, a retired postal worker, had never helped much while Jesse was on trial. She would visit him in jail or sit all day in court, and her husband would only occasionally accompany her. He was too busy fishing, gambling, drinking, or, she suspected, seeing other women. During that first crisis her husband’s fidelity was not the issue, and she did not want to talk about him. She was too saddened by the plight of her oldest son. She faced some difficult questions, the most difficult of all was “Where did I fail as a mother?” We spent five weeks talking about this, and she gradually accepted some reassurance and support. Meanwhile, the court decided her son was not involved in the assault on the prison guard. He was to remain in the adjustment center—the high-security isolation unit in the prison— but he would not necessarily have to “do more time.” Velma was relieved. The next week she no-showed, and when I phoned she told me she appreciated my help but would not be in to see me anymore.

The next time I saw Velma it was several months later, and her youngest son was in trouble. He had been arrested for shoplifting, but because of previous jail sentences, he could end up in prison. This time when she came to see me, Velma complained bitterly about her husband. He did not adequately support her. She believed he was unfaithful, but he denied this. She felt he was not sensitive to her needs, would not talk about feelings, and in response she felt cold toward him, "Like there's a stranger in my bed," and wanted to have nothing to do with him. Again I supported and reassured Velma, challenging the distortions in her feelings of inadequacy and sympathizing with her sadness. She suffered through the trial, and her youngest son was given probation only. Then she dropped out of therapy again, this time telling me first she appreciated my help and would call again when she needed me.

One day Velma phoned, crying, and asked me if I would go examine Jesse in prison. He was about to appear at a hearing for parole. In his record were several psychiatrists' reports indicating he was a "sociopathic personality" and "violence prone." The Legal Aid attorney who had defended Jesse told Velma that an outside psychiatrist's report might help Jesse's chances for parole. I agreed to go. It took two lawyers almost a month to arrange with prison authorities for my visit.

A visit to a state prison can be a rather intense learning experience. The blatant display of force and guns by the guards, and the thoroughness of the search and security system make it clear to the visitor that this is a world apart. It

is quite striking to see that over two-thirds of the prisoners are black and Chicano. Here is an inside glimpse of the inequality of opportunity in our society, and of one cause of depression for so many mothers in the community.

I met Jesse and performed a psychiatric examination. He was not a sociopath according to any standards I was taught. His empathy, guilt, and sadness seemed appropriate to his situation. He admitted his rage and attached it to his circumstances, his feeling "penned up like an animal." He described the way the guards taunt prisoners who seem strong-willed, wait for them to become angry, and then provoke them to strike out or defend themselves. The tensions mount daily. A guard is never accused of assaulting a prisoner.

Jesse did not seem to me particularly "violence prone," and I am neither inexperienced nor naive about such things. I have seen and been manipulated by sociopaths. I mention this because I believe the psychiatric report I sent the prison authorities was ignored, most likely because they believed their own psychiatrists —who spent less time with Jesse than I did—were more realistic than any outside practitioner. In any case, my report was that Jesse did not have a "sociopathic personality," and that his depression and anger had more to do with the frustration of being incarcerated. My report did no good, and Jesse was denied parole.

Several months passed and I heard nothing more from Velma. Then she

called to tell me her son, Bill, had been killed in an automobile accident. I did not know Bill, but I went to the funeral. Velma did not come in to see me afterward, as she had promised. We talked on the phone and she told me she had her family gathered around her, she was okay, and she would be in to see me when she felt a little better.

Several weeks later I received a phone call at 2:00 A.M. from one of Velma's teenage daughters, who said Velma had taken an overdose of Valium. Velma had been drinking, her husband was out and could not be located, and her two daughters were frantic. I spoke with Velma on the phone. She denied taking the pills but said she wanted to. Her husband arrived at the house just then, and I suggested he take her to the emergency service for evaluation immediately. Velma was not hospitalized and I insisted on seeing her each of the next three days. The struggle now was about life and death.

Generally, someone who is really committed to killing himself or herself does not talk with a therapist about it. Anyone who talks with a therapist must have at least mixed feelings about suicide. It is as if a part of the person wants to die, another part wants to go on living, and the two parts are in battle. It is often very useful for a therapist to point out this simple dynamic to a client considering suicide. It puts the client's internal battle into words that are shared with another person, and it helps the client delineate the forces involved on each side in the battle.

Velma could articulate some forces at the command of the part that wanted to die: She felt trapped in a marriage with a man who would not really talk with her and toward whom she claimed to have no feelings; she felt she had failed miserably as a mother; and she could no longer bear all the pain without adequate love and support. All she could say about the part of her that wanted to live was: "I just want to stay alive for Jesse, until he gets out of prison."

The sessions were difficult that week. Velma required much prompting to discover reasons for staying alive, and each session ended with the negotiation of a contract. I would say, "Will you return tomorrow?"

"Well, maybe." She would look sullen.

"What do you mean? Are you still planning to kill yourself?"

"I can't say." We would continue to talk until she could promise to return for the next session.

Psychotherapy cannot proceed while suicide is a real possibility on a day-to-day basis. I say this not only because such acting out is destructive, but also because more of a longitudinal commitment is required for therapy to work. Underlying distortions cannot be examined when it is not clear if the client will be alive for the next session. Sometimes the therapist must demand a conversation "outside of therapy" to negotiate a contract about life and death issues. "We

cannot proceed with therapy unless you can somehow assure me you will not do anything to harm yourself until we have the opportunity to work through the issues surrounding your wish to kill yourself."

As a general principle, I am very opposed to involuntary hospitalization. But when I cannot get this assurance from a client, and when I believe there are major distortions in the way the client currently views the option of suicide, then I might involuntarily hospitalize the client to permit him or her time to think the issue through. I even might tell a client, "There will be plenty of time later for you to act on the wish to die; for now, I feel I must take control to give you time to decide which part of yourself you want to listen to, the part that wants to die or the part that wants to go on living."

I was worried Velma might kill herself. Her life was hard enough already. Now, the loss of her son and no support from her husband, it was unclear what she might do. But each day I received enough of a commitment from her to take a risk she would appear safely the next day. For her part, she was stingy with reassurances in order to communicate how pained she was, and she wanted me to worry— an indirect expression of anger toward an important other who claimed to care and yet could not prevent the loss of her son or make her situation better.

By the third session that week Velma had given up the idea of suicide. The crisis was over—but her pain continued. While we talked about suicide and the

two parts of Velma, I told her about the dung beetle. Dung beetles live throughout Africa. The scarab of Egypt is one type of dung beetle; there are many other types. The interesting thing about this beetle is that it lives in the dung—and builds its castle there! The spirit of the dung beetle is well known in the ghetto, displayed, for instance, in the form of junk art. It is an inspiring testament to life that so much beauty can be created out of waste. Velma knew about that spirit but said she had forgotten it. The spirit of the dung beetle became the phrase she and I used as code for the part of her that wanted to live.

We spent much time that week and over the following weeks discussing her feelings of inadequacy as a mother. Therapists often tell parents that children grow up in their own ways and that parents usually assume their role to be more salient than it is. And clients usually agree with the therapist's words, but go on wondering somewhere deep within, "How would it have been different if I had raised him better?" This is what Velma wondered as she berated herself without mercy.

By now Velma had become more committed to the therapy, and we had agreed she would continue to see me for longer than the four to six sessions that had been her pattern. The next issue that arose was her dissatisfaction with her husband. It occurred to me that if this man really cared for her as little as she believed he did, he would not have continued to support her financially and emotionally during the period following Bill's death. I began to suspect that her

husband really loved Velma, and that his problem might be that he did not know how to express it. I suggested several sessions of conjoint marital therapy. Velma protested for a while, and then at the end of a session full of resentful talk about her husband asked if I would see him alone and try to talk to him. I agreed to do so.

I had received reports from Velma that her husband, Matt, was antagonistic to her coming to see me. Yet Matt seemed excited to have me listen to his story. He told me how hard he had worked all his life to provide for his family. Since retiring he gambled regularly, and consistently brought home profits. He told me his family needed that money to support their life-style, and yet Velma was unappreciative and only complained that he stayed out nights gambling. He had greater difficulty finding words to tell me he did not understand his wife's moods and felt totally powerless to do anything to please her. He was willing to attend conjoint sessions, so I arranged to see the two of them together.

The next week I found myself sitting in a room with this middle-aged black couple, listening in turn to each of their stories, feeling as though I was concurrently in two separate rooms meeting with an individual in each. They never looked at each other, they talked about each other in the third person, and they never responded directly to each other about anything. I pointed this out—to no avail. Matt seemed gratified that I listened. Velma seemed hopelessly stuck with anger she refused to verbalize. In the second and third sessions she began to

verbalize it. She was resentful that during their boys' teenage years, while her husband was busy working, she had to wait by herself at principals' offices, court procedures, probation hearings, and jail visiting rooms. "They needed their father and where was he?" She still would not look at him. She denied she was angry about this any longer, but at least she had stated her complaint. He protested to me he had been busy working. I pointed out they seemed to be blaming each other for the awful things that had happened to their family. This helped a little, and they glanced at each other.

I asked them about their backgrounds. They reported they had come from the rural South. He was twenty, she sixteen when they married. On both sides their parents remained together. Velma's mother had died six years earlier. This was about the time their boys began to get into trouble, and about the time they both agreed their marriage "went bad." We talked about mourning. We talked about love, and the kind of support they both needed from each other. We talked about the possibility of divorce. He insisted he could not give up gambling. She insisted she would never forgive him. The conjoint sessions ended with little clarity about what was to become of their marriage.

Velma was more animated than usual when she returned for further individual sessions. She had been able to air her dissatisfactions with her husband. Whether or not they remained together, she had begun to untangle the knot of personal feelings that kept her immobilized and confused about what she was

feeling. Depression is a tangle of feelings—hate, sadness, guilt, fear, anxiety, etc.—a tangle that gets so tight all the emotions seem to fuse together, and the person becomes overwhelmed, lethargic, and lost. When one emotion begins to stand out and become recognizable, untangling becomes possible. Velma ventured to verbalize her rage toward her husband, paving the way for other feelings, such as guilt, to emerge from the tangle.

Depression generally involves significant guilt, and this guilt is connected intricately with the low self-esteem that also accompanies the depression. According to psychoanalytic theory, guilt and lowered self-esteem occur because of an attack by an overgrown or overly harsh superego on the ego. This means that guilt arises because a person internalizes an image or memory of a harsh critical parent and from then on is critical of himself or herself in the parent's stead. Lowered self-esteem arises in part because a person has internalized an image or memory of a parent or parent's expectations that is too good, too powerful, or too ideal in some way for the person ever to aspire to emulate. In other words, when one's ego ideal (part of the superego) is out of reach of one's actual capabilities, one tends to consider oneself a failure and thus feels low self-esteem.

Velma's mother was poor, a sharecropper, and she tolerated a man who gambled, drank, and was probably unfaithful, too. Yet she raised ten healthy children, all but one still living, and all but two involved with families of their own.

"Her sons didn't mess with drugs, and you didn't find any of them going to prison." Velma refused to distinguish her childhood days on a farm from more recent times in an urban ghetto. She used her idealizations of her childhood happiness and her mother's achievements as a standard against which to measure her own current situation, and judged she had failed miserably. We had to reach a point of lamenting the way "times have changed" for her to suddenly realize how unemployment and angel dust wreak havoc in boys' lives today, but were not hazards in her mother's time and locale. She announced her realization to me by beginning one session: "These youngsters nowadays . . . they gotta survive somehow. . . . There ain't no jobs—so they steal. They take, they gotta survive somehow. George's [her third son] pay is pitiful. He can make more on the street."

Velma seemed to cope with her depression best when involved in caring for children or listening to other people's problems. She had two grandchildren in the house much of the time, provided child care for several other children of working mothers, and listened to problems presented by two or three people per day who stopped by because they needed her sympathy or advice. A problem with compensating for depression by being a mother to others is that resentment—"No one ever takes care of me like that"—builds up. Velma did admit that she was beginning to resent "always having to be a shoulder for people to cry on," and not having anyone whose shoulder she could cry on. She began to express grief related to her mother's death.

Then came news that Pam, the mother of Velma's grandchild, had been brutally tortured and raped while under the influence of angel dust. Velma had accepted Pam as a daughter-in-law, and felt conflict about going to the hospital to be with her. "It's just too much. I've been through enough already. ..."

With a depressed client, the question arises, "How does the current loss reenact for the client a more formative early object loss?" In other words, what early loss—such as the death of a family member or a parental divorce—set up the prototype for all this client's later bouts of depression. Perhaps if the therapist can identify that early loss and help the client work it through in some new way—for instance, with sadness and mourning rather than with immobilizing depression—then the more current loss might be tolerated better and with less depression.

I searched for early object losses in Velma's childhood. Her father drank and her parents fought, but Velma remembered being her father's favorite and that he kept the family well fed and relatively happy. I explored her rivalry with her mother and asked if open hostilities ever arose. She said they argued, but generally family life was permeated with love and caring. I knew she was idealizing, but still I had not found any early object loss severe enough to explain her current depression.

Velma suffered through arrests of all three boys, the imprisonment of one,

and the violent death of another. She was fearful that her two remaining sons would always be underemployed and never happy. She was frightened of leaving her husband and unhappy remaining with him. She had spent her entire adult life raising a family and she felt ill prepared to cope with any other kind of activity in a world too fast, too violent, and too urban for her. And now her daughter-in-law had been brutalized and she had no strength left to comfort her. Even someone with an idyllic childhood would have problems coping.

I have woven into this presentation of Velma's story various theoretical understandings of depression—of depressive equivalents, of suicide ideation, of depressive immobility, of the internalization of harsh punitive parental images, and of early object loss. These theoretical understandings are merely tools the therapist utilizes in interacting with a depressed client and attempting to facilitate change. But what do I really understand of this woman's sadness? What does all this theory explain?

Many people have objected that psychodynamic psychotherapy is not useful with low-income clients because current stresses, such as poverty, and current traumas, such as death and incarceration, are too overwhelming to permit the client space to examine the transference or reevaluate events from early childhood. There is a kernel of truth in this objection. Current life stresses can be so overwhelming that a therapy concerned mainly with subtleties of feeling and perception becomes irrelevant. But, at the same time, a therapist well versed in

theories and techniques of examining psychological subtleties is that much better prepared to practice therapy with a client who is overwhelmed by current life stresses. In other words, the theory and technique often help to prevent the therapist from losing the way in the midst of the pain and chaos.

Velma continued to unravel the tangle. One day she seemed embarrassed as she told me: “You’re going to think this is awful, but I’ve had the thought the past few days of killing my husband—I’d get off because they’d say I was crazy.” She laughed, but only to hide her fear. This fantasy frightened her, probably because she was not certain she would be able to draw the line between fantasy and action. She was afraid of the anger she had been suppressing for so long. I helped her draw the line, pointing out that she was permitted any fantasy she could invent, but action was a very different matter. We talked about her fear that she would not be able to control her rage. She told me how once, several years before, she had picked up a kitchen knife and screamed at her husband, “Don’t you dare come near me!” They both stood glaring at each other in the kitchen, stunned by the intensity of emotion that had flared up between them. She had not outwardly expressed anger toward him since.

We talked about her memories of good times with her husband, and about the positive feelings mixed in with her anger toward him. In the process, she was able to tell me she was angry at me, too. She no longer needed to no-show to express this. She was angry because I had not sufficiently taken her side in the

conjoint sessions with her husband.

The next week Velma told me she was very worried because she woke up crying—she could not control herself. “What’s the use of crying—it won’t bring my boys back to me—it won’t do any good!” I agreed it would not do any good in that way, but said that holding back the tears made her feel worse, and that crying, when it felt natural, permitted her to better cope with the pain. She cried during that session and intermittently in the following ones.

Meanwhile, Velma was losing weight, and her physician reported that her blood pressure was significantly lower. There was not necessarily any direct correlation between her blood pressure and her capacity to express emotions. The mediations are complex, and certainly include her following doctor’s orders better when less depressed, and her losing weight.

Velma called me early one morning, quite anxious, to report a dream. She dreamed that large rats were crawling all over her house and that nothing she or her husband did seemed to stop them. I have not said much about the interpretation of dreams, yet dream interpretation is an important part of my work. But in the public clinic, work with dreams is a relative luxury. There are so many material hardships to discuss, and so many issues involving trust and motivation, that by the time the therapist and client are able to discuss dreams, the therapy is already well under way.

Alternatively, a client might offer a therapist a dream in their first encounter as a test. “Hey, Doc, I had this dream I was wondering about, and I’d like to know what you think of it.” The client is flirting with the idea of seeking therapy, and is watching carefully how “Doc” handles the situation. During this kind of curbside consultation, the therapist must be sensitive to the client’s fear that the therapist will be able to read his mind. Thus, the therapist’s interpretation must not be so deep that it exposes intimate issues the client is not ready to share. Yet the interpretation must be deep enough for the client to see that the therapist does know something and might be a safe person to explore some conflicts with.

In Velma’s case the therapy was well underway, and we could explore her dream in some detail. She associated the rats with her daughters and told me of her feeling that they were eating her “out of house and home.” They were also unappreciative and disrespectful. We linked her family associations to the social reality, the meaning of rats in the ghetto, and the pains she experienced in connection with racism and poverty. We then examined her feelings of helplessness, and her disappointment in her husband’s power to make things better.

At this writing, after two and a half years of intermittent therapy, Velma continues to see me. She still discontinues our sessions periodically, only to return several months later. She has decided to remain with her husband, and their relationship is peaceful, if not intense. She is actively developing a support

network composed of close friends. She works part-time caring for an invalid mother and her young children. The pain and hardship associated with her poverty continue, but she is much more capable of differentiating the part of her plight that arises from social inequities, the part related to her husband's inadequacies, and the part that is caused by her own conflicts and distortions. Now, instead of remaining trapped in the numb, tearless, gray immobilization of depression, she periodically cries and feels intense sadness, and then goes on to energetic activities and even moments of joyful exuberance.

CHAPTER 8
Transference and Countertransference in Black and White

Transference is the unconscious distortion the client introduces into the therapeutic relationship by displacing onto the therapist feelings, ideas, and memories that derive from or were directed toward previous important others in the client's life—for example, the client acts toward the therapist as if the therapist were his or her parent. *Countertransference* is the equivalent unconscious process on the therapist's part. Laplanche and Pontalis define countertransference as "the whole of the analyst's unconscious reactions to the individual analysand—especially to the analysand's own transference."[42] They point out that the therapist's countertransference can be exploited in the service of the therapy, provided that the therapist is aware of it, usually as a result of a personal therapy or analysis. This is what Freud was suggesting when he wrote: "Everyone possesses in his own unconscious an instrument with which he can interpret the utterances of the unconscious in other people."[43] In other words, the therapist ideally has already examined his or her own transference toward a personal therapist and is thus able to continually reexamine his or her countertransference toward clients and their transferences. The client's transference and the therapist's countertransference feelings and distortions become the best clues to the therapist about how to proceed during the therapeutic process.

When the therapist is white and the client black, the process becomes more complicated. How is the therapist to distinguish distortions due to transference and countertransference from concrete reflections of realities of race relations in our society? For instance, when is the black client's rage toward the white therapist a displacement of rage toward a parent, and when is it a legitimate reaction to a racist statement the therapist has just unknowingly made? I will discuss the interaction of white therapist and black client because I am most familiar with this constellation. Others have written about the black therapist's experience with white clients.[44] Equivalent issues arise when men treat women, when heterosexuals treat homosexuals, or when white therapists treat any other minority member. Whenever a member of the dominant group treats a member of a dominated group, the isolation of transference and countertransference distortions from all the other complications of relationships is a difficult task. Yet unless the task is successfully accomplished, interracial therapy cannot usefully proceed. The black client too often feels that the only response he will get from the white therapist when he complains about the therapist's racial bias is an interpretation of the transference aspects of his anger. No wonder he no-shows or drops out of treatment.

The first problem for white therapists is often to admit that a problem exists. Assuming that the only kind of racial bias is outright bigotry, many white therapists prematurely close the question by insisting, "I am not a racist!" Black therapists sometimes respond with the same forceful insistence: "Whites should

not treat blacks!" With the discussion thus polarized, both are proved correct, and interracial therapy is impossible. The white therapist assumes that the black client's charge of racism is unfounded, or perhaps a reflection of the client's paranoia. The black client observes the white therapist's value-laden attribution of pathology and this confirms his or her view that white therapists should not treat black clients. And since there are not sufficient black therapists to meet the demand—a reality caused by racial inequities in our educational system—very many black clients remain unserved by competent therapists.

I believe it is not useful for whites to entirely disclaim any racial bias in themselves. Our society has been plagued by racism for centuries, and it is unlikely that any white person living and working in this society can be untouched by such a deep-rooted and widespread phenomenon. Rather, I think we should remain open to the possibility that one or another attitude, pronouncement, or action on our part might contain some element of racial bias, however subtle or unaware; and that we struggle constantly to become aware of and transcend these scars of our social and personal histories. This is not to say that I attribute conscious malevolence to all whites. Bigotry is not the only form of racism; it is merely the least subtle and most self-conscious form. Racial bias appears in many forms and many degrees of subtlety. The bigot consciously hates blacks and means to do them harm. The concerned white attempts to alleviate the suffering of blacks, but may act so paternalistic toward them in the process that blacks feel even more offended. The more sensitive white may sincerely believe that he or

she treats all people as equals but in fact chooses to live among and relate almost exclusively to other whites. Racism in our society is reflected in outright bigotry, paternalistic caring, benign neglect, and innumerable other stances on the part of whites.

Therapy does not occur in a vacuum. Interracial therapy occurs within a society plagued by racism, and the therapeutic relationship necessarily reflects the larger societal tensions. When a black client confronts a white therapist with the charge of racism, the therapist should be willing to explore the possibility that he or she has adopted, however momentarily, a biased stance toward the client before interpreting the client's transference distortions. If the therapist is not prepared to be self-critical when confronted on a biased assumption or statement, the discerning client cannot develop enough trust in the therapist to proceed. But if the therapist is too compliant or self-critical, he or she cannot confront the client about what actually is a transference distortion on the client's part. The therapist must constantly distinguish between the realities of race relations in the consulting room and the distortions of transference and countertransference that occur between therapists and clients of any race.

While a personal psychoanalysis or therapy helps to prepare the therapist to examine transference and countertransference, it does little to prepare most white therapists to examine interracial dynamics and tensions, since most white therapists have undergone their own personal therapies at the hands of other

white therapists. Race might be an issue when white encounters white in therapy, but the issue does not have near the immediacy it has when one party to the therapy is black. When a white client discusses a black person with a white therapist, the therapist is likely to use the black person's presence in the material to demonstrate a projection or fantasy on the part of the client. For instance, the therapist might interpret that a black man in a white male client's dream represents a shadow figure, the "other," who symbolizes the denied and projected mental contents that the client cannot accept in himself. Such an interpretation may be very apt. But the issue of race lacks the concrete immediacy it has in the lives of black people who must live as a minority in a society where racism remains ever present. Since interracial dynamics are not very thoroughly explored when white client sees white therapist, a white therapist is not very well prepared by personal therapy to work through interracial distortions that later develop with black clients. There is another kind of experience that provides whites with valuable lessons about interracial relations.

I believe there are significant parallels between the interracial dynamics that occurred in the civil rights movement of the 1960s and some of the dynamics that commonly occur in interracial therapies. For instance, an important lesson for whites from that movement was that racism often creeps into the attitudes and actions of even the most progressive and free-thinking activists. No white person in our society can be entirely free of racism. The way to transcend racism or racial bias is not to deny its presence but to be constantly alert to its possible effects and

to be open to feedback, particularly from black activists, so that biased stances can be overcome. The process is continuous and without end. The point is not for whites to become permanently free of all racial biases but to proceed with the process of struggling against racism.

I can identify five somewhat distinct stances that whites have taken toward blacks before and during the civil rights movement: bigotry, neutrality or "color blindness," paternalism, unquestioning compliance with black power, and collaboration and mutual respect. There have been others. I will describe these five as illustrative, and I certainly do not mean to imply they always occur, or that they occur in any certain sequence. Each of the stances I will describe contains some potential for bias, but the degree of bias shifts from stance to stance, the level of awareness of bias shifts, too, and different possibilities emerge for successful collaboration to end racism.

White therapists discover at various times that they have adopted a stance toward a black client that resembles one or another of these five stances. It is certainly neither necessary nor desirable in psychotherapy to focus constantly on the issue of race. But when race does seem to be an issue, or when the therapy seems to be obstructed and the issue is not clear, it is often useful for the therapist to explore the possibility that his or her racial biases are causing the obstruction. If the white therapist can identify his or her stance toward the client as approximating one of the five I describe, then he or she has a better chance of

distinguishing the biases that are part of that stance from the transference and countertransference that are also in play.

Stance 1: Bigotry

This is the most blatant and malevolent form of racism and the form most people connect most clearly with the word. Hangings, Klan rallies, segregated lunch counters, racial epithets, and other violence against blacks are associated with bigotry. The sadistic white policeman or prison guard acts out this form of racism in brutal attacks on black people. Prior to the civil rights movement, this type of racism took legal form as segregation. Today it is less legal, but still prevalent.

There is not much good and plenty of harm that can come of therapy when the therapist is a bigot. Alexander Thomas and Samuel Sillen have written about the effects of racism on the psychiatric view of black people:

> Even in the days of slavery, white supremacists found it expedient to unfurl the prestigious banner of science. . . . The black man, it was repeatedly claimed, was uniquely fitted for bondage by his primitive psychological organization. For him, mental health was contentment with his subservient lot, while protest was an infallible symptom of derangement. Thus a well-known physician of the ante-bellum South, Dr. Samuel Cartwright of Louisiana, had a psychiatric explanation for runaway slaves. He diagnosed their malady as *drapetomania,* literally the flight-from-home madness,
>
> "as much a disease of the mind as any other species of mental

alienation."[45]

The inequities of slavery, segregation, and racism have been rationalized through the years by a series of "scientific" findings about deficiencies or illnesses in black people that account for their lower status in society: depending on the "scientist," they have smaller brain sizes, genetically determined lower IQs, personalities permanently marred by slavery and racism, destructive patterns of sex and family life, or a necessarily greater incidence of severe mental disorders. Sillen and Thomas trace the history of white racists' attempts to "blame the victim," and expose the fallacies of the false science used to rationalize racism.

The bigot is unable to practice therapy constructively with black clients. Viewing black people as innately inferior, sexually promiscuous, or violence-prone, the bigot can only attempt to control or restrain the client's impulses or tendencies. When the bigot is in a position of significant power or authority—for instance, as psychiatrist in an outpatient clinic or as nurse or technician on a state hospital ward—the black client or patient is likely to be medicated excessively or handled brutally.

When the black client protests against overtly discriminatory or brutal treatment, the protest and anger are often viewed as further signs of mental disorder. Medication dosages are increased or restraints further tightened. No real therapy can occur when such blatant misuse of power and insensitivity to clients' needs accompany the racist attitudes of therapists. There is no use talking about

transference and countertransference distortions when the reality is racism and the client's angry protests are clearly reality-based. The only way to work through this form of interracial relations is via a social struggle to end racism in our society.

Stance 2: Neutrality, or "Color Blindness"

There were many whites in the North and South who were not bigots but lived in all-white communities, benefited from the school and job preferences given to whites, and did absolutely nothing to correct the blatant injustices of segregation. Perhaps they convinced themselves that "Segregation is wrong, and I would never be a racist, but there is nothing I can do to change it." These whites proclaimed themselves to be "neutral" in the matter of race relations, or "color blind" when it came to personal relationships, insisting that they themselves would never discriminate; yet their silence was complicity, as blacks were hanged or forced to sit in the back of the bus.

According to Sillen and Thomas, "the illusion of color blindness" occurs when "the impact of racism on personality is considered superficial and subordinate to psychodynamic forces that are presumed to be universal. . . . The failure to grasp the social context of behavior results in interpreting behavior as deviant even when it is realistic and normally adaptive. The black man's justified suspicion of white people is mistakenly identified as paranoia pure and

simple."[46]

The white therapist who, like the neutral white who did nothing to end segregation, believes that racism is less of a problem in our society than black militants would have us believe tends to view the intense concerns of black clients about racial issues as reflections of pathology. One of the realities of racism in our society is that the minority victims experience racism's effects more directly than do the majority. The comfortable and secluded white middle-class suburb is well buffered from the daily interactions of white policemen with black youths in the ghetto. As a white professional, I can drive to work in the ghetto secure in the knowledge that the police are there to protect me. But black professionals tell me that they are periodically stopped by police while driving to work, made to get out of their cars and stand against the wall and searched because they do not look as though they belong in the fancy car they are driving. Of course, when they produce their ID, they are released. But what if a black person does not have the identification of an employed professional? The point is that the black experience is very different from the white one.

Of course, when the white therapist does not give sufficient attention to the differences, he or she is likely to feel that the black client is exaggerating, obsessing, or becoming paranoid. When the therapist offers an interpretation about this, a vicious cycle tends to occur. The therapist is interpreting what he or she believes to be the client's excessive or distorted concern about race. For

instance, the client might repeatedly complain that racism is the reason he or she cannot find a satisfactory job. The client feels that a black person would understand this concern, and so feels it is this white person's prejudice that prevents him or her from understanding the black experience. The black client might then decide to be quiet and not expose what he or she is really thinking, in which case the therapist will probably think the client is resistant; or the client might express disappointment in or anger toward the white therapist, in which case the therapist will probably search for a transference interpretation. In either case, the communication gap widens, and neither therapist nor client is able to explore the reasons they differ so in their assumptions about the importance of racial issues in therapy.

A prerequisite for a successful interpretation is that the therapist and client implicitly or explicitly recognize that there is an event, a statement, a feeling, or a distortion that warrants interpretation. If the therapist has not established that the client is in fact angry, the therapist's interpretation that "you are angry because ..." is going to be completely useless or dismissed with the client's denial, "I am not angry." The therapist must first establish that the client is angry, and then interpret possible causes for the feeling. Likewise, if the therapist is to interpret a distortion in the client's perceptions, he or she must first establish that the distortion exists. If the therapist feels the client distorts reality by focusing excessively on race (that is, using race as a defense) or by becoming excessively angry, the therapist must first establish that this distortion exists. If the client

disagrees and claims the racial focus is not excessive or the anger not inappropriate, then it may be that the differing perspectives of therapist and client result from their different racial experiences, and not from any transference distortion.

The difficulty for the white therapist who espouses neutrality or "color blindness" stems from failure to recognize the omnipresence of racism in the black client's daily life. Marlin Griffith and Enrico Jones place high on their list of suggestions to white therapists the need to become familiar with black culture and life-style:

> Without such familiarity it is often exceedingly difficult to empathize accurately and to distinguish the realities of the black client's experiences from dynamically determined distortions. An understanding of black culture cannot, however, be attained from treating a few black clients or gleaned from the largely distorted images of mass media, or even from psychological or other social science literature. It must be acquired outside the consultation room, through exposure to black literature, music, and public figures, and black common folk. Longer-term relationships with black peers are also essential.[47]

The white therapist's "color blindness" is a denial of the effects of racism and black culture in the black client's experience. The therapist's denial can serve to collude with the client's denial. For instance, if the client needs to deny his or her blackness in order to feel competent and lovable in a white-dominated world, he or she also will tend to deny racial issues and tensions and attempt to conform to what he or she believes is the therapist's ideal of a "good" white client. Both will

collude in the "color blindness" and will cover up the client's self-devaluation in terms of black identity.

I had seen a young black man for three or four sessions before I remarked that we never seemed to talk about the fact that he was black and I was white. I hardly ever wait that long to bring up the topic, but in this case the client was very knowledgeable about psychology and had filled the early sessions with a flood of symptoms, dreams, and seemingly insightful self-interpretations. As soon as I mentioned race, he responded: "How do I know you're not really black, just like me?" The ensuing discussion was very fruitful. This man was very concerned about power and status in the world. He had gone through a phase of black militancy and believed wholeheartedly in "the cause." But now, at thirty-three, he was attending college and reading psychology books in order to consolidate some success in a professional career. Our exploration of his need to deny the racial difference between us led to our uncovering his shame about coming to see a white man for help, his depression, and his sense of a "mid-life crisis." He wanted to halt his youthful rebellion and start to collect some rewards from what he called a "white is right society." We were able to begin to talk about his need to deny the part of himself that had emerged during his militant phase, and about the possibility that he might integrate his earlier black identity and aspirations for liberation with his current need to succeed in the world. I had been colluding in "color blindness" during the first three or four sessions. Only after the illusion was confronted could he and I begin to work on the transference and

countertransference issues that also played some part in our collusive denial.

Usually, white therapists who are convinced of their neutrality, or "color blindness," remain in private practice where they are very willing to see black clients, but few want to come in for therapy. Reasons for this include their location and their fees, but their sense of neutrality prevents them from understanding that such factors skew their client population and decrease the likelihood that they will treat many black people. These same therapists, when they work part-time in public clinics, are astonished to find that black clients no-show often, and assume this is because they are not motivated or sophisticated enough.

Stance 3: Paternalism

The early white activists who supported black protests were largely college students. In the mid-1960s they went to the South to register voters, to protest segregation, and to organize for liberation. But they organized and protested in their own ways, ways they had learned from books and experiences in white organizations and institutions. They gave leadership to the early civil rights movement, but in their leading they often became paternalistic. Black psychiatrist Alvin Pouissant once characterized this white paternalistic approach as the "Moses syndrome." White college students went to the South in order to lead black people to freedom. Many blacks and whites began to talk about "guilty liberals." There was too little respect for the possibility that black people might want to lead

their own fight for freedom, and in their own way.

As long as the do-gooder white therapist is available to assist the black client, the paternalistic approach seems to work fine. The client becomes dependent, the therapist wishes the client well, and both join forces to make the client feel better temporarily. But when the therapy ends the client is probably no better off than when it began, and perhaps worse, because he or she has become less self-reliant in the process.

Griffith and Jones suggest that the white therapist should adopt a very supportive role early in interracial therapy:

> Some black clients may expect more in the way of tangible benefits in the early sessions than their white counterparts. Lower-income black clients frequently bring to therapy pressing reality concerns which must be attended to before underlying psychological issues can be addressed. Helping the client with these reality concerns may require nontraditional practices, for example, giving direct advice or encouragement or intervening with community agencies.[48]

I have described in Chapter 6 the place of advocacy in psychotherapy, and in Chapter 5 I discussed the usefulness of the therapist's initially fostering dependency in group psychotherapy. The critical qualification in both cases was that the therapist must then help the client become aware of dependency and facilitate progress toward self-sufficiency. The therapist who adopts a paternalistic stance toward black clients is unable to facilitate this progress, and

the therapy remains very limited in spite of the therapist's well-meaning attempts to help the client.

Paternalism might be reflected in the therapist's imposition of white values on black clients. The therapist has some need to be looked up to and appreciated for his or her "unselfish" ministrations. The client either conforms to the therapist's expectations and thereby adopts the therapist as an ideal or model of a mentally healthy person to some degree; or the client refuses to comply and conform, the therapist is hurt by this "ingratitude," and some kind of hostile exchange occurs, either overtly or covertly.

Paternalism can be less obvious or more subtle. I was paternalistic toward Anna, the forty-two-year-old black woman I described in Chapter 4, when I tried to impose my values on her by encouraging her to stand up to her husband. I frequently find that my ideas about feminism conflict with black clients' ideas about how couples should relate. One black woman told me, "I don't believe in all that feminism stuff, I just want to make him happy." It took some effort on my part to continue therapy with her, especially when I found I was continually trying to impose my values on her. I was aware that I liked being in the role of the more liberated man in comparison with her husband, and I had to be careful not to let my unconscious jealousies and rivalries interfere with my helping her to live her life the way she wanted to.

The white male therapist encounters a certain dilemma periodically in treating a black woman. The difference in skin color does provide a convenient context for projections. The client might split her ambivalent feelings toward men, directing her appreciation of men who are sensitive and empathic toward the white therapist and her resentment about male insensitivity and inability to talk about feelings toward her black mate. The situation is a setup. If the therapist has some unconscious need to be preferred by the black woman, he might foster such splitting, and the process is not confronted until it explodes in the mate's jealousy or the client's sexualized seductiveness toward the therapist. An equivalent dynamic occurs between female therapist and male client. Therapy might be prematurely terminated or a subliminal seduction might proceed for some time, but in either case the client's splitting and very real conflicts about her primary intimacy are not explored and resolved. Only when the therapist is aware of his part in this interracial drama can he make the necessary interpretations and help the client explore her conflicts and distortions.

There are other ways in which a paternalistic therapist might fail to respond to a black client's needs. If the therapist assumes that all or most of the client's problems are due to the inequitable and racist social conditions in our society—an assumption that is progressive only in an extremely mechanical way—then the therapist will tend to ignore the client's personal contribution to his or her plight, and ultimately the therapist will be denying the client's uniqueness as a person. The client will be reduced to a mere casualty of racism in our society. Sillen and

Thomas criticize Kardiner and Ovesey's 1951 book, *The Mark of Oppression*, on this account. They claim that this book generalizes and "defines the black's 'basic personality' in terms of the stigmata of his condition in America. The stress of racist discrimination has produced not merely an inerasable mark but a deformity in the black man's psyche."[49]

When the therapist denies the client's uniqueness in an effort to be supportive and to prevent the client from blaming himself for his or her oppression, the therapist is unable to confront and interpret the client's actual unique defenses, distortions, and self-destructive behaviors. In the same way that the "guilty white liberal" civil rights activist attempted to help black victims of racism, the paternalistic therapist attempts to explain away the client's pain and plight. The client understandably feels unheard as an individual. Sometimes clients begin to act crazier or complain of worse symptoms merely to let the therapist know that they exist and suffer as unique individuals.

Finally, the paternalistic therapist cuts off a very important moment in any therapy—the moment of the client's wrath. How can a client be angry at a therapist who is so good, so understanding of the effects of oppression, and so giving in the struggle to correct the evils of racism? Or, when enough rage builds up in the client, who has suffered through the therapist's efforts to homogenize him or her as one of the oppressed minority, the rage can be explosive, just as it was in the black power days of the civil rights movement.

Stance 4: Unquestioning Compliance with Black Power

Stokely Carmichael proclaimed black power in the late 1960s, yelling, "Honkie, go home!" White freedom fighters were confronted about their paternalism. Black people would decide on the politics and strategies of their movement. Many white people left the movement or withdrew their financial support, charging black activists with "reverse racism," discrimination against whites who were only trying to help. But many whites remained in the movement, agreed there should be black leadership, and tried hard to find a place for themselves as supporters of what they recognized as a necessarily black-led movement. These activists and supporters who remained bent over backward to support black leaders and black power, and in the process sometimes failed to criticize even when they were aware of important mistakes. This is what I mean by "unquestioning compliance."

The exchange between the white therapist who insists "I am not a racist!" and the black therapist who insists whites should not be treating blacks is not a dialogue at all. Neither hears the other. The black power phase of the civil rights movement was a phase of racial separation. Black militants told white activists, "Go home and organize your own white brothers and sisters to struggle against racism."

The separation had some very positive effects. A new black identity evolved. "Black is beautiful." Black writers and researchers described their own culture and

history instead of relying on sympathetic whites to chronicle their experience. In psychology, the emerging black identity was paralleled by studies of the black child, the black family, the black personality, and the black in therapy. William Grier and Price Cobbs, authors of *Black Rage*, described that rage as strength and pride rather than as psychopathology. They described a "cultural paranoia," a "cultural depression" and a "cultural masochism":

> Too much psychotherapy involves striving only for a change in the inner world and a consequent adaptation to the world outside. Black people cannot abide this and thoughtful therapists know it. A black man's soul can live only if it is oriented toward a change of the social order. A good therapist helps man change his inner life so that he can more effectively change his outer world.[50]

Black scholars criticized the racist biases of IQ tests, tracking in the schools, and claims that blacks had innately less intelligence than whites. The pride of black culture and the explosive entry of black stars and black stories into the media provided an excellent context for black therapists to prove they could reach and help a population of black people who had never been helped by psychotherapy before. Frantz Fanon, in *Black Skin, White Masks*, provided a theoretical critique of "The Negro and Psychopathology":

> A normal Negro child, having grown up within a normal family, will become abnormal on the slightest contact with the white world.. . .
>
> One can hear the glib remark: The Negro makes himself inferior. But the truth is that he is made inferior. . . .

> For the Negro there is a myth to be faced. A solidly established myth. The Negro is unaware of it as long as his existence is limited to his own environment; but the first encounter with a white man oppresses him with the whole weight of his blackness.[51]

Inspired by Fanon and others, black therapists began to stress black pride and focus on the strengths of black folks, black families, and black culture, rather than on their pathology.

As I mentioned earlier in this chapter, there were not enough qualified black therapists to go around. Though a literature about black therapy and research has rapidly evolved, the majority of black people who need psychotherapy must still wait in crowded waiting rooms, take more than their share of numbing medications, and see white therapists who might have little competence or little love for black people. In other words, the civil rights movement has largely passed, and the plight of most black people has scarcely improved.

Concerned white therapists, like white activists confronted by black power, have tended to respond in two ways. Some have accepted the black leadership that emerged, and some have picked up their marbles and returned home to private practice, grumbling about the lack of appreciation for their selfless services.

Some white therapists who remain to follow black leadership and continue to practice therapy encounter difficulties in that practice. For instance, they might

hesitate too long to confront a black client or interpret a client's acting out. Or they might fail to establish limits with a client because they identify so strongly with the black client's need to lead and take power. This leaves the client feeling that there is no one in the therapist's seat to lock horns with and may even cause him or her to fear that the therapist cannot help him or her contain the rage that he or she feels mounting within. Unless the therapist can separate his or her political support for black political leadership from his or her therapeutic task with a particular black person who needs help establishing personal boundaries, the therapeutic venture can become a painful failure.

This dynamic, when it involves relationships between staff members in the public clinic or relationships between trainers and trainees, can have other negative repercussions. White staff might deny their own skills and talents in order to make room for more black leadership, and instead of black and white staff pooling their skills to provide clients with the best services possible, the whole staff functions at partial capacity while everyone waits for someone else to know what is to be done. Training programs sometimes sacrifice technical and clinical depth and turn a disproportionate amount of energy toward social and cultural issues, because it is white staff who know more about the former and black staff who know more about the latter. Again, everyone is trying so hard to keep political tensions to a minimum that the department fails to gain the maximal effect of pooling everyone's best effort.

The clinic or department that survives a phase of black power usually gains much from the experience, and it is in such a clinic that optimal results are possible when white therapists treat black clients. I believe Grier and Cobbs explained why:

> The essential ingredient is the capacity of the therapist to love his patient —to say to him that here is a second chance to organize his inner life, to say that you have a listener and companion who wants you to make it. If you must weep, I'll wipe your tears. If you must hit someone, hit me, I can take it. I will, in fact, do *anything* to help you be what you can be—my love for you is of such an order.
>
> How many people, black or white, can so open their arms to a suffering black man?[52]

Stance 5: Collaboration and Mutual Respect

The white activists who remained in black-led movements— which by now involved many more issues than civil rights—began to work out better ways to collaborate in the struggle. They and black activists began to recognize their common interests and the need to change a system that precluded real freedom for black and white alike. Some proved to black activists that they were reliable by consistently working to keep the movement going. Then they were able to speak out on issues of politics or strategy and hope to be heard by blacks and whites. Constructive criticism was finally possible. Black activists had asserted and satisfied their need to be heard and followed, and white activists had proved they could listen and follow. Both realized they had interests in common. Now it

became possible for blacks and whites to criticize each other and even argue, hopeful that the arguments would not end their more firmly established alliance. A mutual respect has arisen between white and blacks who-have learned to “take leadership” from each other.

I will present three illustrations of collaboration and mutual respect in interracial relations, involving therapists, clients, and other staff at a public clinic.

1. A forty-eight-year-old black woman arrived at a group session and, while someone else was talking, leaned over to show another black woman something in her purse. The two of them whispered excitedly to each other, then sat up and paid attention to another group member who was discussing a problem with the whole group. The group had been meeting weekly for a year, with myself and my cotherapist, a black paraprofessional man. All nine client-members attended this session, so eleven people were present, divided almost evenly between black and white, men and women. Later in the session, the woman who had shown her purse to her neighbor began to tell of her current difficulties. A man she had been seeing off and on for the past eight years was threatening her with bodily harm. He had a drinking problem. She had told him two weeks earlier that unless he stopped drinking, she would refuse to see him again. Since then, on several occasions, he had come to her apartment at 1:00 or 2:00 A.M., very drunk, and demanded loudly to be admitted. She refused, afraid of what he might do in his condition, and he proceeded to bang on the door and break several windows. After

this happened twice, she went to the police. They said they could not do anything until after he had actually hurt her. They suggested she see a lawyer and get a restraining order. She could not afford to see a lawyer and, besides, had heard that restraining orders are of no use in such situations. She had a revolver in her apartment, and out of fear that he would accost her on the street, she began to carry it with her wherever she went.

I asked if she had shown the gun to the other group member at the beginning of the session. Both women laughed and answered yes. The group began to discuss her plight. During the discussion, I said I wondered if she was worried about the possible repercussions of carrying a gun around with her—it being illegal to conceal a weapon, and also dangerous. My comment initiated a group discussion about the advisability of her carrying the gun. During the discussion, several members pointed out that my concern about legality was based on my status as a white professional, and that black people in the ghetto could not rely on police for protection. Several women told how they or their close friends had been severely beaten by men in similar situations, and one group member told of a cousin who had been killed by a drunken former lover.

While this discussion was occurring, I was partly engrossed in the emotional fervor of the group, partly worried about the real danger this woman was in, and partly involved in figuring out the dynamics of the session and what would be a constructive therapeutic intervention. My cotherapist seemed in agreement with

everyone else that it was necessary for the woman to carry the gun. I wondered if she had shown her purse to another group member precisely in order to call attention to herself and to get someone to confront her about the dangerous thing she was doing; and I wondered if the group was colluding with her dangerous act, at least in part to act out some need to rebel against me when I confronted the danger. I did raise the question about the danger involved in her carrying the gun. I decided not to interpret the whole group's disagreement as a need to rebel against the group leader. Rather, I listened to the group, including my cotherapist, tell me that I was naive about life on the street; that "black folks understand these things"; and that "I'd rather get caught by the police with a gun than get caught by that man without one."

Of course, there were identifiable group dynamics and unconscious processes in play, and I could have continued to make interpretations. But I decided the group was trying to teach me a lesson about the bias in my white middle-class perspective. They respected my knowledge of group dynamics and wanted me to respect theirs of street life. The woman carried the gun for several weeks longer and did not have any more trouble from that man.

2. An attractive white woman therapist sees an attractive black male client in a public clinic. During the first several sessions, the therapist feels the client is only half listening. He tells her he hears voices, becomes anxious, and cannot sleep. She begins to question him about his symptoms, and he interrupts to ask

questions. “Are you married?” “You seem so young, you couldn’t have finished school too long ago.” “Do you ever see clients socially?” The therapist makes it clear that the client has come to the clinic for therapy, and that is what he will receive. She politely but firmly tells him anything else is inappropriate. The man returns several more times, seems very troubled by his symptoms, continues to act in a seductive manner, and then no-shows and discontinues the therapy.

The therapist notices that other young black men have behaved similarly. They seem hesitant about coming to the clinic, they ask personal questions and frequently compliment her, and they discontinue therapy soon after she clarifies her professional boundaries. She knows this has something to do with power. These men feel one down coming to the clinic, having to talk in psychological language about their problems, and seeking help from a young, attractive woman. Perhaps they compensate by assuming a role they know better, and in which they feel more in control. The therapist attempts to interpret these feelings as she sets limits in terms of socializing with clients. But the limit-setting and interpretations do no good, and young black men continue to drop out of therapy.

An attractive black woman therapist in the same clinic seems to have more success treating young black men. The white therapist asks the black therapist what her secret is. The black woman says, “I flirt with them.” She explains that some men are not used to talking about feelings and being needy with a woman. Rather, they want to impress a woman with their attractiveness and excitement.

This black woman sets limits—she will not socialize or permit sexual interactions to occur. But within those limits she is willing to flirt, at least until the man has begun to enjoy their meetings enough and feels attractive enough to settle down and talk about what is really bothering him, what is on his mind, and what he needs her help with.

The white woman appreciates the feedback. But she wonders if a white woman can flirt with a black man in the same way a black woman can. Will the man as easily accept the boundaries and limits she sets? The two women begin to talk about race relations, about the conflicts of black men, and finally about this white woman's fantasies and fears involving black men. A peer consultation and exchange is occurring, without which this white therapist would not be able to transcend what turns out to be a significant countertransference obstacle to her treating black men.

3. After several months of discussion at staff meetings of whether or not staff-development training was useful or desired by the staff of the clinic where I was working, I was finally asked to give a series of training sessions on group psychotherapy. The staff was equally divided between black and white, but, as in many clinics, there were more white professionals and more black paraprofessionals. I was to do the training sessions every other week at staff meetings and the alternative weekly meetings were to be used for all other staff business and activities. I presented three successive biweekly sessions, which

were all fully attended and well received by the staff. Because of the focus of the training, and because of the optimism about groups the training encouraged, four or five new group therapies were commenced by various staff members. At this point, one of the four clinical teams requested that I postpone the next training session. This was a team made up of almost all minority staff, and they had decided to make a presentation about black history at the staff meeting I had scheduled for the next training session. Black History Month extended over four staff meeting dates, so there was no reason the clinic's black history presentation had to occur on the date scheduled for group training. When I mentioned this, the representative of this team said, "That's okay then, we won't do a presentation."

I felt torn. On the one hand, I felt that the staff's commitment to training was important; I owed it to the staff who were commencing group therapy to maintain the continuity of training through their early attempts to lead groups, and there was something slightly disruptive and rigid about this one team's insistence that they make their presentation only on the one date. On the other hand, I felt it was crucial to interracial staff relations for me, a white professional, to recognize the leadership of black staff and rank the priority of black history as high as that of clinical training in the context of a community clinic.

I decided to stand firm, to insist that I would continue the training sessions as scheduled, and to suggest that the more recently planned black history presentation be scheduled for an alternate weekly staff meeting. A vote was called

for during the meeting but never actually occurred because the staff decided that they did not want to have to decide the issue.

I did not feel quite right about my stance, so after the meeting I consulted individually with several black and white staff members. Some said I had acted properly, that our first commitment must be to the continuity of training. Others suggested that my stance reflected a racist bias, and that even if the team requesting the schedule change was a bit rigid, their bid for leadership must be recognized and the training meeting postponed; later the interracial staff dynamics could be explored and better ways to resolve such questions developed. I decided that the latter approach was more constructive and communicated to the team involved that I would be willing to postpone the next training session. The black history presentation occurred and was a stunning success. The next week the staff returned for the rescheduled training session with renewed enthusiasm, and during that session we talked about interracial dynamics in groups and institutions.

These are three illustrations of collaboration among clients, therapists, and staff colleagues. In each instance a white therapist was confronted with the possibility that some of his or her perceptions, statements, or actions contained racial or even racist bias. In the third illustration, for instance, it was not immediately clear to me whether my initial stance was one of "color blindness," or whether my inclination to agree to the schedule change reflected paternalism or

excessive compliance with a disruptive black power movement. In each instance the white therapist finally was able to make sense of the experience and move forward with the therapy or training by collaborating with black clients and colleagues to understand the interracial dynamics.

I have discussed my belief that white people in this society have a necessarily distorted perspective on race, whether or not the white person is consciously malevolent. These racist distortions can take the form of outright bigotry, a false sense of neutrality or ''color blindness," paternalism, overcompliance with black power demands, etc. Only by being open to the possibility of subtle racial biases and distortions within him or herself can the white therapist hope to recognize such biases and distinguish them from the types of transference and countertransference distortions that characterize all psychotherapeutic relationships. Further, I believe honest and open explorations of interracial relations between therapist and client and between therapist and colleagues is an absolute prerequisite to constructive interracial psychotherapy. In other words, I do not believe, based on my own experience and that of other white therapists, that a white person practicing in isolation can treat black clients without introducing significant and counterproductive racial bias into the encounter. Therapy is a process of correcting distortions in interpersonal relationships. Collaboration and mutual respect are essential ingredients if therapy is to proceed usefully between white therapist and black client.

CHAPTER 9
The "Chronic" Problem

A frequent exchange in a mental health clinic begins when one clinician says to another, "He's just a chronic." The usual response is, "Well then, I don't want to treat him." As if the word chronic conveys all the information the second clinician needs to deem the case hopeless.

Though I would prefer not to even use the term, *chronicity* has become a field of study, even a subspecialty in psychiatry. But I want to make it clear that I do not believe all the people lumped together in that category suffer from the same basic condition. Rather, whatever their basic condition, they have adopted or been fitted into a certain life-style to which the label "chronic" has been attached, and to a significant extent, the label brings with it a self-fulfilling prophecy.

The current meaning of the concept of chronic mental disorder has evolved from Eugen Bleuler's dispute with Emil Kraepelin. Kraepelin was the great systematizer and cataloger of mental disease types. During the last decade of the nineteenth century, he reclassified all then-known varieties of madness as subvarieties of two major mental diseases, dementia praecox and manic-depressive psychosis. He based the distinction between the two major forms of madness largely on what he assumed to be the natural course of the diseases.

Dementia praecox appeared during late adolescence and followed a progressively deteriorating course until the patient became totally and irreversibly demented. Manic- depressive psychosis followed a course of repeated acute attacks, improvements, and interim disease-free periods.

Bleuler substituted the term *schizophrenia* for the category of disease Kraepelin had labeled dementia praecox. And Bleuler disagreed that the natural course of the disease was progressive and inevitable deterioration. In fact, he felt the deterioration was more the result of the barbaric treatment patients suffered in asylums:

> We can only understand a psychically determined psychosis if we distingish the symptoms stemming directly from the disease process itself from those secondary symptoms which begin to operate only when the sick person reacts to some internal or external process. . . .
>
> Almost the totality of the heretofore described symptomatology of dementia praecox is a secondary, in a certain sense, an accidental one. Therefore, the disease may remain symptomless for a long time. Whether a particularly chronic schizophrenic is able to work peacefully today or wanders about and quarrels with everyone, whether he is neat and clean or smears himself—that is, the nature of the symptoms—depends mainly on past or present events and not directly on the disease. Some affectively charged experience releases a hallucinatory agitated state. A transfer to another hospital may bring about the disappearance of the same hallucinations.[53]

Today, the term *chronic* refers not so much to the chronicity of schizophrenia—many "chronics" have never actually suffered from schizophrenia

—as to the situation of being a long-term mental patient. In other words, it is not a set of disease symptoms but a type of life-style that is the focus in discussions of chronicity. The term *chronic schizophrenia* still appears in the literature and presumably refers to what an author considers to be long-term primary characteristics (Bleuler) of the disease schizophrenia. But most authors include people who are not diagnosed schizophrenic in the group they label chronic—for instance, people who suffer from manic- depressive psychosis, severe character disorders, or alcoholism. The secondary characteristics of long-term mental conditions, such as dependent living, work disability, lack of spontaneous affect or activity, and dependence on psychotropic medications, identify the chronic, whether or not the person was ever hospitalized for a mental condition.

Across the country the trend in mental health systems today is deinstitutionalization. Mental patients are to be discharged from state hospitals and provided the support systems they need to live in the community. Jimmy and Rosalynn Carter's Mental Health Systems Act identifies chronic mental patients as an underserved target population. Public clinics are given the task of "maintaining" the increased population of clients in the community. In the absence of sufficient funds to provide quality therapeutic, rehabilitative, and vocational programs, and in the absence of employment programs to make jobs available to all such clients, the maintenance of former mental patients in the community ends up being largely a matter of prescribing large amounts of medications to suppress symptoms. The heavily medicated former mental hospital patients join certain

other unemployed individuals to form the "chronic" client population.

There are two very different perspectives from which to view chronicity, one involving a focus on individual psychopathology, and the other involving a focus on social realities such as unemployment. The focus on individual psychopathology tends to locate the problem in the chronic client's personal deficiencies. If the chronic client is not merely dismissed as lazy and manipulative, then the description is only slightly more subtle. I will quote from the introduction of one article on the subject:

> The chronically mentally ill possess numerous disabilities that make work rehabilitation efforts . . . ineffective in the majority of cases. A list of such disabilities would include the following: passivity and lack of motivation vis-a-vis employment, abnormal susceptibility to disorganizing levels of anxiety, inability to fix and maintain attention for long periods of time, deficiencies in basic employment habits and skills, the lack of a sense of adult responsibility for self, and a propensity toward deviant and inappropriate behavior.[54]

The focus that begins with the personal deficiencies of chronics inevitably ends with more or less successful ways to motivate them to work. A recent publication, *Community Support Systems for the Long-Term Patient*, includes articles on providing "continuity of care," "work rehabilitation," "training in community living," "volunteer support networks for chronic patients," and the use of "parents of schizophrenics as advocates."[55] The approaches are innovative attempts to "help the most disabled group of psychiatric patients live among the rest of us."[56] Results reported are mixed. Strikingly, there is little or no mention

in this entire volume of two obvious social realities: (1) the current rising rate of unemployment and (2) the diminution of funds and resources for treatment and rehabilitation relative to the increasing numbers of long-term mental patients in the community—and how these exacerbate the problem of chronicity.

Repeatedly I hear from clients: "I been through that Voc. Rehab. program, Doc, they trained me to be a baker, but there aren't any jobs!" I have been told the same story by clients who attended day treatment, sheltered workshops, and technical training schools—many clients having been recycled in two or three trades or industries. Is it merely their lack of motivation that explains their continued unemployment? Or do they give up when confronted by overwhelming odds against satisfying work? Whatever measure of each characteristic is present, the fact remains that in the current economic slump, too few jobs are available.

The most innovative of the treatment and rehabilitation programs become overcrowded or understaffed as budget cuts occur, or whenever greater client demand results from the closing of mental hospitals, or from the greater incidence of mental breakdown during periods of high unemployment. Under such stress, the best of the programs function less well, failure rates increase, and staff feel burned out. Thus the focus on individual psychopathology is a very limited perspective, as evidenced by its advocates' shortsightedness regarding potential employment for program graduates and continued adequate funding for programs themselves.

A contrasting perspective involves a focus on social realities such as unemployment. There is a deep connection among unemployment, the incidence of mental breakdown, and the incidence of chronicity.[57] Of course, even with full employment, individuals would still periodically become disabled by severe emotional turmoil. But if they had meaningful work to return to after recovery, and if their treatment were adequate—for example, if medications were not utilized as an alternative to quality psychotherapy—then they would expect and be expected to return to work after their turmoil was resolved. I include the qualifier, meaningful, because unfulfilling and alienating labor, or "the impossibility of employing one's talent in one's work," has been found to predispose toward the development and prolongation of mental disorder.[58]

From a social perspective, the whole group of chronic mental patients are merely a fraction of the total population of unemployed people. As long as a significant unemployment rate remains and affects some sectors of the population more than others— minorities—it is likely that some of the unemployed will adopt the life-style of the chronic mental patient. Whatever the successes of unique model programs, no rehabilitation program will be effective on a wide scale until meaningful employment is available for this subpopulation.

As viewed from this social perspective, the plight of the chronic mental patient exemplifies the social-control and labor-regulating function of mental health and other social services. According to Piven and Cloward, "The structure

of the American public welfare system meshes with and enforces the work system. . . . harsh relief practices also maintain work norms by evoking the image of the shamed pauper for all, especially the able-bodied poor, to see and shun."[59]

I have presented two perspectives on the "chronic" problem, one focused on individual psychopathology and the other on social realities, in order to point out the shortsightedness of the first and the difficulty of effecting the second. I believe most mental health professionals bracket the second because they do not believe that they can change the social reality, and focus exclusively on the first because by training and inclination they hope to effect change in some individuals' psychopathology, whatever the inadequacies of their program budgets.

I do not mean to imply that I believe the set of attitudes and behaviors we identify as part of the chronic syndrome are caused solely by high unemployment rates and underbudgeted social services. Human beings are not merely passive reactors in the determination of their personalities, life-styles, or fate. For instance, childhood experiences and family dynamics play as big a role in the formation of adult chronicity as they do in the formation of character styles and neuroses. There are particular intrapsychic forces at play whenever anyone chooses any life-style—and eventually these need to be explored if the chronic client is to make real progress in therapy. Biological variables likely will be found to play some role, too, along with many other variables. But I want to focus here on how the chronic client chooses his or her fate in the context of a pressing set of

social realities—of which unemployment is only one example—that severely restrict his or her choices. As long as social stress is aggravated, whether by unemployment or by practices at underfunded mental health clinics, the problem of chronicity will be with us and will continue to seem unsolvable.

I believe that the "chronic" problem results in large part from our social priorities and will not be alleviated until those priorities change—for instance, until there is full employment. But this belief does not prevent me from offering therapy to individuals who have adopted or been forced to adopt the life-style of chronicity. I believe the therapist, if he or she is to be of any help to the troubled client, must keep in mind both the individual's role in choosing the lifestyle and the social realities that impose a limited set of choices.

DIANE'S "REFRACTORY PERIOD"

In order to delineate further the phenomenon I am defining here as chronicity, I will describe someone who is not a chronic but who might have been.

I met Diane, a thirty-six-year-old black secretary at a big corporation, when she came to the clinic confused and frantic. She glared at me in terror and told of a plot on the part of various men at her office to seduce her to get information the FBI would use against her. She knew about this because she heard voices, often her mother's, warning her not to trust them. She lived a block away from her mother. She was entirely unable to cope and presented all the signs of serious

thought disorder and decompensation. We arranged for her to stay with her mother and take some pills I prescribed.

Diane had never had any similar experience before and had never seen a psychiatrist. She responded within a week to moderate doses of Thorazine. She was seen at the clinic for each of the next four days and seemed progressively less anxious, more coherent, and less delusional. The dosage of medication was lowered, and Diane was asked to attend group psychotherapy weekly.

Diane was quite a beautiful woman and dressed very nicely. She quickly became the object of adoration of several men in the group. She moved back into her own apartment a few weeks later, and resumed her social life—mainly dates with various men. She had no close women friends. She went on disability rather than return to work, and continued to take low doses of Thorazine.

In group Diane was polite and smiled frequently but was otherwise distant and guarded. She never shared much about her personal life and displayed little spontaneous feeling. She rarely talked, and when she did it was about men she dated or about the man she soon began to live with and her conflicts about marrying him. She bragged about how handsome and successful he was. She seemed shallow, superficial, vain, and lacking in warmth and empathy. She told the group she would never tell her lover that she visited a “shrink” or took medication.

For six months Diane seemed very resistant in group. Then she suddenly changed. She began to express anger in group, becoming impatient with a member who refused to share feelings. She occasionally laughed raucously. Or she cried or became anxious. None of these expressions was inappropriate, but they seemed unusual coming from Diane. The cotherapist and I discussed whether or not Diane was beginning to suffer another breakdown. We decided she was not, and we liked the new woman we were seeing emerge in group. She seemed to empathize more with others. Even the greetings and farewells she offered seemed warmer and more authentic.

Three or four weeks later, Diane asked for an individual session with me. She entered my office and began to cry as she told me about an illegitimate son she had borne sixteen years before. She immediately gave him up for adoption and never saw him again. But lately, beginning just prior to her breakdown a year earlier, she had been thinking about him a lot. She was very worried that she would never bear another child, and she wondered if she had made a dreadful mistake giving him up. For the first time, I learned that her breakdown was related to her guilt about this, and that since then, for fear of a relapse, she had pushed all thought of her baby out of mind. This meant to her also denying her feelings and not allowing deep intimacies, for fear that the dangerous material would erupt. After telling me this, she decided to explore with the bureau of adoptions the possibility of locating her son.

Meanwhile, the group repeatedly remarked about how she had changed and complimented her on her warmth, depth, and sensitivity. She admitted that she had been distancing herself from the group all year, and explained why. She had spent six months controlling her emotions and not allowing anyone to matter to her or to know what was occurring in her head. Now, she finally risked telling her lover about her breakdown and current therapy. And she told the group about her son and reported that the adoption agency told her she would not be told her son's location, but when he reached the age of eighteen he would be given her name and address. She shared her anxiety about his eventually contacting her. She soon returned to work at another secretarial job.

Sometimes, but certainly not always, there is a refractory period following an emotional storm or breakdown. A nerve cell, or neuron, just after it fires, enters a refractory period during which time it cannot fire again. Meanwhile, chemical changes occur within the neuron that prepare it to fire again after the refractory period. I am borrowing the concept from this physiological process when I say that a refractory period can follow an emotional storm. During that period, a person might call a moratorium on all intense feelings and relationships, perhaps in order to integrate the recent experience, or perhaps in the hope of preventing another such trauma. The person closes off a part of the self. Diane did this for about six months following her breakdown. For others, refractory periods are much briefer.

I recently interviewed another woman who had been discharged from a psychiatric hospital a month earlier. She told me, “I feel like a big part of myself is missing.” She described a level of rage that she had felt before being hospitalized: “I was frightened I would kill someone.” She told me that in the hospital she had cried “until I thought I’d drown in tears.” She said that since discharge, she had not permitted herself to feel or express any anger or sadness. I said, “Maybe that part you feel is missing is still there, but right now you just don’t want to know about a part of you that has been through such an ordeal.” She liked my reformulation, and she began to tell me more about her ordeal.

The phenomenon I am identifying as a refractory period occurs quite frequently. I believe it explains part, and in some cases most, of a client’s experience of postpsychotic depression, or what is labeled in D.S.M.—III a “residual type of schizophrenia” (D.S.M.— III, 295.6x).[60]

If there is a refractory period and a recoiling into self for protection, as there was for Diane and this other woman, then how therapy is managed during that period is a very delicate matter. Diane’s superficiality, lack of spontaneity, affectual flatness, and lack of desire to change mimicked the stereotype of the chronic. What would have happened had she dropped out of psychotherapy and been given higher doses of major tranquilizers during that time? Would she have ever reached the point of wanting to work through her pain and conflict? Not likely. If a client is heavily medicated during a refractory period, treated as an

invalid, and complimented most when most "well controlled," then that client is likely to become a shadow of his or her former self—that is, a chronic. On the other hand, if the client is treated as a valued adult who is temporarily withdrawing, if sympathy and support are offered along with willing therapeutic help whenever he or she wishes it, then the client is likely to make use of that refractory period to prepare himself or herself for the work of reintegrating into a self grown larger from the experience. But it is not only the choice of treatment approach that matters here; the client also makes important choices about becoming a chronic.

Diane chose to deaden herself for a while during her refractory period, in order to recover in her own way from the shock of her mental breakdown. Once recovered, Diane chose to come alive again, also in her own way. She changed her mind about her choice to deaden herself. I will describe someone who made a longer-term choice to deaden himself, and in the process became a chronic.

JACK'S RAGE

Jack's childhood was filled with brutal beatings by his alcoholic father. His mother never intervened. He fought often in the schoolyard and was sent to the vice-principal's office. In high school he began drinking. He soon became involved with drugs, including "crank" or "speed." He was caught while joyriding in a stolen car. From then on, he repeatedly found himself in courts, jails, and youth authority

camps until he was nineteen. In that year he killed a man in a knife fight, though he was never caught; and he met and married a woman his same age, who, he says, offered him sympathy and forgiveness.

Two years later the police caught him on a Saturday night, chasing another man and screaming at the top of his lungs, “I’ll kill you, you son of a bitch!” He would not calm down, he kept yelling about voices telling him what to do, and he accused the police of conspiring with the man he was chasing to have an orgy with his wife. They took him to a hospital emergency room and he was diagnosed paranoid schizophrenic. He was treated with injections of strong tranquilizers and admitted for a month to a psychiatric ward.

Jack is thirty-two and white. He recalls that he suspected the man he was chasing of having had an affair with his wife, and remembers vividly how he really wanted to kill him. He believes his reaction was madness—he was crazy to be so jealous and angry. He has taken large doses of tranquilizers ever since, in order to insure that he will never again be so crazy.

Jack is six feet two inches tall. He is somewhat overweight, probably a side effect of the drugs. He appears strong and, when angered, menacing. He lives with his wife, receives total disability benefits (SSI) for his mental condition, and spends most of his time watching TV.

Jack drinks, but not every day. In fact, he limits himself to drinking one night

a week—after 8 P.M. on Saturday night. Then he really drinks, usually until he is unconscious. By drinking he expresses his ambivalence about life. He takes Thorazine to deaden himself—to kill the pain or to control the rage. Then he drinks because "I have to do something to feel alive."

About once a year Jack's drinking gets him into trouble. Instead of passing out, he gets into a rage. The last incident occurred a year ago. He went dancing with his wife, saw her dance with another man, became intensely jealous, kept on drinking, and finally he blew. "I'll kill the son of a bitch!" The other man got the message and left. Jack could not be calmed. He smashed car windshields on the walk home, and then stood on his front porch screaming obscenities until the police came and took him away.

At the hospital Jack was treated with injections of Haldol, until he relaxed and fell asleep. Jack probably did appear psychotic, glaring angrily and assuming everyone was part of a plot to humiliate him. But very likely something other than his appearance determined the treatment he received. Anyone who has a history of repeated hospitalizations is likely to be taken to a mental hospital rather than to a jail when he or she is out of control, and treated again with major tranquilizers. When a hospital or emergency room is overcrowded and the staff rushed, no more rigorous diagnostic evaluation is likely to occur, and the seeming success of the treatment—in Jack's case he calmed down—is interpreted as proof that the diagnosis was correct. After a few days of being calm, Jack was discharged from

the hospital and given a supply of a tranquilizer that was stronger than what he had been taking prior to this incident.

Over ten years and six or seven somewhat similar hospitalizations, Jack's pattern has been cyclical. Between eruptions he defends against his rage by rigidly controlling himself, or by ingesting chemical tranquilizers. His rigid defenses do protect him for a while, until the rage builds up inside and bursts forth; for instance, under the disinhibiting influence of alcohol. Then, he has no mechanism left to cope with the rage, and loses control. The particular set of rigid defenses he chooses composes the life-style called chronicity. In other words, he relies so exclusively on pills to cope with his feelings and reactions that his other coping mechanisms atrophy, and when his feelings overwhelm the chemical controls he is left defenseless and unable to take control of himself. He then assumes only stronger pills will help, his other coping mechanisms atrophy further, and the cycle continues at progressively higher medication dose levels.

One problem with taking major tranquilizers to control one's temper is that the temper is not all that is controlled. Each time his medications are increased, Jack becomes more sluggish. He sleeps ten hours per night and feels little energy during the day. He stays home and watches TV because he is afraid that if he goes out he will get into an argument with someone. He is never really sad and never happy. He remains relatively numb, bored, or depressed. He says, "Those pills really slow you down. You can't feel and you can hardly move." He cannot halt his

weight gain, and he has almost no sex drive. All this in order to control his rage—not atypical of the chronic life-style.

It is often said that the chronic is lazy and manipulative. Webster defines a manipulator as one who controls or plays upon others "by unfair or insidious means, especially to one's own advantage." Of course, some people consider it unfair for anyone to receive an income if they have not worked for wages. Jack is not motivated to work. He tells me he has tried all kinds of training programs and jobs. Unskilled labor jobs have been seasonal, employment interviews traumatic, and competition rough for the few slots open. When working, he earns little more than disability pays him, and loses his medical (Medi-Cal) coverage besides.

How can it be said that Jack's disability is "to his own advantage"? He is miserable. If he is a manipulator, he is very bad at it. He never has money to buy clothes, to pay for entertainment or travel. He owns an old car, which he repairs himself, but he cannot afford gas and rarely drives it. In order to control his temper he has given up practically all feeling, he has given up spontaneity and creativity, he has given up sex, he has given up activity itself—he has given up most of what we know as life. I believe Jack is truly disabled by his mental condition, though he can be helped by therapy and eventually return to work.

Jack is not schizophrenic. His problems are his anger and his belief that his anger is madness. Another way to say this is that Jack's anger is split off, or not

integrated into a whole self, and because of this, his self is incomplete or split. He is kind, sweet, needy, and caring when he attends group therapy. He denies any anger or negative feelings in the here and now. Then, at certain times, his explosive rage takes over and he is unable to moderate it with any loving feelings. I am describing the kind of splitting and denial that typify the borderline character structure. Probably this is a better diagnosis of Jack's underlying condition. He is not schizophrenic, so the diagnosis and treatment he received at the hospital were inappropriate.

This type of misdiagnosis and controlling treatment are most common in overcrowded and underfunded public facilities. Jack's symptoms of numbness, lethargy, and unhappiness are the result, not of his underlying condition, but of the superimposed chronicity that has been the price Jack has had to pay to control his rage. Even if Jack really did suffer from periodic psychotic or schizophrenic episodes, complete with hallucinations, delusions, massive anxiety, fragmentation of self, and bizarre behavior, the medications he takes and the life-style he adopts between the breaks would add up to the same picture of chronicity.

Before proceeding to a description of Jack's therapy, I will mention Jack's choices in all this. Again, I will clarify that though I believe chronics make one set of choices, there is a whole other set of choices imposed on them by circumstance. I make this clarification in order to avoid blaming the victim. Jack does not choose chronic unemployment. He does not choose to receive treatment in a public

facility where he is misdiagnosed and controlled by medications. He is unable to afford more dynamic psychotherapy. There are other choices he did not make voluntarily, such as the choice of second-rate public schools that ill-prepared him for more fulfilling work. There are a whole series of choices made for Jack in our society that constrict his options and tend to limit his potential. Within these constrictions, Jack makes other, more personal, choices. And within these limits, Jack has chosen to control his rage at the price of a massively constricted life.

Therapy with chronic clients profitably focuses on reconsidering choices and reopening questions. Diane chose to temporarily numb her feelings and withdraw from meaningful intimacy. After a refractory period, she chose to open up again to herself and others. Jack chose to close himself off in a similar fashion, but then never seriously reconsidered the choice, and continued for ten years to live in the style of a chronic. If his life-style is to change, his therapy must confront him with this choice and help him make other choices about how to handle his rage.

Therapy

Therapy with chronic clients must focus continually on choices—the choice to numb oneself in order to avoid painful feelings, the choice to be inactive in order to avoid chaos, the choice to be alone in order to avoid rejection, the choice to give up in order to avoid failure, or the choice to be dependent rather than feel terrified while independent. The therapist confronts in order to help the client

continually reconsider such choices. In Jack's case, these choices center on his anger, so I will use the example of his anger to illustrate how a therapist can confront a client about the choice of chronicity.

The concrete form of this confrontation is familiar to any therapist who has worked with clients who have difficulty directly expressing anger. Whether the client is passive-aggressive, depressed and withholding, or borderline and denying, the therapist's task is to recognize the moment when the client might appropriately feel angry, and then question, interpret, or confront the client about why he or she does not express this anger directly. In Jack's case, the moments are numerous. I pressure him to decrease his medication dosage, I ask how he feels about this, and he responds "It's okay—you're the doctor.'' Or someone in the group interrupts him or criticizes him, he withdraws, and when asked how he feels, he says, "Fine—it didn't bother me." These are the moments when the therapist might usefully suggest that Jack really feels angry, but is denying his feeling in order to maintain control, perhaps because he fears any expression of anger might lead to uncontrollable rage. Until Jack recognizes he is angry, he cannot make use of these interpretations.

The process is tedious. Sometimes the first breakthrough comes when Jack becomes fed up with such suggestions and finally admits. "Now you are making me angry by repeatedly saying I'm angry when I'm not!" Fine. This is a good start. Jack has shared his angry feeling, however subdued. The group can begin to

explore how he handles anger. As Jack gains confidence that he can express some anger without losing control, and that such expressions do not lose him favor with the therapist and the group, he begins to express more anger with more spontaneity.

The process must be coordinated with some bolstering of Jack's self-esteem. He must learn the group cares for him, all of him, or him as a whole person, and that he does not need to split off his anger and constantly act sweet in group in order to maintain the group's esteem. As he learns this, and gradually begins to express his anger in a spontaneous and appropriate way, he feels less need for controlling medications, and he is less likely to explode in rage. In Jack's case, the mediating step is that with the group's support he is able to stop drinking, and so the potentially explosive situation is less likely to occur. But as this process continues—and it must continue for many months or years if Jack is to make long-lasting choices other than chronicity—Jack becomes more spontaneous in other ways. He begins to laugh more, to risk sadness and even tears, and to tolerate anxiety without taking more pills. His sex life improves, he starts to lose weight, and then more serious discussions begin about his dependency on his wife, about his jealousy, and about the love and hate that exist concurrently in the group.

I have schematized this discussion and focused on Jack's anger in order to begin to outline a strategy of therapy with a chronic client. Usually, it is not only anger that is split off and denied as the chronic client chooses numbness and a

constricted life.

Some chronic clients are as frightened of their sadness as Jack is of his anger. They take pills to ward off the sadness, they isolate themselves to lessen the chance that someone they care for will hurt them, and they limit their activities to decrease the risk of grief. Other people believe that they cannot tolerate any anxiety. If they have difficulty falling asleep or if they become anxious about financial matters or about marital discord they hurriedly take pills to calm down. Others are frightened of chaos or of having another breakdown. Others are terrified of independence. Whatever the fear, medications and the life-style of chronicity offer respite—but at what price? Sadness is traded for a numb lethargic state. Anger is traded for joylessness and impotence.

Some of these people have experienced actual psychotic breaks. Others were told they were crazy; for instance, when drunk and acting bizarrely; when transiently in a rage state and taken to a hospital; when under the influence of a hallucinogen like LSD or angel dust; or when severely depressed and suicidal. When the feeling or experience a person most dreads is diminished or calmed by the treatment offered for their "madness," that person is at risk of becoming a chronic.

The therapist helps the chronic client reconsider the choice to be chronic by helping him or her reintegrate the feeling, experience, or part of self that was

previously unacceptable. With Jack, this was anger. Another client might dread her sadness, fear that any expression of sadness will lead to unending gloom and madness, and take strong tranquilizers to prevent any such occurrence. With her, the therapy first focuses on sadness rather than anger. She is helped to tolerate sadness and to learn she can be sad without going "mad." Meanwhile, she must learn that others do not find her sadness ugly, and that trusting and relating to others can make her burden lighter and her life more enjoyable. As she becomes more spontaneous and tolerant of her sadness, other issues and feelings will emerge.

I described a course of therapy with Jim in Chapter 4, and in Chapter 2 I described my work with Emma. Jim probably suffered from a toxic psychosis early in his adult life, and Emma probably suffered from a psychotic or very severe depression. But at the time I began their therapies, both clients suffered mainly from chronicity itself. Chronicity involves not only numbness and lack of spontaneity but also dependency and powerlessness. These are the aspects I will discuss next.

Dependency and Powerlessness

Many writers stress the chronic client's predisposition to dependency. Jack Zusman writes:

> The social breakdown syndrome will occur only in persons with weakened

> or deficient inner standards regarding interpersonal relations, rules of behavior, social obligations of themselves and others, and social roles. . . . The person rendered susceptible, because frames of reference derived from past experience are not available (e.g. during an acute episode of mental turmoil), becomes unusually dependent on current stimuli for cues regarding appropriate behavior, determining what is right and wrong, true and false, and judging which impulses to obey and which to inhibit.[61]

While I believe this predisposition to dependency is very important, I think it is more productive in therapy to focus first on the primacy of a client's feelings of powerlessness, and then to view dependency as an outgrowth of this feeling.

I mentioned in Chapter 4 Michael Lerner's concept of surplus powerlessness —"a powerlessness that is not simply a reflection of reality, but rather an internalized sense of futility and frustration that takes on a life of its own, becomes an independent reality." The powerlessness of chronicity is not only surplus, it is total. The chronic client believes that it is each person against the whole world, but that in his or her particular case his or her powers are so minimal and the forces he or she is up against so massive and immutable there is absolutely no hope of budging that world one inch; all he or she can do is to give up and accept whatever happens to him or her. The chronic client's sense of total powerlessness prevents him or her from even trying to affect his or her reality. Dependency follows. If he or she has no power to affect his or her circumstances, then at least he or she can cling to a big, strong protector, whether that protector be a parent, a doctor who prescribes pills, a mental hospital, or a residential facility. Dependency and powerlessness together inhibit all the chronic client's

efforts to experience life more fully and block the therapist's efforts to help.

Therapy cannot be provided for a passive client. The client must engage in the therapy. In this way, therapy is an active practice in which therapist and client must be involved. The therapist must find a way to help the client actively engage in therapy. In order to accomplish this, the client must begin to hope to affect some change in him or herself, in others, and in his or her circumstances. Only then can the client be helped to reduce his or her degree of dependency.

The advocacy experience offers one excellent opportunity for the therapist and client to examine the question of powerlessness. The client feels powerless against the all-powerful government or institution. The therapist joins the client as advocate, and together the two struggle with the institution that had seemed to the client so immovable. Some gain, however minimal, may be achieved—for example, the client wins an appeal hearing, or minor charges against the client are dropped. The client has at least entered the arena to struggle for some power. Now the client must come to terms with the therapist's actual capabilities in the larger arena—for example, the therapist might seem very powerful if the gain is achieved, or the therapist might disappoint the client's idealization of him or her if an appeal or court battle is lost. Whatever the case, the client is interacting with forces and agencies that previously had seemed all powerful, and in attempting to affect change is able to reassess his or her own capabilities and limitations. Perhaps grandiose fantasies emerge—"We showed them, now I'm going to start a

business of my own and make a fortune." Perhaps devaluation of the therapist's part occurs—"I really didn't need you-at all, I could have won all by myself." Perhaps there is further disappointment in self—"I could have won if I had just not gotten so nervous when I testified." Whatever the result, the experience opens the way for therapist and client to examine the power relationships between them, and between them and the larger institutions.

Similar dynamics can be explored in group therapy in relation to the group's dependency on the leader (see Chapter 5). As the therapist helps the group members see how they assume all power rests in the hands of the leader, the members' surplus powerlessness is brought into question. Again, in regard to no-shows (Chapter 3), the therapist's willingness to go one down or to play with the issue of appointment times brings the question of power into the here and now of the therapy.

A related issue involves the giving of gifts. I mentioned in Chapter 5 the importance of a client's providing a home-cooked meal for a group. Such gifts and expressions of gratitude are particularly important in therapy with chronic clients. In order to be able to give a gift, a person must feel like he or she has something to give. The chronic client often feels like nothing. He or she feels incapable of creating or giving anything. An anecdote will illustrate.

As a field trip for a college psychology course, a friend visited a state mental

hospital.[62] During the course of the visit he was assigned to spend an hour in the arts and crafts room where an occupational therapist was working with some of the patients, helping them to sculpt in clay. She went around the table and threw down a lump of clay in front of each patient. While all the other patients began to pick up and mold their clay, one patient sat slumped, stiff and silent, not making any motion toward picking up the clay. My friend walked over to this patient and said, "What's the matter, don't you want to make something out of clay?" The patient said without any change of facial expression, "I can't possibly make anything better out of that piece of clay than she did when she threw it down here like that."

A person who feels like nothing and does not believe he or she can create anything is not capable of giving a gift to a therapist or to a group. In fact, most chronic clients come to the public clinic believing they have absolutely nothing of any value to give anyone. They tend to believe they come to the clinic for charity, and that it is the therapist who has all the gifts to give out. The hope is that during the course of therapy, the client's self-regard will be elevated, and the client will feel like someone who has something to give.

One client mentioned to me as an aside during each weekly session the name of a jazz artist and a little-known album by that artist. Meanwhile, we discussed in the sessions his feeling that I am an expert and have much to teach him, but he has no way to repay me for my help. It took three or four weeks and my finally

listening to one of the albums he mentioned before I discovered the connection. He was an expert on jazz and was giving me tips on good listening in appreciation for my help. When I mentioned this, we were able to reevaluate his self-esteem and feeling of powerlessness in relation to me.

A fifty-year-old black man who had spent twenty-five years in prison felt I was really helping him, and that if it were not for me he would surely be back in prison or be totally insane. He did not like my casual appearance, so one day he brought me an old white dress shirt he had bought in a thrift shop. Another client, a middle-aged black woman, after receiving her first disability check, gave me a vest she had sewn herself.

Much has been written on clients' gift-giving.[63] Robert Langs writes: "An offer of a gift from a patient should be handled by delay of acceptance and analyzing its meaning and implications for the patient. Hopefully, this will lead the patient to withdraw the offer; if not, the gift ultimately should be refused and the patient's reactions to this explored."[64] Other writers are not as rigid, but generally they advise careful interpretation of the meaning of the gift. In the examples I have cited, one meaning is clear: The client had attained a level of self-esteem sufficient for gift giving. The therapist, by simply accepting the gift and saying thanks, is often doing enough. Further examination and interpretations might be appropriate, but refusal of the gift is likely to do the client no good. The offer and acceptance of a chronic client's gift can mark his or her progress from a

feeling of total powerlessness to some minimal sense of willingness and competence to affect reality. From then on, the therapy proceeds much more energetically.

All I have said so far about therapeutic intervention relates to the here and now, or "real," relationship between therapist and client. It is only in this context that the therapist can gain a foothold to help the client out of the depths of feeling overwhelmed and powerless. The client is unlikely to value insight into childhood experiences while the present reality seems so immovable. The therapist must join with the client in challenging the seeming immutability of present circumstances before the client can meaningfully explore past history. Then discussion and insight about the client's childhood can follow. It was after I appeared in court as his advocate that Sam (Chapter 6) told me about his early childhood disappointment that his father never stood up for him. It was after I accompanied her to a hearing on welfare fraud and we talked about self-respect that Betty (Chapter 6) confided in me that when she was a child and her stepfather molested her, he repeatedly told her she was a whore.

It is only after the question of the client's feelings of powerlessness has been confronted that the therapy can proceed to a discussion of dependency. In other words, the client must have some confidence that he or she can affect his or her circumstances before he or she will be willing to discuss moving toward more independent living. Whether the client lives with parents, a spouse, or in a Board

and Care Home, his or her tendency to be excessively dependent on others or on pills must be examined if he or she is to live life more fully in the future. As the client's dependency is examined, interpretations of his or her surplus powerlessness or insufficient narcissistic libido will help him or her risk steps toward more autonomy.

Thus far, I have touched on several issues involved in therapy with chronics. When there is a refractory period, it is crucial that the therapist be sensitive to the client's needs and not rush to medicate. Whenever a therapist works with a chronic client, the focus must be on questioning his or her *choice* to numb and inactivate self. This questioning might take the concrete form of confronting the client with the presence of whatever feelings or experiences (anger, sadness, or chaos, for example) the client has been splitting off and denying. Attention must be given at the same time to the client's low self-esteem. Then the questions of powerlessness and dependency must be brought into the here and now therapeutic material. Advocacy and gift-giving are examples of issues around which this might occur.

Selection for Psychotherapy

Reasons given why so little therapy is practiced with chronic clients include, "They do not want to change," "They have no psychological insight," or "It's a waste of time." Yet if a client with an equivalent mental condition and just as little

motivation and insight happens to have an affluent family or some other way to pay private fees, he or she might be considered treatable enough to undergo years of psychotherapy, or to be hospitalized in an exclusive private facility and undergo extensive tests and vigorous treatments. Here is another example of the double standard and the most extreme case of the substitution of medications and behavior control where quality therapy is not possible.

But not every chronic client desires psychotherapy. The client's anger may present the therapist with an interesting dilemma. To the extent that the client really does desire psychotherapy, the anger must be recognized, confronted and interpreted, just like any other resistance. But to the extent that the client's anger represents protest against a therapy he or she does not desire to undergo, the therapist must respect the client's right to refuse treatment. But first, some process must occur so that the client understands the pros and cons of both medications and therapy. Then the client can make an informed choice.

I allow clients to select therapy for themselves. I see very many chronic clients in medication clinic. I attempt to reduce medication dosages to a minimum. Some clients resist very strongly any attempt to reduce the dosages, complaining that they cannot sleep or that they fear they will go crazy with the lower dosages. Others complain about the same fears, but are more willing to talk about these fears and attempt to cope with them in some other way. I recommend individual or group therapy to many clients. Some are interested and some are not. When a

client is in a crisis, or seems to be decompensating, I offer more intensive therapy sessions. Out of all these negotiations, some clients decide to try psychotherapy, and of these, some stick with it. Many others refuse or no-show early in therapy. This process of selection permits me to see a manageable number of clients in psychotherapy—more in group than in individual or family therapy. I explain to the clients who refuse therapy that long-term medication usage contains serious risk of side effects and encourage them to reduce dosage levels. Meanwhile, I encourage all the clients to become active in whatever supplemental programs are relevant, be they vocational rehabilitation, a peer self-help group, a halfway house, a former mental patient advocacy group, a community organization, or a day treatment program.

I realize that because I both practice therapy and prescribe medications, I have an advantage in selecting candidates for psychotherapy. Therapists who do not prescribe medications have less leverage in selecting and working with chronic clients. All I can suggest is that improved collaboration between M.D.s and non- M.D.s would permit the best use of all disciplines and permit all therapists to take advantage of the M.D.'s leverage with chronic clients.

Therapy is not effective or even indicated with every chronic mental patient. Some do not wish to change their life-styles. Others may be suffering from an underlying condition that is too severe, too deep-seated, or too long-lasting to respond to therapy. I have assumed that chronicity is a secondary condition

superimposed on a wide variety of primary conditions. Even though institutionalization and prolonged medication largely shape the life-style of chronicity, it is still possible that a certain number of people suffer from an underlying condition called chronic schizophrenia. I have no new evidence about the incidence or prognosis of that condition, except that I believe the category is overused in an oppressive way. But I am convinced that a great many clients who are placed in the category of chronic do not suffer from any very severe or long-lasting primary condition. And even many clients who might more appropriately be diagnosed chronic schizophrenia can make great advances when offered psychotherapy and other services, and when medications are prescribed for them as an adjunct rather than as an alternative to therapy.

The Limits of Therapy and the Ethics of Disability

I mentioned at the beginning of this chapter that I do not believe psychotherapy alone will ever solve the "chronic" problem. Full and fulfilling employment is a prerequisite to a real solution. The need is also great for adequate funding of innovative living arrangements, vocational rehabilitation programs, advocacy, and other services to help chronic clients establish more satisfying circumstances. As long as social priorities are such that full employment and adequately funded large-scale public mental health services are not possible, and the social roots of powerlessness and dependency are not alleviated, psychotherapy will remain a very limited modality for chronic clients, however

many individuals are helped to halt their medications and expand their personal horizons.

It is important that the therapist keep this social perspective in mind while working with chronic clients, in order to prevent therapist burnout, and also to help counter the client's sense of personal worthlessness. The client believes his or her unemployment and failure in society result from his or her own flaws and deficiencies. If the therapist discusses with the client the harsh reality of mass unemployment in the community, the client can modify his or her total self-blame, begin to acknowledge some anger about social inequities, and start to value himself or herself more. Then the client is in a better position to decide what to do about blatant social inequity.

Finally, it is time to talk about the ethics of disability. Many clinicians are torn: "Should I help this client win disability payments and thus diminish her motivation to ever work again?; or should I refuse to help, causing her more pain and hardship in the short run, but increasing her potential for self-sufficiency in the long run?" I believe such questions are poorly formulated. The important question is not about the client's motivation to work, but rather about her motivation to live. I am not at all convinced that laboring at backbreaking or demeaning jobs for sub-standard wages is better for one's mental health than is receiving disability benefits. I am not advocating unemployment. But I think professionals with well- paying jobs are too quick to decide for clients with a less-

than-high- school education that work is necessarily good for them. Satisfying work, where the worker expresses some skill or talent and is reimbursed with decent wages, ought to be a human right. But when people are deprived of this right, when unemployment rates are high and subminimum wages are all the uneducated and unskilled worker can find, then I have real questions about declaring work a prerequisite to a clean bill of mental health. The mental health professional's emphasis on work becomes a message that blames the victim for unemployment.

The more important question for me is whether or not a person is living his or her life to the fullest. When a chronic client, in order to control a temper, avoid sadness, or prevent madness, gives up the experiences of joy, intimacy, sex, or creativity, then a real tragedy is occurring. A therapist does better to prevent such a tragedy than to convince someone living this tragedy to accept demeaning or substandard wage work. Then, if the client is helped to open up and experience life more fully, it is more likely that he or she will eventually decide to return to school or seek job training in a desired field. Only then does meaningful or satisfying work become possible.

CHAPTER 10
Training in the Public Clinic

In the public clinic, the staff with the most clinical and technical expertise, the professionals, generally have the most middle-class biases and too little understanding of their clients' everyday lives, while the staff who best understand the community, such as the community aides and psychiatric technicians, have very little technical training and very little say about how the clinic is run and how therapy is conducted.

Many clinic directors attempt to improve the quality of therapy practiced by bringing in one staff trainer after another. They assume that with more training the staff will feel they are growing on the job, burnout will be less of a problem, and staff will serve clients more competently and energetically. The idea is a good one, but actual results rarely fulfill expectations. This is largely because the types of training and the process of training itself fail to bridge the gap between clinical expertise and real understanding of the clients and the community. I believe the only way to bridge this gap is by viewing therapy, as well as training and education, as an exchange among participants.

In this chapter. I will explain what I mean by exchange and will examine the parallel process that occurs between trainer and trainees, on the one hand, and between public therapist and clients, on the other. This discussion necessarily

focuses on the entire public clinic staff, not just the professionals. But I will begin the discussion by examining some issues involved in the traditional training of professionals to practice psychotherapy, and then proceed to the issues of exchange and parallel process.

The Training of Professionals as Psychotherapists

Psychotherapy proceeds through three phases. During the initial phase the client and therapist get to know each other; the therapist gets to know the client's presenting problems, and together they work out some ground rules for what is to occur in therapy; the client works through many doubts about therapy and initial distrust of the therapist; and the therapist teaches the client how to make use of therapy. By the middle phase the therapist and the client have learned to collaborate well and work intensively together on the client's problems, resistances, and disorders. This phase is the longest, and ends with serious talk of termination. The third or termination phase is the time the therapist and the client turn their attention to consolidating the client's gains from therapy and working through feelings and fantasies about separation and autonomy.

There are no clear demarcation lines between phases, and all these issues repeatedly appear throughout therapy. During the initial phase the client struggles mainly with questions of how to behave in therapy, what is expected, does it do any good, and how competent is this therapist. During the middle phase

the client takes much more responsibility for the work of therapy, and questions are aimed more at the meaning of the client's actions and the structure of the client's personality. The prospect of termination raises questions of self-sufficiency for the client: "Can I get along without the therapist or are all my gains dependent on the therapist's actual presence in my life?"

I believe that the training of therapists proceeds through three phases, too. During the first phase the trainee feels some abstract commitment to becoming a therapist but is not quite certain what the practice is about or whether it really works. The trainee shops around for a technique or teacher, is more or less impressed that a particular technique or teacher is effective, and struggles hard to understand the basic principles. Meanwhile, the trainee is meeting clients, not quite understanding which psychodynamic or psychopathological diagnosis applies to which client, and becoming more or less impressed when something gleaned from a book or something a teacher or supervisor said can be applied with a modicum of success to work with a client. The terms in the psychological theories—*ego, id, unconscious, transference, defense, splitting, projection, internalized object, etc.*—have a certain intellectual appeal and more or less fit together in a conceptual model, but the trainee cannot quite connect all these terms with the events that occur in therapy—for example, the client's sudden hostility or confusional state, the trainee's anxiety in the session, or the failure of the client to appreciate a correct interpretation. Even when the interpretation works, the trainee wonders whether or not the client is really making any

progress, or ever will.

The second phase in the training of a therapist involves more clarity. The therapist catches on. He or she has had some success formulating interpretations, has observed clients making breakthroughs when new levels of understanding are reached, and though interpretations are not always or even regularly proven correct, he or she knows the difference between an interpretation that works and one that does not, and can marvel at the regularity with which more senior, or master, therapists can hit the mark. No longer is the question, "Does therapy work?" The trainee, if he or she is undergoing personal therapy by this time, wonders in relation to his or her therapist and teachers, "Will I ever become a competent therapist, too?" "How can I become a better therapist?" This is a phase of intensive reading, attending seminars, undergoing therapy and supervision, and hooking up the benefits from all of these activities while feeling ever more competent as a therapist and curious about the psychological mysteries being unveiled in oneself and one's clients. During this phase, the trainee feels "inside" the therapy process. The technical terms, the experiences with clients, and the insights into personal psychological phenomena fit together. The trainee can make good use of the supervisor's feedback and the personal therapist's interpretations. But questions arise: "Am I capable of functioning autonomously as a therapist? Or am I just parroting with clients words my therapist, teachers, and supervisors feed me?"

A concrete example of this kind of questioning involves prognosis. While the trainee feels inside the process of therapy, he or she has not yet seen enough clients and has not had the experience of terminating by mutual agreement enough therapies, to have an accurate sense of which clients will gain optimal benefit from therapy and which types of interactions between client and therapist bode well or poorly for the eventual outcome of a particular therapy. These experiences are prerequisites for the trainee's accurate estimation of prognosis. Until the trainee has accumulated enough clinical experience, he or she relies on supervisors' assessments of prognosis, and feels very dependent on supervision.

During the third phase of training the therapist consolidates the confidence in his or her own skills, the mastery of models and techniques provided by books and teachers, and the breadth and depth of clinical experience, to become much more autonomous and creative as a practitioner. A singular personal style evolves with less reliance on a particular technical approach or a supervisor's advice. While the more advanced therapist hopefully continues to read, take refresher courses, and receive periodic individual or group supervision, he or she functions much more independently. There is a feeling that though there are no easy answers or universally valid techniques, the therapist is proficient enough to find some constructive course with the client.

There are no predictable time schedules for these three phases in a therapist's training. But, generally, if it is a depth psychology or therapy the

trainee is learning, and if the course of an average depth therapy is measured in years rather than months, then it takes at least six to ten years for the trainee to reach the third phase I have described. Of course, official degree programs for M.S.W., M.F.C., Ph.D., and M.D. therapists involve fewer years. Graduates of such programs who go on to become candidates in psychoanalytic institutes do remain in official training long enough to reach that third phase. But for other graduates the expectation is that once graduated they have completed their training. They expect themselves, and others expect them, to function autonomously as therapists. Problems arise, particularly in the public clinic setting. I will examine some of these problems in the cases of interns, psychiatrists and other professional staff.

Interns are trainees in graduate psychology, social work, and counseling programs who come to public clinics during or immediately after their degree programs, usually for nine-month or one-year stints, for the practical experience required by their licensing boards. Generally, interns come to public clinics early in their training, for their first or second year of clinical experience, and thus are in the first phase of training I described.

The first phase is difficult enough for the trainee in any setting. It is painful and confusing to be wondering what is expected of one, to be questioning whether or not therapy even works, and to be constantly reexamining the correctness of this choice of a profession. In the public clinic the difficulties are greatly

compounded by the realities of the public sector: inadequate resources, clients with urgent and seemingly overwhelming problems, communication barriers due to class and racial differences, poor client motivation, no- shows, premature terminations, staff burnout, etc.

Interns who encounter a high no-show rate tend to blame themselves. They have not experienced enough success as therapists to assume the clients might have reasons for no-showing that are independent of the novice therapists' competence. They tend not to believe supervisors and other staff therapists who say, "I have a high no-show rate, too." Then the intern who is treating a low-income client discovers that interpretations have little, if any, beneficial effect, and what the client seems to need more is very concrete help, such as transportation on an errand, money loans, help arranging baby sitting, or advocacy in the form of a letter to a probation officer or accompaniment to the welfare agency. The intern has sporadic success making interpretations and observing a shift in the client's resistances or an improvement in the client's daily life. But these seem small compared to the client's total needs.

In a private or academic clinic setting, such as the clinic attached to a university graduate department, clients probably have taken college psychology courses and know many peers who are in therapy. Though the clients attend the clinic because they cannot afford private therapists' fees, they are likely to be striving toward a higher income bracket. For instance, students in professional

schools often attend university clinics for psychotherapy. In such a setting there is room for the therapist trainee to wait before intervening, to experiment with interpretations, and to make mistakes. The client's motivation and confidence that therapy works permit her or him to tolerate some initial disappointment in the therapist. And such clients are likely to work hard in order to gain what they can from a beginning therapist's less-than-masterful interventions. Not so in the public clinic! The therapist must be more active and closer to the mark in the initial sessions if the less-motivated client is even to return for further appointments. This makes it all the more difficult for the intern to grasp the technique. Not only must the intern learn how to conduct an interview, how to formulate an interpretation, and how to assess the client's condition and response; at the same time the intern must learn how to prevent no-shows, how to cope with racial and class barriers, how to handle the client's fear of stigma in attending the mental health clinic, and how to integrate advocacy into the therapeutic venture. The intern's task is very difficult, even when he or she comes to the clinic out of sincere motivation to provide services for this underserved population.

Some interns despair of ever practicing effective psychotherapy. They have not yet reached the second phase of their training, in which they know therapy is effective and they set to work learning the technique. Rather, frustrating experiences delay their grasp of therapeutic technique and inhibit confidence in their capacity to effect change in the client.

In some cases, the beginning therapist is able to evoke significant growth in a previously unmotivated client, in part because of the beginner's enthusiasm and energy for the task. But just as often the client refuses or fails to make progress. The intern feels an increasingly urgent need to induce change in the client and thereby prove that he or she is a good therapist or that therapy works. Then the therapist becomes impatient or angry, and without being aware of the source of such feelings, pushes the client too hard or too fast and causes the client to resist all the more. This dynamic is exaggerated at the end of the intern's year in a public clinic.

It is not really appropriate to speak of termination as a phase of psychotherapy when the intern's therapy with a client ends at the close of an academic year. The client may or may not be ready to terminate; the timing of the end of therapy is based more on the intern's academic schedule than on any needs of the client. The intern's most pressing need is to believe that he or she has completed a successful piece of therapy and that the client's condition is somehow permanently changed for the better. Meanwhile, the client is concerned about the issue of separation. The client is losing a therapist, probably just at the moment he or she has let himself or herself believe therapy might do some good. While the therapist should be sensitive and attentive to the client's conflicts regarding separation, the beginning therapist, who is trying to prove to himself or herself and to others that therapy works, is trying to facilitate the client's growth in a few more areas. The client appears to the therapist as resistant, while the therapist

appears to the client as disappointed and disapproving. The client regresses and the therapist pushes harder. Both leave the therapeutic encounter feeling a failure.

Some interns turn to advocacy and community organizing, feeling they can be of better use there. Others vow never again to work in a public clinic. They go on to work in private or university clinics, and then on to private practice or teaching. Still others quit or turn to a career in research or administration.

Some interns or trainees latch onto simpler, more short-term therapeutic modalities, such as crisis intervention, relaxation training, parent effectiveness training, biofeedback, behavior modification, etc. With these modalities they find they can attain quicker knowledge of the literature, an earlier feeling of mastery, and quicker observable results. Where the choice fits the therapist's interests and provides satisfaction, and where the clients selected can benefit from the modality, this eventuality expands the variety of services offered by the public clinic. But I have discovered in talking with many therapists who made such choices early in their careers that they often regret having given up on long-term, more psychodynamic approaches to therapy. They complain that their simpler model has become limited and their methods are not effective except with very select clients. For instance, when psychosis or deep characterological disorders are apparent, many of their clients do not respond to the less dynamically oriented modality.

It is hard for the relative beginner in the initial phase of training to recognize that training is a long and tortuous process and to adjust expectations realistically to the current phase of that process. Adjustment to this reality is even more difficult when the internship is divided into nine- or twelve-month segments, and each therapy is necessarily terminated within that time span. If the intern were able to adjust expectations to the brevity of the therapy and the complexities of practice in the public clinic setting, he or she could gain great satisfaction from the realization that a small but important piece of therapeutic work has been accomplished with each client, even though a complete therapy, with a well-resolved termination and resolution of the client's major difficulties, has not occurred. Then, over the years of the training process, the trainee could fit together all the pieces of therapy accomplished and move on to the second and then the third phase of training. It seems to me that the key to this process for the intern in a public clinic is the realistic adjustment of expectations and the appreciation of small gains. The teacher and supervisor play important roles in this adjustment, just as they do in teaching the intern how to cope with no-shows and resistant clients.

Psychiatric residency programs generally last three years. Prior to residency the future psychiatrist's education and training has focused on anatomy, biochemistry, medicine, surgery, and pediatrics. The physician enters psychiatric training well prepared in some areas, and unprepared in others.

The very first day I walked into a psychiatric ward, after completing medical school and an internship in medicine and pediatrics, a nurse came up to me to say that I was the physician assigned to a patient who was acting out by screaming, throwing things, and disturbing everyone. She wanted to know what she should do. Having had very little prior psychiatric training or experience, I really did not know what to say. But at least my medical education had prepared me to remain calm and *act* as though I knew. I asked the nurse, "What do you usually do in such a situation?" After she told me the usual procedure, I merely said, "Do that." She departed, convinced of my competence, and confident she could now handle the situation.

Admittedly, this anecdote is a caricature. But even without prior psychiatric training, I had been so well prepared to play the role of physician-in-charge that I could take command of a strange and chaotic situation. The nurse knew what to do, but she had been trained to have a physician-in-charge, so she did not even mind teaching me what to do in order to feel reassured that it was I who was giving the orders. She also felt that she was participating in my training. I have often felt that the remainder of my training centered on preparing me better for that role of physician-in-charge, so whenever I faced a confusing situation, I would have some research literature to quote, some diagnosis to suggest, or some pills to prescribe. Such confidence has both good and bad ramifications.

Unlike the situation twenty years ago, today physicians have no monopoly in

the psychotherapy field. Previously, one practically had to be an M.D. to practice psychoanalysis, and psychoanalysis was the predominant mode of psychotherapy. Then came the 1960s and a rapid proliferation and popularization of a variety of therapy modalities. Therapists emerged from various professional disciplines, and no longer was it even necessary to have an advanced degree. As often happens, the decade of massive proliferation and popularization of therapy has been followed by a decade of controls, bureaucratic red tape and professional exclusivities. It has become more difficult to practice therapy without a degree and a license. But still, with many states licensing marriage and family counselors, art and dance therapists, and clinical social workers, the mental health professions have greatly expanded.

For example, as the counseling and therapy professions have opened up to a wider variety of practitioners, one large group that has taken advantage of the opening has been mothers whose children are grown. Many women have found that with some professional training they can apply their talents and experiences, including the experience of parenting, and become very competent therapists. Some of them can reach the third phase of training much more quickly than can younger professionals with more exclusively academic learning. With their entry into the field, with the emergence of so many newer modalities of therapy, and with the entry of many other varieties of therapists and special training programs designed specifically for therapists, *it is no longer necessarily the case that the physician/psychiatrist is the most accomplished or competent practitioner of*

psychotherapy.

Now the psychiatrist is left with a dilemma. He or she has been trained to be the expert and physician-in-charge. But the field of psychotherapy has expanded so rapidly and so many very competent practitioners abound who do not possess M.D. degrees that the psychiatrist's expert role is no longer assumed.

Physicians do not easily give up such a prestigious role. If psychiatrists are not going to be recognized as the most expert psychotherapists, psychiatry will withdraw some of its energies from the practice of psychotherapy and turn instead to work where its mastery is still unchallenged: differential diagnosis, the organic aspects of psychological problems, and physical or biological treatments such as psychopharmacology. In recent years, there has been a shift in the priorities for residency training programs, professional journal articles, and convention agendas. Less time and space are being given to issues and training involving the practice of psychotherapy; and a greater proportion of attention is focused on rigorous diagnosis, organic factors in mental disorders, and chemical treatments. There is much talk in psychiatry about a "return to medicine," the need to develop 'hard science" and a more "biological psychiatry," and a growing skepticism about the efficacy of psychotherapy and psychosocial approaches to mental disorder.

In fact, while a three-year training program in psychiatry can barely get the

resident past the first phase of psychotherapy training, three years is plenty of time to finish a specialized medical education and become very proficient at differential diagnosis, biological research, and pharmacological cures. Developments in these areas offer many potential benefits. But when these medical expertises are employed to fill gaps in the psychiatrist's training as a psychotherapist, the psychiatrist is likely to orient his or her practice toward more medical and biological modalities.

Then, when these psychiatrists work in public clinics and become overwhelmed by the relatively excessive demand for services, they are likely to suggest rigorous diagnosis and medication treatment as the only possible solution. When staff members seek consultation from the psychiatrist on difficult cases, they are likely to be told that they have misdiagnosed or that their client is out of control and requires stronger prescriptions. I have already discussed (Chapter 4) some of the dangers inherent in this approach. Here I will mention only that clients are denied quality psychotherapy and that psychiatrists and other staff members are falsely reassured that their difficult questions have been answered. An unfortunate result of disproportionate focus on diagnoses and medication is an expanded social-control function of the clinic.

Other professional staff. A phenomenon that greatly hinders staff training is the relative isolation of staff members. Each staff member tends to sit in an office with the door closed, working with one client after another, and rarely discussing

with other staff members what goes on behind the closed door.

Typically, the professional staff who work in public clinics entered the public sector immediately after their training. They, like the recently trained psychiatrist, were probably in the first phase of training as therapist, or perhaps beginning to enter the second phase. Their schedules were quickly filled with appointments to see clients whose needs seemed overwhelming. They approached their work with conscientiousness, vigor, and creativity. Perhaps they worked overtime to meet the demand in their first few years in the clinic. But then their energy began to dwindle. Rewards for their efforts were few and frustrations many.

Though clients tended to no-show, there were so many needing services that most available hours remained filled. There was hardly time to ponder why the clients no-showed or why the therapy failed. And, in most cases, there was little opportunity to discuss each clinical vignette with a supervisor or peer. Many staff members in various clinics have told me that training sessions and case conferences are a waste of time that could better be employed seeing more clients. And often they are right.

Generally, I have found that at staff meetings therapists are very hesitant to share their experiences. There are reasons. They have been out of training for some time and they have adopted very pragmatic approaches to the various clinical situations they have encountered. They often feel other therapists would

not value their idiosyncratic techniques. When their techniques fail, when one of their clients is readmitted to the hospital or commits suicide, they find it difficult to expose their sense of failure to others and risk criticism or humiliation. Without close clinical supervision, without having firmly entered upon the second phase of their training as therapists in spite of their degrees, and as the years of isolated practice accumulate, public therapists feel out of touch with the latest therapeutic techniques. Often they do not attend weekend or evening continuing-education workshops because they are too tired after a week at their job or because they are too pessimistic about the possibility they might learn something of value in their work. Diminishing budgets preclude the clinic itself from organizing very sophisticated training events for the staff, so, in many cases, the staffs training needs are not met. I am describing a bleak picture in order to identify some themes. Many public therapists do seek out workshops and supervision for themselves, but even those who do so are familiar with some of these themes.

My experience has been that traditional psychotherapy, even when competently practiced, is not effective enough in the public clinic; and traditional training practices are not particularly successful with public clinic staffs. Both therapy and training must involve more dialogue and exchange if they are to be effective.

Education and Therapy as Exchange

Paulo Freire defined education as an exchange. As a Brazilian educator, Freire spent many years teaching peasants literacy. He discovered that in order to hold students' attention and motivate them to learn, he had to learn about their local culture and teach them to read and write words that were important in that culture. He also found that his students learned better when they were involved in the creation of the lessons. He insisted that they learn to think critically rather than to memorize and recite lessons by rote. He discovered that when he was really teaching according to this model, and not merely indoctrinating his students, he learned as much from them as they did from him:

> Liberating education consists in acts of cognition, not transferrals of information. . . . Through dialogue, the teacher-of-the-students and the students-of-the-teacher cease to exist and a new term emerges: teacher-student with students-teachers. The teacher is no longer merely the one-who-teaches, but one who is himself taught in dialogue with the students, who, in turn, while being taught also teach. They become jointly responsible for a process in which all. grow.[65]

Therapy, like education, is a process of mutual respect and growth. When client and therapist forget this—for example, when they act as if the therapist is doing all the giving and the client all the receiving—then therapy becomes a process of indoctrination, in which the therapist judges the normality of the client's various behaviors, and the client is left with the choice of either complying with or rebelling against the therapist's instructions and advice.

Alternatively, if the therapist deeply respects the client's way of life, and

attempts to get inside that way enough to understand and appreciate it, he or she can utilize technical expertise to offer the client some feedback that might serve to improve the quality of the client's life. It seems to me that this is the central task of all therapy, but when class and racial differences exist between therapist and client, the task becomes very much more difficult.

This is not merely a matter of therapeutic strategy. A therapist might, as part of a strategy to boost a depressed client's self-esteem, take care to compliment her on her home-sewn garments or ask her how she is able to grow such consistently healthy looking vegetables in her backyard. But unless the therapist really is impressed with her sewing or really is interested in learning how to grow vegetables, the client will soon realize that the compliment is only part of the therapist's strategy, and will feel even more inadequate or more a charity case. In other words, if a personal sense of inadequacy comprises an important part of a client's emotional problem, then compliments offered by the therapist as a remedy will only reinforce that sense. On the other hand, if a therapist is truly interested in a client's way of life, then that client has something to give or teach the therapist, and an exchange is possible.

I use concrete examples such as sewing and gardening to represent something that is much more difficult to put into words. For example, Velma's world is very unfamiliar to me (Chapter 7). As a professional man with a well-paying job, it is difficult for me to know what it is like to be poor, to have one's

sons chronically unemployed, imprisoned, or dead, and to live in such constant proximity to violence. As Velma and I talk about her life, I learn something from her about as often as I offer her something of value. I offer her interpretations, feedback to help her correct distortions, or a shoulder to cry on. She teaches me about another way of life, a way to cope with repeated loss and deprivation, another way to view death, and experience the passage of time. Then, in some quiet moment when I am alone and contemplating my own experience, something Velma has said will come back to me and lend me new insight.

Again, this kind of exchange is, or ought to be, a part of all psychotherapies. Therapists have the privilege of hearing from clients intimate details of life histories and styles of coping, with which they can compare and contrast their own histories and styles. Therapists hear about various clients' experiences of marriage, of parenting, of illness, and of death. They receive instruction in business ethics and legal strategies. They even hear about books to read and plays to see. And in every interaction with clients, therapists are taught something about human behavior and response. What is missing from the psychotherapy textbooks, the public therapist must learn from clients. Teaching and learning in psychotherapy, just as in education, must comprise an exchange. This exchange does not occur in a vacuum, and seems to me to be closely related to the formal and informal process of staff training. I will describe a parallel process involving psychotherapy and training, and discuss the exchange that occurs in each.

The Parallel Process

Rudolf Ekstein and Robert Wallerstein describe a parallel process—the interpersonal dynamics among supervisor, student, and student's patient:

> The development of the professional self of the student depends on his specific and unique ways of seeking help and of helping—two faces of the same coin that have a definite functional relationship to one another. These idiosyncratic ways are decisive in patterning the interview with the patient as well as the conference with the supervisor. Such observations can be made more clearly if a teaching method is utilized that does not deny the affective, the interpersonal, aspects in the teaching as well as in the therapeutic situation. Other teaching methods, particularly those that are based primarily on information-giving—the authoritative transmission of technical advice—will tend to obscure these patterns, since both the interview with the patient as well as the conference with the supervisor will be dominated by the supervisor's way of doing things.[66]

An illustration occurred in my clinical supervision of a therapist, Sandra, regarding her weekly psychotherapy client, Anita. Sandra reported during a weekly supervisory session that Anita was undergoing some significant turmoil in her marriage. We discussed some dynamics that might be occurring between Anita and her husband. I suggested that Sandra try a particular type of interpretation to help Anita distinguish between what her husband was doing to her and what part she was playing in their squabbles. Sandra, who had entered my office quite anxious and feeling she did not know what next to say to Anita, left the supervision session feeling confident that she better understood Anita's situation and knew how to manage the next therapy session.

The following week Sandra returned for her next supervisory session and reported that in the intervening therapy session Anita was very angry at her, and that the interpretation I had suggested proved to be totally useless. Anita was angry at her therapist because she was not available enough during stressful times. Anita complained that though she felt very good and more in control immediately following a therapy session, the good feelings dissipated a day or two later, and she once again felt very alone, inadequate, and overwhelmed by the problems in her marriage. She would begin to resent Sandra, whose "magic doesn't last,'' and who is "never around when I need you most."

As sometimes happens, the interpretations Sandra and I had arrived at in discussing the last week's therapy session did not apply very well to the new material of the ensuing week's session. Sandra admitted she was disappointed and a little angry at me for this. She felt that I was not sharp enough to help her predict and manage Anita's anger and disappointment in her. Here is the parallel process. Sandra was angry at me for the same reason Anita was angry at her. Both complained that the strong helper they relied on was not powerful enough or available enough to prevent their feeling alone and confused by events that occurred between sessions.

As if to confirm the presence of the parallel process, Sandra then commented to me: "1 guess the reason I need to be so much on top of everything that goes on in my sessions with Anita is that I feel so lost myself when you're not around and

able to tell me what's going on with my clients." In other words, Sandra felt some of the same needs as her client, and was not able to tolerate her client's disappointment in her because she was so upset by her own equivalent disappointment in her supervisor.

The parallel does not end with the client/therapist and therapist/supervisor pairs. As I mentioned in Chapter 5, the concept can be extended to the staff dynamics in a public clinic, and then to the process of staff training. There are public clinic staffs, unfortunately too many, among whom little, if any, discussion of interpersonal relations occur. Each staff member practices behind closed office doors, and little is said at staff meetings or anywhere else about feelings staff members have about each other or about the way the clinic is run.

I was asked to consult with the staff of one clinic in which the director was very volatile and authoritarian. Sometimes he was present in the clinic and very critical of staff who came to work a few minutes late, failed to prevent a client's re hospitalization, or did not see enough clients per month. At other times he was away from the clinic for weeks at a time, for instance, visiting the state capital on clinic business. Each staff member tended to have strong feelings toward this director, especially regarding his critical stance and inconsistent availability. But since he was away so much, not many had a chance to sit down and talk with him. And staff members tended to share very little with each other about their feelings about the director and the way the clinic was run.

I do not believe therapists can be open and aware of interpersonal processes with clients in a setting where they cannot be open and aware of interpersonal processes with one another and with their administrative hierarchy. This is what I told this staff. The director was present during this consultation, and they began to share their common dissatisfactions with him. There began a long and gradual process of struggle among the staff to make the previously authoritarian administration more participatory. I will not describe the course of that struggle but will merely mention that a by-product of the staff's risking to air their grievances was their discovery that they all desired more clinical training and supervision. They began to share their clinical experiences with each other. Several staff members eventually told me it was easier to be aware of interpersonal dynamics with clients when the atmosphere in the clinic fostered open discussion of interpersonal dynamics among staff and between staff and administrators.

It is in the training of a staff composed of both professionals and paraprofessionals that the parallel process becomes most obvious. I began this chapter by mentioning the problem of professionals having the most expertise about psychotherapy and the paraprofessionals having the most understanding of the clients' culture and community. After discussing some issues related to the training of professionals, I explained the concepts of therapy-as-exchange and of parallel process. I will now examine the parallel process between therapy-as-exchange and staff-training-as-exchange.

Training-as-Exchange

The white professional therapist treating the low-income black client and the white professional involved in training a staff that includes many black paraprofessionals face very equivalent problems. I select .this constellation because these are frequently my circumstances and because this specific constellation serves to illustrate a more general point. The same parallel process occurs at other racial, class, sexual, and cultural interfaces. And the same type of exchange across race or class lines is required if effective therapy and training are to occur.

Entirely didactic training programs have very limited effectiveness in public clinics. This, in part, is because the staff, as trainees, are too passive or participate too little when lectures are the main training modality. Therapists must share their cases and personal experiences with the trainer if they are to really comprehend the concepts being taught and integrate them into their therapeutic practice. But this is not the only reason why didactic approaches fail.

Staff members frequently complain that clinical training sessions are irrelevant to their work: “How can we expect clients to desire insight into their psychological conflicts when their energy is put into finding work or stretching their money to pay grocery bills?”; “What good will it do for me to learn about transference when what my clients need is for me to go with them to fight a bum rap in court?”; or “I’m too busy getting clients through the red tape at the welfare

office to come to your training sessions."

Then there are value clashes. At one staff training session I was explaining the need to confront a particular client's manic denial and flight from depression. A black paraprofessional interrupted to say she felt that too often white professionals try to get black clients to be in touch with their pain when what the client wants is to be able to get away from the pain for a while, to do something upbeat and forget about overwhelming daily stresses. "I'm tired of white folks telling us they know about 'the blues.' You don't know nothin' about 'the blues,' and your 'no pain/no gain' therapy stuff won't help black folks any." This particular exchange led to a rather intense and productive discussion among the staff about class, values, and psychotherapy.

I do not mean to imply the professional's technical expertise is useless in the public clinic or that the staff should be homogenized to the point where no one's clinical expertise is recognized. In the above example, I completed my point about the client's use of manic defense mechanisms to deny and avoid depression, and made some suggestions to the treating therapist about how he might help his client better cope with the depression so as to eventually transcend it in a more grounded way. Then we had the discussion about values and psychotherapy. And then we discussed the possibility that if some staff members would contribute their expertise on clinical matters and other staff members would contribute their expertise on the community, then all the participants might benefit from the more

comprehensive discussion about therapy. It was in the context of this discussion that we decided to invite a black consultant with a different perspective to come to the clinic and do several training sessions.

I have not mentioned this incident merely for anecdotal relief. It actually illustrates two components I consider very important in staff training. One is that the entire staff participate in deciding on the direction the training program takes, and in its planning. The second is that whatever the class and race of significant portions of the client population, some members of those classes and races be brought in as consultants and trainers.

If the trainer facilitates this kind of exchange out of paternalistic motives— that is, if he or she condescendingly listens to the input of staff members only in order to gain the staffs trust and attention— then the exchange will not achieve the desired end. Just as the therapist must sincerely value the client's part in the exchange, so in training the trainer must value the staff members' contributions. A client I saw in group therapy was a real expert on the red tape of welfare and disability applications. I was not. He contributed to the group advice about filling out forms and winning appeals. I learned a lot while treating him.

In parallel fashion, I described, during a staff training session, a group dynamic that involved the group's rebellion against my leadership. I attributed the rebellion to their anger and envy. A black therapist raised her hand and suggested

I might be excessively interpreting anger because of some hangup I have, when really the group was not so much rebelling against me, but more expressing the cohesiveness and assertiveness I had been encouraging. Both interpretations were probably true to some extent, but I found her alternative perspective and emphasis very helpful. In ensuing group therapy sessions I shifted my focus from the anger expressed toward me to the evolving cohesiveness of the group. The group sessions immediately became more productive, and group members later told me they had been holding back while I was interpreting their anger because they feared I would be hurt by their assertiveness. When the focus of my interpretations shifted from their anger to their growing cohesiveness, they felt freer to take risks and explore some deeper group dynamics—for instance, why they felt I was so fragile.

In other words, the trainer can learn as much from a real exchange as can the trainees. Similarly, the professionals have as much to learn from the paraprofessionals as the paraprofessionals do from the professionals. Again, I do not mean to homogenize all the staff's talents and fail to recognize unique expertises. Rather, I am suggesting that the transcendence of some major obstacles to the competent and noncoercive practice of public therapy can evolve only from an exchange among the entire staff, and that training events are an excellent opportunity for such an exchange to occur.

Staff training conducted in this fashion offers to professionals a method of

preventing stagnation in their training as therapists. I mentioned in discussing interns, psychiatrists, and other professional staff that work in the public clinic often impedes their progress to the third phase of training as therapists. This does not have to be the case. Since they are practicing public therapy, with all the problems of that practice, their participation in training-as-exchange contains great potential for their continual growth as therapists and eventual mastery of a very difficult type of therapy practice.

I believe that psychotherapy, if it is to be effective in the public clinic, must comprise an exchange between therapist and client. In parallel fashion, training, if it is to be effective, must comprise an exchange between trainer and trainees. These parallel exchanges cannot guarantee quality noncoercive therapy for low-income clients, because social and external obstacles remain, but such therapy and training provide the best tools to help us overcome some of the obstacles.

CHAPTER 11
Termination

The termination of psychotherapy, like other separations and losses in human relationships, is a complicated and troublesome event. Everyone experiences repeated losses and separations throughout life, and everyone has a personal style of coping. Generally, an individual's style of coping with separation and loss has much to do with his or her reasons for seeking psychotherapy. Thus, some people are so frightened of being rejected or deserted that they withdraw from all meaningful intimacies and consequently feel isolated and alone. Others adopt a pattern early in their lives of denying the pain connected with rejections and disappointments by loved ones, and continually deny that they actually need anyone else. They drift from one superficial relationship to another and eventually seek help from a therapist because they are bored with life and relationships and fearful that they cannot accomplish satisfactory intimacy. Others act helpless, chronically sick, or hopelessly depressed, cherishing the illusory expectation that some strong person will come along to take care of them and never leave them. Others fall to pieces and become confused in the face of any intense or painful separation—for instance, such a person may experience a "psychotic break" when it is time to leave the parents' home or when a parent or mate dies. And still others are so needy and so consumed with rage toward loved ones who disappoint and desert them that they bring into every new human interaction an intensity of rage and ambivalence that precludes the establishment of a loving relationship.

Whatever the individual client's prior experience with separation and idiosyncratic style of coping with loss, the therapy is designed first to foster dependency and then to help the client separate in her or his mind old patterns and distortions from current needs and realities. The therapist establishes with the client an intense relationship that reawakens old fears. "If I let myself be dependent on you, you'll desert me or attack me just like all the others." "If I express anger you'll retaliate by rejecting me." "If I tell you what I'm thinking, you'll think I'm crazy and lock me up." "If I'm a good client and only feel the things I'm supposed to feel, you'll keep on seeing me and being nice to me." The therapist helps the client to recognize previously unrecognized fantasies and to explore the relevant themes.

In the artificial setting of the therapeutic encounter, and in the presence of a therapist who discusses the whole matter with the client, the client reexperiences dependency in a more constructive manner. Then, just when the client has accomplished the work of therapy and evolved a better way to cope with the inevitability of separations, he or she is faced with a very real and massive loss—that of the much-needed therapist. The therapist's task at termination is to help the client work through the impending loss in a new way, free of the self-destructive and maladaptive mechanisms that earlier permeated the client's coping style and led him or her to seek therapy.

Termination is a process that occurs by mutual consent of therapist and

client. The two decide it is time because the client's symptoms have sufficiently diminished, the therapist believes structural change has taken place, and both are confident that the client has sufficiently internalized and integrated the experience and lessons of therapy to proceed in life in a new way.

How does the therapist know it is time? According to Frieda Fromm-Reichmann, the client must be able to accurately "see people and situations in general as they are rather than as shadows of their past experiences." She suggests that the therapist will know when to terminate by watching for a diminution of the client's transference distortions, or "when the patients' statements pertaining to the therapist become increasingly true to fact."[67] Harry Stack Sullivan generalizes that as a consequence of therapy, "the successfully treated mental patient, as he then knows himself, will be much the same person as he is known to others."[68] Heinz Hartmann writes, "a healthy person must have the capacity to suffer and to be depressed."[69] Each of these psychoanalysts are explaining what they consider good signs that structural change has occurred. There are many other signs.

The concept of structural change is a theoretical consideration (Chapter 2). The therapist has some explicit or implicit theory about psychological structures and about change as a result of therapy. If the therapist thinks in terms of ego, superego and id, then examples of structural change are the stabilization of a more integrated ego, the evolution of a less harsh and punitive superego, or the

formation of a more appropriate boundary between id and ego. If the therapist thinks in terms of object-relations theory, then structural change might mean the attainment of better "object constancy" or the integration of previously "split-off part objects." There are other theories and other terms for therapists to use to think about structural change. The point is that structural change is something that occurs within the theoretical model of the therapist and is not something easily understood or observed by the client. An important aspect of termination is the therapist's explanation to the client of the structural change, and this usually cannot be in theoretical terms.

A useful way to talk with clients about the timing of termination and the long-lasting effects of therapy is to talk of *internalization* and *integration*—in the popular, rather than the technical, sense of these terms. A client who is chronically depressed and who throughout most of the course of psychotherapy uses the therapist to bolster his self-esteem and supply some hope for the future may be ready to terminate when he has internalized these functions of the therapist enough to maintain his own self-esteem and supplies of hope. A client who tends to be flighty or hypomanic may use her therapist to ground her in reality and help her stay in touch with her sad part—she must internalize the capacity to stay grounded and face sadness before she is ready to terminate. A client who sees a therapist because he cannot otherwise "hold himself together" or literally "falls apart" during psychotic breaks must internalize the therapist's function of holding him together through stressful times before he is ready to terminate. A client who

finds in the therapist “the only person I can really talk to” and begins therapy with an impoverished support network must internalize some capacity to relate intimately with others and form a more functional support network before terminating.

Beyond internalizing, the client must be able to *integrate* what has been learned and thus be able to go beyond the specific lessons of the therapy. According to Peter Sifneos, termination of a successful therapy ideally occurs when the client is able not only to apply the insights gained in therapy to new situations but also to reach new insights in face of new stresses and in the absence of the therapist.[70] I will give an example from my own practice.

During a casual meeting a year after the termination of therapy, a woman who had been my client reported that in the intervening year her brother died of a heart attack. While mourning, she was able to separate the part of her feelings toward him that arose out of their unresolved childhood rivalries from the part that represented pure grief. Only then was she able to work through the former and remain in touch with the latter, thereby accomplishing the proper work of mourning. Though, for a year and a half of therapy we had focused mainly on her pain and sense of inadequacy following desertion by her husband, she had integrated the therapeutic gains well enough to be able to cope, maintain her self-esteem and arrive at new insights in the face of a new loss. The process of conflict resolution and growth does not end with the termination of therapy. Termination

is constructive only when it is likely that the client will continue the process independently.

Three Termination Themes

The process of termination, or the phase of therapy stretching from the negotiation of a date for termination to the end of the last session, can be intense and full of conflict.[71] Not surprisingly, the issues that dominate the termination phase tend to be related to the issues that mattered most to the client throughout the therapy. Thus, the client who throughout the therapy is acutely sensitive to any action on the part of the therapist that might be interpreted as a rejection is likely to experience termination as a massive rejection. The client who is very anxious about being alone in the world is likely to become more anxious at termination. The client who handles such anxieties by regressing, clinging, becoming sick, or becoming excessively dependent is likely to do so anew at the time of termination. The client who copes by denying feelings will likewise do so at termination.

All of these themes emerge at certain moments in therapy with every client. They are merely the various aspects of anyone's reaction to separation and loss. But for certain people, one or another of these themes dominates. With them, the theme that dominates throughout the therapy will likely be the theme that dominates at termination. Three fairly common themes are resentment about

rejection, regression in the face of anxiety about being alone in the world, and denial of both dependency and loss.

Resentment of rejection. Some people are hyperaware of rejection and typically respond with resentment. They have great difficulty coping with what they perceive or imagine to be rejections in their daily lives, and even end up manufacturing rejections where none exist. One client came to see me six months after breaking up with his wife of four years. He left her in order to pursue a relationship with a woman with whom he was already having an affair. Six months after leaving his wife, this new relationship ended, and he returned to his wife, seeking a reconciliation. By this time, she had decided there was no hope for the marriage and had begun to see another man. She did not want a reconciliation. My client felt crushed. He complained of feeling totally rejected by his wife—in spite of the fact that it was he who had left her.

Soon after beginning psychotherapy, this man came to a session twenty minutes late. When I said our time was up, he complained, "You don't really care about me—you never have enough time to listen to my problems." I pointed out that he was doing the same thing to me that he had done to his wife, and we talked about his dread of being rejected and his lifelong pattern of rejecting others first in order to avoid being rejected himself.

Most clients experience feelings of rejection whenever the therapist is late

for an appointment or changes a regular appointment time. Or the client might resent the therapist's suggestion that he or she switch from individual to group therapy, or might become upset when the therapist announces a vacation. Clients feel rejected when their therapist forgets a detail of their personal history or resent the fact that their therapist sees other clients. Such feelings arise in all clients at certain moments. With most clients, these feelings, once expressed, are easily worked through. With others, it is not so easy. One of the reasons a client is diagnosed as having a borderline character disorder is that dependency and rejection are particularly conflict-laden issues—and "borderlines" scream their protests loudly.

Whether the client merely mentions the issue or loudly shouts his or her resentment about being rejected, the dynamic that has not been sufficiently uncovered and worked through during the course of the therapy will become very difficult to work through at the time of termination. The therapist is "just like all the others" in one way—he or she does ultimately leave the client to his or her own path. The client can be expected to have mixed feelings. He or she potentially takes away from the therapy some good memories and some bad ones. Examples of good memories are the times the therapist was warm and understanding when the client was needy, or the times the therapist gave a helpful interpretation or piece of advice, or the times pleasant thoughts about a recent therapy session carried the client through a depressing period between sessions. The bad memories are of times the therapist seemed mean, unsympathetic, unhelpful, or

rejecting. Just as the therapist must, throughout the course of therapy, help the client recognize and work through the negative feelings in the transference, so must the therapist, at termination, help the client recognize the anxiety and anger about being deserted or left alone on his or her path. Once recognized, the negative feelings can be separated from the positive ones, and the positive ones can be accepted. The therapist might comment: "It is clear you are really angry at me because therapy is ending; I hope that doesn't mean you will forget the positive feelings and positive experiences we have shared." A constructive outcome of therapy depends on the good memories coexisting with and, in the balance, outweighing the bad, so that the client leaves feeling that, in spite of some disappointments, the therapy experience was generally helpful.

Anxiety and regression. Some clients dread being alone. In their intimate relationships they become excessively clingy or dependent. They regress and become very needy whenever the therapist plans a vacation, or may become ill or increasingly depressed when the therapist suggests a transfer from individual to group therapy.

One woman went to see a therapist after attempting suicide with an overdose of sleeping pills. After a year of therapy she seemed much less depressed and not at all suicidal. Her therapist, believing that this client now needed less support and advice and could handle deeper interpretations, began to reassure the client less and interpret more forcefully her need to be dependent and

helpless. Three days after the therapist shifted her tactics, the client phoned her. She had never before telephoned between sessions. She seemed panicky on the phone and told the therapist she was planning to commit suicide. The client had interpreted the therapist's tactical shift as abandonment, become very anxious, and acted in such a way as to impress the therapist with her inability to function more autonomously. The therapist then had the difficult task of working through with the client her dread of abandonment and of being alone, and ultimately helping the client recognize and strengthen her capacity for independence.

When it is time to terminate, these clients again react with anxiety about being alone. Their dreams and fantasies involve terror, emptiness, or death. They might regress either by experiencing a return and worsening of old symptoms or by becoming more needy and less autonomous. Or they might find a strong nurturing person, perhaps a new lover, on whom they can depend while their therapist leaves them.

In other words, they reject the gains of the therapy, as if to say, "if you're going to desert me, I'm going to disavow everything I've gained from knowing you," or "Can't you see how upset and helpless I am? How can you possibly leave me now?" In more extreme cases, the client attempts suicide, perhaps in order to convince the therapist or someone else of his or her neediness, or perhaps to express rage and invoke guilt about the abandonment. More often, the client merely refuses to proceed with the work of termination and regresses while

undoing previous gains.

With this kind of client the therapist's task is to focus on the conflict about dependence/independence all along in the therapy, interpret the fantasies and anxieties that underlie the dependency need, help the client verbalize and test, in reality, the dread of being alone, support and nurture the client's capacities for independence, and then introduce the prospect of termination only after the client has worked through these issues sufficiently to face the loss of the therapist in a nondestructive and growthful fashion.

Of course, the therapist can accomplish this task only if he or she has mastered personal countertransference needs to maintain the client's dependency. Most therapists become therapists because they want to help people. They also want to be appreciated for the help they offer. Sometimes a therapist's needs in this regard are counterproductive. Some, but certainly not all, public therapists work out deep-seated personal conflicts by helping others. For instance, the therapist might need to help others to compensate for feelings of not having been helped enough himself. By identifying with a client's neediness and then satisfying that client's needs, the therapist is able to make up for a sense of having been deprived of adequate caring early or recently in his or her own life. The therapist cares for the client in ways he or she wishes someone had or would care for him or her.

It would be nice if all therapists worked through all such conflicts in their own personal therapies before practicing with clients. But unfortunately this is often not the case. The therapist who has not worked through such issues then has a great deal of trouble coping with feelings aroused by ungrateful clients: "They don't appreciate anything I do for them!"

Such feelings make it very difficult for some therapists to stay with angry clients up to and through the termination phase. They tend to drive such clients away, usually through unspoken messages, so all they know is that they encounter very many no-shows. Then they react by filling their caseloads with more dependent clients who more readily say thanks. This is an unfortunate dynamic and one that requires good clinical supervision, plus openness on the part of the therapist, to correct. Meanwhile, the therapies that occur between therapists who need to be thus appreciated and clients who are dependent and appreciative can be somewhat stagnant and without end. Left unchecked, this dynamic leads to very early therapist burnout.

Denial of dependency and loss. Still other clients react to separations by denying their dependency on the therapist in the first place, and then by denying any feelings of loss at termination. The extreme example is the client who fits the description of the narcissistic personality. He listens carefully to the therapist's words, selects from among them what seems useful, fails to acknowledge that the useful ideas came from the therapist's interpretations, refuses to recognize or

appreciate that the therapist is even helpful or needed, and then, after leaving the consulting room, mulls over the helpful ideas and convinces himself that it was he and not the therapist who thought of them. In other words, he takes and uses what the therapist gives him, all the while convincing himself that "I don't need him, I'm actually treating myself and doing a better job than he ever could." The narcissist needs to devalue others in order to protect himself from the risk of rejection and in order to bolster his very tenuous self-esteem.

Many other clients devalue the therapist's usefulness for other defensive purposes. But the effect is the same: the client denies that she or he is really dependent on the therapist and thus avoids the potential catastrophe of rejection or desertion by a highly valued and needed other.

This theme is not limited to the narcissistic personality. Most clients who undergo psychotherapy at some point and to some degree deny their dependency on the therapist and deny their feeling of loss. At termination, the client might minimize the importance of the approaching termination date. She might say seriously, "Well, you're a pretty good shrink, but really I haven't learned as much from you as I get by doing Yoga and thinking over my own experience"; or she might say in an offhand way, "I really won't need to see you anymore, everything's going to be all right now." Her underlying fantasy is likely to be, "Since I never really let you matter much to me, your loss won't be a big hardship. I'd be destroyed if I let you matter as much as someone once did, and then you deserted

me the way that someone did."

If the therapist is able, during the course of the therapy, to break through the barrier of denial—and this is no easy task—the client will be able to explore his or her conflicts about dependency and in the process begin to distinguish between fears about dependency that come from earlier traumatic experiences and ones that are appropriate in the immediate context. Then, at termination, the therapist can help the client accept that a big loss is occurring and weather it without having to deny feelings.

I have artificially isolated three very familiar themes of coping with separation and loss. The reaction of every client to separation actually involves some degree of resentment, some anxiety about being alone, and some need to deny painful feelings. Each client's coping style puts different emphases on these and other coexisting themes. But whichever pattern is dominant, the task of the therapist throughout the course of the therapy, and particularly at termination, is to help the client examine his or her own coping style and work through the particular distortions and conflicts that characterize that style. Then the client can experience separations and losses in a more constructive way. If, as a result of therapy, a client is no longer hyperaware of rejection, no longer regresses for fear of being alone, or no longer needs to deny dependency and grief, then the client still must face the real loss that occurs at the termination of therapy. The therapist helps the client stay with the feelings of loss and to discover that such feelings will

not destroy him or her and that the loss does not mean that he or she is worthless or unlovable. In other words, whatever experience of earlier loss caused the client to constrict his or her life and suffer certain symptoms, the therapy should aim not only to remove the constrictions and symptoms but also to help the client with the experience of real loss. The therapist terminates the therapy by preparing the client to mourn the loss of the therapist. The client who no longer magnifies rejections, regresses, or denies feelings can then survive the feelings about losing a valued therapist and go on to better cope with relationships and realities.

The Three Themes in Public Clinic Practice

The main problem with terminations in the public clinic is that they do not occur often enough—at least not in the ideal way I have described. Therapies end and clients stop visiting the clinic, but usually not by a well-worked-through process. More often, a client no-shows when the symptoms begin to lessen or, at the first sign of anger or disappointment, announces that he or she will never return. The therapist is left feeling unfinished, without even a way to evaluate outcome.

There are many reasons why clients prematurely terminate therapy. Sometimes it is debatable whether or not the termination is actually premature. The therapist believes it is, since the client has not worked through the deeper issues underlying the symptoms. The therapist might feel that the client's partial

improvements are merely a “transference cure,” a resolution of symptoms caused by the therapist’s presence in the client’s life, likely to be followed by renewed symptoms when the therapy ends. Or the therapist might feel the improvements are a “flight into health,” the client’s effort to temporarily squelch symptoms in order to escape the need for therapy. The client, on the other hand, is likely to feel that he or she came to see the therapist for relief of symptoms, the symptoms are relieved enough for now, and there is no reason to continue seeing the therapist.

This difference of opinion reflects a deeper disagreement about the relevance of therapy. The therapist has an abstract concept of therapy as a process that results in deep and long-lasting psychological change. Symptomatic improvement is the first step, after which the real work of the deeper change can occur, including the process of termination. This abstract concept is shared by many clients in private practice who have read and talked a lot about therapy and view therapy as a desirable process to undergo and as a potential help with their personal problems. With a shared abstract concept of therapy as a practice desired for itself, private therapist and private client are likely to continue meeting through transient periods when therapy does not directly affect symptoms or when the whole purpose of the therapy seems rather vague. The private client sees the point of becoming involved in a dependent relationship with the therapist and eventually terminating that relationship. This is part of that abstract concept of therapy.

Not so in the public clinic. The client probably will balk at the prospect of dependency. Dependency on public service providers is a losing proposition. And public clinic clients generally do not value therapy for itself. They came to have their symptoms treated. Certainly, the therapist should attempt to educate the client from the beginning about why it is useful to continue after the symptoms have improved. But if the client leaves satisfied with the improvement, the therapist should not devalue the work that has been completed just because the client does not wish to return to finish the therapy. Perhaps, if the discussion about this is open enough, the client will even say thank you for what has been accomplished, and may even return for more help when more symptoms or another crisis occur.

A middle-aged white woman came to see me because she was depressed. She had a wretched self-image. She saw herself alternately as a whore and as a helpless child. She was very obese and very depressed. I began to bolster her self-esteem by chipping away at the distortions in her self-image. We talked about sex and whether or not she had a right to enjoy herself now that her husband had left her and she was desiring a man's company. I asked how helpless could she be when she managed to survive on welfare, sew her own clothes, and make sure her three teenage children went to school every day. After seven weeks, this woman began to think better of herself. She met a man she liked and with whom she enjoyed sex, and she resolved to lose weight. Fine, I thought, her symptoms have diminished somewhat; she is better able to trust me and stay with the process of

therapy, and now we will proceed to deeper issues. The client thought otherwise. She decided to terminate the therapy. “You’ve been really helpful. I’m not depressed anymore. I’ve met someone. I don’t need to see you now.”

Even when public therapists initiate talk of termination, a frequent reaction they receive is: “That’s okay, I’ll miss you, but I’ll get along.” Is this an expression of the denial of dependency and loss? Or is it merely the remark of a too-polite person thinking to himself or herself: “I appreciate what you’ve done for me; I won’t question your wish to move on, and I won’t hold it against you”? Or is it the reappearance of the kind of total self-devaluation that marked the client’s initial depression: “I’m not very worthy, I don’t really deserve to take up much of your time, so I sort of expected you’d be ending the therapy”? We would like the client to show a little disappointment, anger, or sadness. That way, we would know we were valued and would be missed.

Sometimes *resentment about rejection* is the more apparent theme. Clients come regularly for appointments and then discontinue just when improvements begin. Some drop out at the first mention of termination. Other clients fail the very last scheduled appointment, as if to say, “You can’t kick me out of therapy, I’ll decide when we end.” I know of one client who practically begged the therapist to extend the therapy one more week after the agreed-upon termination date and then, after showing up on time for all prior sessions, no-showed for the extra session and refused to have any more contact with the therapist.

A power struggle may be involved. As noted in Chapter 3, it often seems to the client that all the power is in the hands of the therapist. The client comes to the therapist's office, sees him (or her) on his time schedule, and talks about what *he* decides is important. Unresolved feelings about this emerge as termination approaches. The client indirectly expresses anger at the therapist about the termination and, at the same time, gains control of the final meeting time.

This theme might emerge in any psychotherapy, with clients of any race and class. But there are specific concomitants in the public clinic setting. The low-income client already feels deep ambivalence toward service providers before even meeting the public therapist. Perhaps a caseworker doled out grossly inadequate funds, or a probation officer threatened to revoke probation. The client has experienced feeling caught between the need to offer the caseworker polite thanks for what was granted and the urge to tell the worker to take the proffered crumbs and go to hell. Or the client with the probation officer was tempted to refuse all the insulting conditions of probation and suffer the consequences. Then the public therapist explains that this relationship, which has just begun to be trustworthy and productive, must come to an end—and for some abstract reasons that the therapist and not the client understands.

As if to highlight the social reality involved in our encounter, one client told me: "You don't live here. When they cut off food stamps, you don't suffer any. You go home to your family, have a drink, and forget all about us folks that's got to live

here. I don't know why you're here, but when the going gets rough, you'll clean out your desk and go open a private practice somewhere, just like all the other shrinks that pass through this clinic."

I used to deny such allegations and at least think to myself that they were not true. I believed I practiced in a low-income community largely out of a sense of social commitment and concern about the inequity of a double standard of mental health services. But then I discovered my countertransference. I denied the allegations because of my need to be seen as the good guy. But by denying the allegations, I was preventing clients from expressing a legitimate gripe against me and other public service providers. I had to admit the reality basis in such complaints and allegations.

"Maybe there's some truth in what you say, but does that mean there's nothing we can accomplish and learn with each other?" Here again is the crux of the termination issue, and the theme of *resentment about rejection*. Maybe the client does have good reason to be disappointed in the therapist, to feel rejected, to feel that the therapist is biased or does not understand the local culture. Maybe the client is appropriately angry, envious, or resentful. The question remains whether or not this therapist can help this client with some particular problems.

The "shrink" can leave the ghetto, and the therapist is often the one who initiates talk of termination. The therapist's current options are greater than the

client's. But this does not mean that the therapist cannot commit a certain period of time to be available to the client. And it does not mean that the client cannot derive some benefit from the relationship. For instance, the client can explore his or her envy of the therapist's mobility and his or her aspirations for more mobility. All relationships are ultimately transient, at least in the sense that an intimate might die. But also close friends move to faraway places, love affairs break up, and other circumstances cause everyone gradually to replace some relationships with others. When a person is so afraid of the risk of rejection that he or she does not permit intimacy and trust to develop with anyone, he or she suffers from a self-imposed isolation. This might be one reason why a client seeks therapy.

The theme of *anxiety* and *regression* is often played out against the backdrop of a welfare system that fosters dependency and selfdevaluation. Some individuals decide to give up seeking the demeaning and low-paying jobs that are available, and instead adjust to being "on the county." They cannot be lazy—survival requires that they work on the side or hustle to supplement their ridiculously sparse aid. No one lives on welfare when more pleasant options exist, but many people who have no other options are able to accept welfare, ignore the stigma, and retain their pride. Others feel humiliated by their need to be dependent on public assistance. They judge themselves as harshly as does the society that so ungraciously grants the welfare aid.

Helen's problems with dependency and self-esteem are aggravated by her being on welfare. She began her therapy by displaying her meekness: "I won't take up much of your time today, I know you have a lot of clients to see." I responded: "What do you mean you know I have a lot of clients to see? Don't you think you're important enough or special enough for me to want to spend time finding out what's troubling you?" No, Helen did not think she was important or special. In fact she did not feel worthy enough to even express her wishes or hope to have them realized. At forty-six, Helen was obese, very unhappy, and immobilized.

Helen became pregnant at sixteen and married the child's father, even though she did not love him. "It was the right thing to do—I would never dream of getting an abortion." She continually put her own desires out of mind and did "the right thing" to hold onto her man, until three births later, at age twenty-nine, she suffered a massive depression and was briefly hospitalized. The psychiatrist prescribed strong psychotropic medications—Triavil 4-25, a combination antipsychotic and antidepressant drug. He told her she should go home, try to please her husband, "forget your romantic notions about love," be a good mother, and "take these pills for the rest of your life." Helen followed the psychiatrist's instructions. She took the pills religiously, never saw a psychiatrist again, went to her family doctor for prescription refills, and raised four children.

Ten years before she came to see me, her husband suffered a severe back injury on the job. Ever since then, he has remained home, a total invalid and

entirely impotent. Helen had been considering leaving him before he suffered the injury and was having an affair with a man she believed she loved. But after her husband's accident she began to feel very guilty, ended the affair, and decided to stay home and take care of her husband. She quit work and went on welfare. At first she felt terrible about accepting welfare. Gradually, she swallowed her pride and developed a view of herself as a loser in all spheres—a failure as a wife, a failure sexually, and a failure as a worker. She repeatedly asked her doctor to increase her dosage of Triavil. Her depression worsened, and she gained weight.

I worked with Helen on her self-esteem, constantly questioning why she insisted on diminishing her own worth and denying that she deserved any happiness for herself. The therapy lasted over two years, during which time Helen became very dependent on me. Once, when I told her I would be leaving on vacation, she failed to appear for the two appointments immediately preceding my vacation. When I returned and saw her, she seemed more meek and depressed than ever, and reported she had visited her family doctor and he had tripled her dosage of Triavil.

There was a part of Helen that viewed herself as a complete zero, denied she was entitled to any happiness, including a happy sex life, denied she was capable of personal desires or autonomy, felt very guilty about the affair she had, and kept herself fat and depressed as if to fulfill her own prophecy. There was another part of Helen that wanted more out of life, hated her husband for his impotence, was

dissatisfied with her lack of passion, and wanted to do more than just remain on welfare, take care of her home, and gain weight. Helen and I talked about these two parts. She admitted feeling comfortable and safe with the more dependent part but quite anxious whenever the more independent part expressed itself. “I don’t want to upset my husband. I can’t leave him, it wouldn’t be right. And what’s a middle-aged fat lady going to do out there all by herself anyway?” She was scared, and that is why as soon as I deserted her for a few weeks she returned to her old pattern of taking more pills and denying her own desires.

Helen and I continued to explore her conflicts about independence. Her self-esteem grew, she lost forty pounds, and she became more energetic. As these changes occurred, she expressed more dissatisfaction with her marriage, more resentment toward a husband who could not satisfy her, and more desire to get out of the house and become active. Eventually she decided not to leave her husband, but she became involved in occasional affairs. She enrolled at a local junior college, began to play cards with friends, and took a part-time job that paid more than welfare.

When I suggested we terminate the therapy, Helen regressed and once more protested that she was unable to cope on her own. She had taken no medications for six months when we spoke of termination. Then she insisted I prescribe Triavil again. She complained she could not sleep, that she was feeling more depressed, and that she was missing days at work because she could not get out of bed in the

morning. She said she was quitting work and going back on welfare. When I refused to prescribe more drugs, she returned to her family doctor and asked him to prescribe, and she began to fail to keep appointments with me.

Helen was not ready for termination, and we negotiated a contract for six more months of therapy. We agreed that she would not take any pills, would continue to work, and would talk about her fear of termination rather than no-showing. During the ensuing six months, we focused on Helen's tendency to deny the independent part of herself while regressing and viewing herself as totally dependent on pills, welfare, her family doctor, and me. Each time she focused on the dependent part, I reminded her of the independent, passionate, dissatisfied, and very competent part, and the way she both desired and feared that part's expression.

By the end of the six months, Helen decided to continue working and not to take any more psychotropic medications. She was very sad that the therapy was ending, as was I. She was able to express that sadness, knowing that such expression was not a sign of helplessness and worthlessness. "You'll always be a part of my life. I'll think of you whenever I start wanting to quit and just eat and stay in bed."

When therapist and client in the public clinic reach the point where the issues of resentment, denial, and regression can be discussed openly, significant

progress has been made in therapy. A constructive termination becomes possible. It is by understanding and exploring honestly the psychodynamics and the social dynamics that are part of the termination issue, and continually linking the two with each other, that the public therapist stands a chance of working through with the client the termination of psychotherapy.

CHAPTER 12
Staff Burnout

Werner Mendel defines burnout:

> Burnout refers to the failure, wearing out, and exhaustion of professionals and paraprofessionals who provide health care. ... If a particular delivery system treats those mentally ill people who are also the most resourceless and most impaired, namely the chronic patients who live their lives with schizophrenia, then staff burnout is an almost inevitable consequence. The disparity between the publicly accepted model, with its emphasis on crisis care and case closure, and the reality of providing supportive care without closure becomes a major source of difficulty for personnel.[72]

Frequent premature client terminations are one reason why staff burn out. There are other reasons. Before discussing some of them, I must mention that as a physician I have a unique perspective. I am not immune to burnout, but the privileges attached to my role as a psychiatrist offer some respite. My salary is higher than that of anyone else in the public clinic. I have more mobility, in the sense that there are always other jobs available for physicians, and this is less the case the lower on the job hierarchy one sits. I have more leverage with clients, partly because of their respect for doctors and partly because I can prescribe medications as well as practice therapy. I can thus use pills to motivate or facilitate therapeutic progress, and I can function more autonomously than therapists of other disciplines. I have more leverage with other therapists and other agencies—everyone listens a little more closely when a credentialed physician speaks. I have had more training than most other therapists, specifically

training in diagnosis and prognosis. Thus I am better able to draw a line between clients I can treat and ones I cannot, and to rationalize when I fail that the client's pathology is the cause of the failure. I am asked to do much teaching and supervision, so I receive validation from activities other than direct provision of services. And I am in a good position to write about my experiences and receive validation from my writing. I mention all this not to separate myself from other clinicians, but to show that although my situation is less stressful than many others', burnout is still a big hazard in my work. I will give an example.

A white, upward-striving thirty-five-year-old family man came to our clinic after a mild suicide gesture and brief hospitalization for depression. He had failed in his attempt to begin a small business, and his wife was threatening to leave him. He had swallowed four or five sleeping pills just before his wife was expected to return home. After discharge from the hospital he was assigned to a social worker, and she referred him to me for consultation about medications. I prescribed a mild tranquilizer, had a brief conference with the social worker, and she continued to see him in individual psychotherapy. When I saw him a few weeks later to reevaluate his medications, he seemed somewhat less depressed and more motivated to work in therapy. He denied any thoughts of suicide. A few weeks later the social worker asked me if I thought he might benefit from group therapy along with his individual therapy. I agreed to include him in a group I was then leading, and he sat in for a trial session. He talked a little about his feeling a failure, and the group members responded sympathetically to him, but he decided they

were “too chronic” for him, and he did not return. Three weeks later he no-showed for his appointment with the social worker, and one month later we heard he had shot himself and died.

Two things were apparent when we did a retrospective review of this case: (1) this man was a very high risk for suicide, and (2) we missed this. The social worker and I both felt awful. She had not pursued him after he no-showed because she was swamped with other clients needing therapy. I had not been suspicious enough about his suicide potential because he was one of a very large number of clients I was seeing in medication clinic, and I assumed his primary therapist would more thoroughly evaluate and treat him. Of course, this is a copout. Unconsciously, I simply did not want to find out how desperate this man was because I feared I would not be able to satisfy his needs, and so I denied what, in retrospect, appeared as rather obvious clues to a serious suicide risk. Then I compensated for feeling terrible by thinking of quitting my job and going into full-time private practice, where I would have more time and fewer distractions so as to better evaluate and serve each client. Such failure and fantasies are clear signs of burnout.

Some Causes

Burnout results when therapists want to practice psychotherapy and cannot. Sometimes it is difficult to recognize that this is the case. Some professionals and

paraprofessionals seem little interested in their work, come in late, take long lunch breaks, and absent themselves from work every time they accumulate sick leave. Others seem numb to the plight of their clients. Still others seem to rejoice in telling clients how to behave and threatening hospitalization if they misbehave. I believe these staff are burned out already and perhaps do not know it. Others are more aware of and concerned about burnout.

Many public therapists have complained to me about burnout. I want to tell their story. I also want to guarantee their anonymity. Therefore, I will present a composite picture of many therapists' complaints and weave them into one fictitious character, to make the presentation easier. The fictitious character's name is Beverly.

BEVERLY

Beverly, a thirty-one-year-old white social worker, came in to my office one day and asked if she could cry on my shoulder. She complained: "The clients never say thanks. The director never says anything about my work unless a client kills himself or gets hospitalized. I have to come in early and then I can't leave until 6:00 or 7:00 at night because of all the clients in crisis. It just isn't worth it. The pay's lousy. I never have time to go to training events, and there's no one around to supervise my work when I need it."

I knew some things about Beverly's past. She had always wanted to be a

nurse, until she fainted during her first operating- room experience in nursing school. She decided she was too squeamish and transferred to social work school. There were two “tracks” in her school, one clinical and the other community organizing. She chose the clinical. She studied to be a therapist. During her internship she received close clinical supervision and saw a personal therapist for almost two years. When she graduated, she took a job in a county community mental health center and remained there for over five years.

Beverly described her first year in the clinic as “hellish.” “I saw some really crazy people. Their problems were overwhelming, and they didn’t really want help.” She remembers feeling lost, thrown into an impossible job with no supervision or backup. “I’d ask the psychiatrist for help understanding a client’s psychodynamics, and all he’d do was make a diagnosis and suggest more medication.” Beverly observed the effects of the medications on clients and decided whenever possible to offer dynamic psychotherapy and minimize the use of pills. “But then clients would go crazy, and I’d get blamed for not suggesting more pills or hospitalization.”

Beverly took great interest in her clients that first year. She wanted to help, and rejoiced when her clients did well. But many no-showed or abruptly terminated, often without saying thanks. “I was hurt the first few times, but then I got used to it.” She began to fill the open hours with new clients, and kept herself busy. It was as if the clients became interchangeable, one filling the spot vacated

by another, and Beverly had little time to feel unappreciated, to figure out why the therapy had failed, or to mourn the loss of a client to whom she had grown attached. She was becoming numb to it all.

Over the next few years, the numbness spread to other aspects of her work. On two occasions clients she was seeing managed to commit suicide. Others were repeatedly hospitalized. She began to change her mind about medications. She started to recommend that the psychiatrist raise tranquilizer dosages for some of her clients. And she began to order involuntary hospitalization more readily. A client she was seeing terminated the therapy and stopped taking her pills. The client's sister called and said the client was becoming uncontrollable. She suggested the sister bring the client in and they all meet together. The client was angry, mostly about the sister's invasion of her privacy, and there were some auditory hallucinations. Beverly ordered involuntary hospitalization.

The client was admitted to the psychiatric hospital and immediately forced to take high doses of tranquilizers. She protested. She was given even higher dosages. Beverly went to visit her on the ward. "She looked like a zombie!" When the client was discharged, she saw Beverly once and said during the interview, "I trusted you, but you believed my sister and not me. You betrayed me just like all the rest." The client refused to return for therapy.

Just after this incident I gave a lecture about psychotherapy and social

control, and this is when Beverly asked if she could come and cry on my shoulder. A consistent theme in all her complaints was, “I’m getting numb. too. It’s the only way I can cope. I’m becoming a chronic myself!” I have already mentioned my concern about the unfortunate selection process, whereby public therapists who cannot tolerate such numbness leave the public clinic and the ones who stay more readily become numb.

A second theme emerged from my talks with Beverly. She felt she was not growing as a therapist. When clients no-showed or prematurely terminated, she was given no specific feedback about what she had done wrong or could do better the next time. All she knew about was another failure. And her failures seemed to outnumber her positive outcomes. Then she missed training events because her caseload was too large. Or when she attended she found the topics did not relate very much to her work.

A third theme that Beverly presented was her isolation from other staff members. She usually ate her lunch alone, believing she needed the time alone to recover and compose herself after the morning’s frustrations. She found that the other staff members did not like talking about their clinical experiences, and she did not know or trust anyone enough to share her anxieties about work failures, and did not want to chitchat in the meanwhile. Thus, she tended to do her work in the privacy of her office cubicle, arranged to eat lunch alone or with friends who worked elsewhere, and shared little else but polite banter with colleagues in the

clinic.

Beverly complained that her director never said anything good about her work. Most likely this was because her director was concerned about looking good to his superiors in the county system, so his program budget would be maintained or increased. And the way the county evaluates programs and personnel performance has little to do with the quality of psychotherapy provided clients. Where I work a therapist's worth is measured by the number of live bodies that pass through the door to see him or her, and the program's

next budget is determined largely by the "units of service" the entire staff provided over the previous year. Secondarily, the clinic's program is evaluated according to its ability to prevent recidivism or readmissions to the overcrowded county and state hospitals. Thus, the best way for therapists and program directors to receive praise from their respective superiors is for the therapists to see as many clients as possible for brief visits, and to make sure each client is taking sufficient medications to control all symptoms that might lead to readmission. Thus Beverly's perception is accurate, and there is no real validation or reward for her practicing high-quality psychotherapy.

There are variations to Beverly's story. Some staff, instead of overbooking appointments and becoming workaholics, do the opposite and show up for work as little as they can get away with. Others busy themselves doing things for

compliant dependent clients so that when a difficult case needs to be assigned, they can say, “Sorry, my caseload’s already full.” Many staff resist efforts to set up training events and clinical supervision in the clinic. Their clinical failures make them shy about sharing their experiences. The more failures, such as no-shows or suicides, the more shy they become. Isolation results, and with isolation there is no possibility for real peer support. The public therapist tends to keep to himself or herself, and to assume the blame for failures. Failure to grow as a therapist results.

There are other variants. I believe they are the various alternatives a therapist turns to when very sincere desires to practice psychotherapy are thwarted by resistant clients and underbudgeted mental health systems.

Lower Budgets, Worse Burnout

Though staff burnout is always an occupational hazard for the public therapist, it is a worse hazard when budgets are reduced. In contrast to the 1960s, when the war on poverty and the community mental health movement were national priorities, we are now in a period of diminishing public support for social services to low- income communities. The middle class votes for tax relief. Military budgets are not cut. Public schools, libraries, parks, recreation programs, social services, welfare, health, and mental health programs are cut. Police and fire department budgets are generally salvaged, perhaps because these services are

needed more when the others are dismantled. This entire situation places greater stress on clients and therapists alike.

Hard times mean more clients with worse problems at mental health clinics. Stresses are aggravated—unemployment, inadequate housing, and a shortage of groceries. Crime, violence, and drug abuse are more commonplace. And the services that in better times alleviate some of the distress—recreation programs, adult education, job training, public work projects like CETA—also suffer budget cuts. Many people react by experiencing worse anxiety, psychosomatic ailments, marital discord, depression, or severe mental disturbance.

Meanwhile, the mental health program is undergoing budget cuts, too. It is not merely that clinic and hospital budgets are reduced, leaving fewer staff and resources to treat the greater number of people seeking services. Reductions also occur in programs such as halfway houses, day treatment, vocational rehabilitation, low- rent housing, legal aid, and child care. Thus, there is a shrinking network of agencies available to help the low-income person survive and accumulate more skills and possibilities. Therapists find they have much less collaboration and support from these other agencies in providing clients with services. Clients find their fixed income from Social Security, child support, or welfare will buy relatively less, and this stress aggravates their symptoms. Or they drop out of therapy, angry that their therapist cannot do more to improve their material circumstances.

All the mechanisms that result in burnout are accelerated. The public therapist has a larger caseload, less time to spend with each client, and more overwhelming problems to cope with. No-shows are more frequent: "How can therapy help me when I've got good reason to be depressed?" The staff is less open to sharing their clinical experiences, and even if they were more open, the budget and the time for training events and clinical supervision are diminished.

Therapy versus Control

With less of a network to collaborate with in supplying clients with services, less of a budget for the clinic, and less time on the average for each client, a therapist tends to do less therapy and more indoctrination and coercion. Remember the passage by Winnicott I quoted in Chapter 2:

> It is not the moment of my clever interpretation that is significant. Interpretation outside the ripeness of the material is indoctrination and produces compliance. A corollary is that resistance arises out of interpretation given outside the area of the overlap of the patient's and the analyst's playing together. Interpretation when the patient has no capacity to play is simply not useful, or causes confusion. When there is mutual playing, then interpretation according to accepted psychoanalytic principles can carry the therapeutic work forward. *This playing has to be spontaneous, and not compliant or acquiescent,* if psychotherapy is to be done.[73]

Winnicott defines play in various ways. For one, he places the realm of play somewhere between the realm of imagination and the realm of reality. Play

occupies a space between the two realms, involving some of both, and actually being created by the interplay of the two. Therapy must involve the therapist and the client "playing together," at times in reality, at times in their imaginations.

Play requires time. The therapist must listen patiently while the client talks and only intervene at times and with messages that the client can integrate into his or her own pace and direction. If the therapist speaks too soon, the client is thrown off course, and may respond by compliantly taking the therapist's lead or by angrily protesting the therapist's attempts to control. If the therapist is too passive, does not speak enough, or speaks too late the client might not trust the therapist's competence, or might become anxious about the possibility that the therapist is incapable of understanding or of intervening aggressively enough to help.

The therapist must play with the client's choice of direction for self. The therapist listens for the hidden (unconscious) meanings in the client's words. The therapist attempts to integrate all these meanings into an interpretation and tries to point out to the client where he or she is distorting reality or contradicting himself or herself. Then the therapist must wait to make this interpretation until he or she is certain the client is ready to hear it. And then the therapist must put the interpretation into stories, concepts, and words that the client can understand. In order to accomplish this immense task, the therapist must have sufficient time. If rushed, the therapy can turn into indoctrination or coercion. A concrete example

may be useful here.

SARAH

A thirty-four-year-old black woman, Sarah, was brought to the clinic by her sister because she was "crying hysterically and talking to herself." Sarah did seem to be crying frantically. She was moaning, too. It took a few minutes of patient listening and questioning before the moans turned into audible words, and then whole sentences. "I'm being followed. He's going to kill me." She then became too excited to answer the question, "Who is he?" The sister responded: "There is an old man in the neighborhood who follows women around, comes up and knocks on their doors."

The client yells, "I have to kill him." The therapist asks why, and discovers that "A voice tells me to."

"Whose voice?"

"My husband's." The sister supplies some missing information: the client's husband has been dead for nine years.

"Do you mean your husband talks to you?" More sobbing. But it turns out it is not her husband's death that is causing this emotional outburst, it is her son's incarceration. Her seventeen-year-old son had been arrested a week before for

burglary.

This client was clearly hallucinating, her affect was extreme, she could not communicate her thoughts without a therapist's help, she had been this way for days—without much sleep—and she clearly was unable to take care of herself.

The therapist had many possible courses of action to choose from. I will mention only three.

1. The therapist could hospitalize the client. She is hallucinating and unable to care for herself; she qualifies for involuntary hospitalization. The hospital often has fifty or sixty patients crowded into a ward outfitted and staffed for a maximum capacity of twenty-five. There she would be treated with high doses of major tranquilizers and receive little therapy besides the ward group meetings, which are chaotic when there are more than thirty or forty patients on the ward. There would be little time for family therapy sessions, much less for vocational rehabilitation. And the patient would probably be discharged from the hospital in less than two weeks, given a supply of tranquilizers to take at home, and told to see a psychiatrist in the clinic immediately so the prescription could be refilled and future readmissions prevented.

2. The client could be given strong tranquilizers, sent home with her sister, and seen several times over the ensuing week. Each time, the psychiatrist who prescribed the tranquilizers could reevaluate the client's condition and adjust the

medications accordingly. The therapist who first evaluated Sarah was considering this course of action, and that is why he asked me for a consultation. He and I talked to Sarah together and decided on a third course of action.

3. We were concerned that either hospitalization or management solely with drugs would only serve to prolong this woman's symptoms. Better, we felt, Sarah should be given a very low dose of a major tranquilizer, just enough to lessen her hallucinations and anxiety so she could talk. Then she would be seen three times a week in individual psychotherapy. Meanwhile, the sister was to arrange for a family member to be with her at all times.

By the third session that week, Sarah had explained why she was experiencing such overwhelming grief: It was her son's first arrest, she was very afraid for him, and it was at times like this that she missed her husband most intensely. The therapist was sympathetic. Then he very gradually began to suggest that, though crying is appropriate, too much crying prevents her from acting to help her son. Now is when he most needs her help. She might help him better by arranging for a good lawyer than by sitting at home or in a mental hospital crying. By this time her hallucinations had practically disappeared, and she was calm enough to stop crying for fifteen or twenty minutes and think about what her therapist was saying. And in the ensuing weeks, with continued therapy sessions, she began to cry much less and help her son more. Her medication was discontinued.

Was Sarah suffering from an acute psychotic episode? I believe that if she had been sent to the hospital her diagnosis would have been a "psychotic depression," an "acute episode of paranoid schizophrenia," or a "hysterical" or "brief reactive psychosis." She would have received major tranquilizers and been convinced she was crazy. Even if she had been treated in the clinic with medications alone, she would have been considered psychotic, and her symptoms controlled. Only by choosing the third course of action did her therapist have an opportunity to create an area in which there could be "overlap of the patient's and the analyst's playing together."

Medications alone can control symptoms, and their use for this purpose is warranted and needed. But unless the client is provided with enough psychotherapy to at least understand what is occurring in his or her mental life, the client is no better prepared to take control of himself or herself the next time stresses are severe. The client either continues to rely on medications, or suffers more emotional upheavals without learning to control them any better. In this case, it is not therapy that has occurred, but rather indoctrination and coercion.

Therapists know about this problem. When budgets are lowered, there are more clients for less staff, so therapists cannot spend three hours per week helping someone through an intense emotional experience. They find themselves hospitalizing clients who are too disturbed for once-a-week individual or group sessions.

There are more subtle repercussions of inadequate budgets. The therapist does not have time to explore the meaning of a whole series of things: a client's tardiness, a client's concerns about confidentiality, the clues that race-related tensions are obstructing the progress of therapy, a client's change of facial expression, the subtleties of language, the details of dreams, or the events of personal histories.

Therapists know that with less time to work with each client their therapy is less likely to be effective. There will be more no-shows, more suicides, and more readmissions. The medication dosages will be higher. And the chances for clients to find work will be smaller.

The therapist may be too rushed during the final minutes of a session to notice the subtle clues that a client will not return or is thinking of suicide. If the therapist were less rushed, better trained, or less stressed, the session might be extended a few minutes while the therapist inquired, "What do you mean you don't know what good these sessions do?'' or "What do you mean no one would care if you weren't around?" Sometimes the therapist is amazed at how untherapeutic his or her responses can be. He or she might become too impatient with a depressed client or too quick to respond angrily: "You've got to snap out of this depression"; "Stop complaining and start doing something to change"; or "Don't tell me how angry I make you, do you realize how angry you make me?"

It might be objected that public therapists receive clinical supervision on such occasions. But too often this is not the case. Public therapists always receive *administrative* supervision. But *clinical* supervision is more scarce, particularly in times of budget cutting.

Here are some of the reasons why many therapists who remain in the clinic have had to become somewhat numb to clients' plights, and find they tune out some of their clients' complaints; enough for them to miss cryptic messages, to be insensitive to some of their clients' pains, or to be slightly off in the timing of interpretations. Resulting therapeutic failures increase these therapists' tendencies to be impatient, to berate clients, or to prematurely recommend medications or hospitalization. In other words, inadequate budgets make it more difficult to practice therapy, and more likely there will be indoctrination and coercion.

While all these problems arise in therapy with clients who are entirely voluntary, the therapy must also face the reality of involuntary clients. Some are ordered by courts and probation officers to seek therapy. Others disrobe on the street, threaten family members with violence, or merely fail to care for themselves. The public therapist is frustrated in attempts to provide quality psychodynamic psychotherapy to voluntary clients, and then is forced by job requirements to spend a certain proportion of working hours hospitalizing, medicating, or otherwise controlling involuntary clients. Is it any wonder burnout

is such a problem?

A Problem Larger than Budget Considerations

This is not merely a matter of diminishing budgets. Budgets reflect social priorities. Even during the best of times there is still a huge discrepancy between the private and public sectors in the quality of psychotherapy available, and there is a much greater chance that clients in the public sector will be treated predominantly with drugs and hospitalization. During harder times the discrepancy is worse.

If it is so difficult for public therapists to practice therapy, and if the reason has as much to do with obstacles built into the mental health system as with any lack of motivation on the part of the clients, then perhaps therapists in public mental health clinics are not really placed there to do therapy.

When budgets are cut, the first programs to be closed are the more innovative ones, the ones that expand the clients' capacities to work, to love, to create and to play—for example, the vocational training programs that can guarantee employment after completion, the adequately funded day treatment or partial hospitalization programs, and the therapeutic communities. All these seem to close down or fail to have their grants renewed. Or some programs survive budget cuts by providing relatively less staff and resources. But then program quality is diluted; or the program maintains quality by paying staff subminimum

wages. In any case, budget cuts tend to weaken or close these programs first.

The loss of these programs might mean that the clients who had been served will now require more medications. It is rare that a public clinic reacts to budget cuts by reducing the number of physicians prescribing medications. The clients can be controlled on a lower budget by giving them more medications. But then it is not possible to offer them as much access to quality psychotherapy. There is some truth to the public therapist's nagging realization, "I'm not here primarily to do therapy, I'm here to calm and control an underprivileged segment of the population."

I am not claiming that each administrator and program planner of a mental health clinic is consciously designing a program whose purpose is social control. Rather, the whole mental health system has evolved in that direction, and the individual administrator or planner is merely working within the limits of that system. In other words, while private therapy is designed specifically to help clients love, work, and play better, public therapy is restricted—by budget and by assigned priorities—to keeping the most belligerent or socially unacceptable clients controlled on medications or in hospitals.

By now, this discussion has turned to social or political analysis. This is because the public therapist must think in these broader social terms if massive burnout is to be avoided. The public therapist does not need to agree with my

particular analysis in order to see that something is occurring at the system-wide or society-wide level that constricts the possibilities for practicing public therapy. The question is, What does this political or social analysis have to do with public therapy?

An Analogy

The burned-out therapist and the chronic are alike in at least one regard—both blame themselves for their failures. The therapist asks himself or herself where he or she failed each time there is a no-show, a premature termination, or a suicide. I believe it is only because of insecurity about their inadequacy as therapists that very many more public therapists do not loudly protest the constraints the mental health system places on their ability to practice therapy.

I mentioned in Chapter 9 that one of the chronic's problems is that he or she assumes the blame for his or her failure to find meaningful employment. I suggested that the therapist help the client see the social reality of high unemployment, and thus place a seeming personal failure into broader perspective. I can only repeat the same suggestion in regard to burned-out public therapists.

It is very hard for a therapist who is not numb to accept as fact that he or she did the best that could be done to prevent a suicide. The therapist always thinks of something that could have been done better—a clue that could have been

recognized or an extra session that could have been scheduled. Self-criticism is instructive—up to a point. Excessive self-criticism is another cause of burnout.

The therapist must maintain the perspective that given the inadequate resources, staff, and training, and given the responsibility to maintain control of clients in the community, he or she really has done all that could be done. But isolated individual therapists cannot convince themselves of this anymore than isolated chronics can halt their self-castigation. Staff collaboration is the only possible help here.

Wise clinic administrators detect the signs of burnout and take steps to prevent it. They offer staff members extra days off, or "mental health days." They redistribute caseloads so everyone gets a turn working with the most difficult clients. They call for extra staff meetings, increase the quality of training, or bring in facilitators to help the staff talk together about their frustrations. In each case, they try to improve communication and collaboration among the staff. This is because they know that burnout means the staff members have become too isolated, too self-critical, convinced they are not competent and not growing as therapists.

I believe such collective discussions among staff members must also focus on social priorities, the actual function of the clinic in the community, and all the other external factors that make it so difficult to practice public therapy.

In summary, I have assumed throughout this chapter that therapists in public clinics desire to practice quality therapy, and their burnout is caused largely by their inability to do so. If this is not true of all public therapists, it is most likely true of those who would bother to read a book about public therapy. Further, while public therapists encounter immense obstacles to the practice of therapy, their jobs increasingly require that they practice, or at least collaborate in the practice of, questionably therapeutic and clearly controlling acts, such as involuntary hospitalization, high-dose long-term medications, and court-ordered therapies or subpoenas of confidential case files. The therapist who feels burned out because he or she cannot practice quality therapy—meanwhile working with low pay and relatively low status—feels all the more burned out when he or she is forced to practice social control. The issue is larger than budget considerations, it involves social priorities. Public therapists must talk about all this if burnout is to be avoided. In Chapter 13, I will suggest some concrete forms for the talk.

CHAPTER 13
Conclusion

I have described a double standard in our mental health system: One kind of treatment for those who can afford private fees, another for those who must visit public clinics. The discrepancy is not absolute. Many private psychiatric patients receive medications without much psychotherapy, much private therapy is not optimal quality, and many public therapists provide a significant number of their clients with high-quality therapy in spite of obstacles. But on the average, a client is more likely to have the opportunity to undergo "talking therapy" in the private sector; and a client in the public sector is likely to have less time with the therapist, and more likely to be treated exclusively with medications.

In this obvious way, and in many more subtle ways, a second distinction emerges between private and public therapy. There is a distinction not only in quality, but also in degree of external control. Private therapy is designed to help clients love, work, and play better. Where indoctrination and coercion occur, it is because the therapist is not practicing good therapy. At least this is the ideal. But indoctrination and coercion are implicitly the more expected aims of treatment in the public clinic. If the public therapist is not able to provide quality "talking therapy," at least he or she is supposed to prevent his or her clients from making trouble at home and in the community, from being arrested or readmitted to a psychiatric hospital, and from committing suicide.

The question remains: *Is it possible to practice high-quality non-coercive psychotherapy in the public clinic?* Some people say that therapy is useless in the low-income community, that the external hardships and stresses of poverty and oppression cause personal difficulties, and that community action, not therapy, is required for change. I believe this is an extremely important but partial truth. Anyone who assumes that the personal problems of low-income people arise predominantly out of their personal pathology is ignoring the social reality that confronts such people daily and is thus blaming the victim for the repercussions of massive social inequities.

But anyone who assumes that all personal problems result from the inequities of social reality misses some critical mediating phenomena and does not sufficiently appreciate the complexities of individuals and their unique reactions to stressful social conditions. It is true that many low-income people would be helped immensely with their personal problems if there were community organizations and events in which they could participate, collaborate with others, and win some just demands—for instance, more jobs, better education, an end to racial discrimination, more child care. There would be less isolation and feeling of powerlessness in the community, and certainly this would be reflected in less mental turmoil and breakdown. But there still would be some mental turmoil and breakdown, and there still would be people who could benefit from quality psychotherapy.

I believe that personal difficulties people experience arise from both external and internal causes. Poverty imposes stresses on everyone, but some people react by relating with others to struggle for better conditions, and some react by giving up, isolating themselves from everyone, and living a miserable, psychologically impoverished existence. Community organization, advocacy, and many other forms of struggle to end social inequity are high priorities. But meanwhile, a shorter range and less comprehensive goal might be the provision of the same quality psychotherapy to low-income people that is available to those who can pay private fees.

I do not believe that psychotherapy alone can ever resolve the larger social problems. But I believe that the double standard in mental health care must be ended, and that low-income people can be and must be provided with the same quality services as everyone else. In conclusion, I will offer three general recommendations to public therapists.

1. We must practice high-quality psychotherapy in spite of all obstacles. Throughout this book I have attempted to share ways I have discovered to adapt the large body of literature and experience about psychotherapy to the practice of therapy in the public clinic. Obstacles to the practice of public therapy arise from both internal and external sources. Clients might be distrustful, be unwilling to change, feel totally powerless and give up, demand medications, or tend to no-show. Their material hardships and frequent traumatic experiences might make

therapy seem a low priority. And their concerns about visiting the public clinic and trusting the therapist might be very legitimate. The therapist must take all these factors into account and be sensitive to their ramifications if his or her interventions are to be helpful.

In addition, the public institution sets up obstacles of its own: crowded waiting rooms, too much reliance on medications, rigid staff hierarchies, too little clinical supervision, inadequate staff collaboration, and too few rewards for practicing quality psychotherapy. The public therapist constantly finds him- or herself in a struggle to defend the boundaries of a space wherein therapy can occur. For instance, the therapist must insist that each client deserves a certain amount of individual attention and must resist pressure to treat too many clients at once. The therapist must intervene forcefully—as advocate in court or as colleague to another clinician when a client is hospitalized—in order to maintain that space in which therapy and not coercion is to occur. The therapist must fight to maintain strict confidentiality. The therapist of one discipline must refuse to be bullied by therapists of other disciplines; for example, the social worker's opinion might be correct when the psychiatrist's is wrong, or the paraprofessional's might be correct and the professional's wrong. Degrees do not guarantee omniscience. Then, the therapist must practice therapy, and make sure that other practices, such as advocacy and prescribing, complement rather than obstruct the therapy. I hope that this book provides some help in this regard.

2. We must be aware of social realities and bring that awareness into the therapy we practice. What matters to the low-income client is often invisible to the salaried therapist. For example, the local blood bank reduces the sum paid to plasma donors from $12 to $8. Several members of a therapy group become depressed, one even suicidal. It takes the therapist most of an hour to understand what has happened. These several members relied on the $12 they earn weekly by donating plasma in order to afford bus fare and entertainment. Their budgets are so tight that the loss of $4 per week means either that they cannot attend group or must give up smoking. Similarly, very slight changes in unemployment, welfare, and disability benefits have powerful effects. More affluent people have difficulty understanding the impact of a $15 per month income reduction. When the therapist misses the nuance, the client's response—increased anxiety, depression, or a no-show—seems inexplicable.

Not only must the therapist understand social reality in order to understand the client. The therapist must also bring social reality into the consulting room if therapy is to be effective. An incident in my therapy with Velma is illustrative (see Chapter 7). Velma came to see me in tears and quite agitated. Her family had been over for dinner the night before. Two grandchildren fought. One was the two-year-old child of her dead son, Bill, the other the three-year-old child of her youngest son, George. As the two children fought over a toy, Velma tried to separate them. George's wife yelled at Velma not to touch her child and tried to push Velma away. The two women fought briefly. The whole family was in an uproar, with several

members shouting. Velma's husband did nothing. George yelled at her, "You bitch, don't you touch my wife!" Velma screamed at them to get out of her house. They left, saying they would never come back.

Velma had not slept that night. "How dare they treat me like that! And my husband just stood there and did nothing. George called me a bitch! If he ever comes around here again I'll shoot him—I mean it—I've got my gun and I'll empty it into him!" George had broken a near-sacred rule when he called his mother a name, and at that moment Velma was prepared to kill her own son. She was also thinking seriously of suicide.

Remember, Velma had lost her son Bill because of drugs and accidental death, and her son Jesse was in prison. Now her third son was swearing at her. She knew George was under a great deal of pressure. He was unemployed, having trouble supporting his family, and ashamed to be living on his wife's welfare payments. When she thought about killing him or herself, Velma was forgetting all these things.

She and George are alike in one way—both forget the social reality. George forgets about the 30 to 40 percent unemployment rate among ghetto men, forgets the unequal educational opportunities and job availability, and blames himself for his failure. He cannot attack the police who harass him or the job interviewers who refuse him, so he attacks his own mother. Velma forgets the same social

reality, blames herself for her sons' failures, and attacks herself in depression, or is ready to take out her wrath by killing the only son within reach, who is in important ways an extension of her self, and also a symbol of her failure.

Velma and I talked about social reality. We talked about what it means to be a mother in the ghetto, to lose sons to drugs, violence, and prison, and what it means for a son to swear at his mother. We talked about a mother's plight—all the pain and violence she must contain—and from what social realities the pain and violence emanate. We talked about depression in young black men, and how they blame themselves for failures that have roots in social inequities. We talked about mothers' depressions, and the parallel tendency to blame oneself for what one cannot understand or control in our social reality.

I do not know how much the actual content of our discussion mattered. Velma needed a place to ventilate and a shoulder to cry on. Velma and her son eventually made up—he apologized and she forgave. Meanwhile, in order to make sense of that therapy session with Velma, I conceptualized it as an introduction into the consulting room of the social reality the client was forgetting in her turmoil and self-blame.

It is no violation of the therapist's neutrality to discuss with clients the social realities that permeate the therapeutic experience. It is a denial of important parts of the truth not to do so. I do not believe it is particularly therapeutic merely to

discuss politics with clients. Rather, therapy is a process of guided exploration, and the reality to be explored has both a personal and a social dimension. The two must be integrated if therapist and client are to understand and trust each other, and if the client is to be helped to live better in a harsh and threatening environment.

3. The public therapist must be willing to leave the consulting room and participate in social struggles. Public therapists must talk to each other—to share clinical experience and expertise, to complain and be supported, and to figure out how to proceed. Often, public therapists must act collectively to make it possible for anyone to practice quality therapy. The staff might need to discuss interracial tensions or institution-wide bureaucratic obstacles to the provision of quality services. The staff will discover that unless they protest collectively certain actions on the part of the public institution (e.g. budget cuts, reduction of staff or programs, or introduction of repressive policies such as forced drugging of voluntary hospital patients), it becomes impossible to practice noncoercive therapy even in the outpatient clinic.

Collective bargaining is important in this context. Whether through unions or alternative organizations, public therapists can struggle against infringements on their rights and just rewards only by uniting and organizing. The enlarged caseloads that result from reduced agency budgets are equivalent to a speed-up on the factory production line. The increasing necessity for public therapists to act

as policemen or agents of social control is equivalent to the deterioration of working conditions in the factory. Though this issue is not the main focus of this book, I believe public therapists must engage in forceful collective bargaining if the work of public therapy is to be a rewarding endeavor.

Larger issues than agency budgets and policies impinge on the practice of public therapy. Poor quality education leads to more severe emotional disorders, so it is far from inappropriate for public therapists to join community struggles against budget cuts or segregation in the schools, as well as community campaigns against blatant police brutality or tax measures that harm public services. Though I do not believe therapists should use their influence over clients to coerce them into social action, I do believe it is appropriate and even therapeutic for public therapists to be visible in community and social struggles that affect the client population.

Recently, the Ku Klux Klan intiated a series of violent attacks in the community where I work. White youths beat up black youths and painted on black churches graffiti including swastikas, derogatory epithets, and the initials KKK. Crosses, lawns, and homes were burned. One black woman spoke with the press about the increasing incidence of such violent acts, and the next day her car was blown up by a bomb minutes after she had parked and left it.

The Klan was openly recruiting unemployed white youths to act out the

desperation they felt about their plight in acts of racist violence. These white youths donned sheets and hoods and marched through the halls of local schools carrying guns and taunting black youths. In one high school, large numbers of black students were choosing either to stay home from school or to carry guns to protect themselves. The police and school district did nothing except to report the absentees, or arrest the black youths with guns.

Our clinic discussed this state of affairs at a staff meeting. The first issue raised was whether a mental health clinic staff should even be discussing such "political" issues. Several child therapists described children they were treating whose symptoms were aggravated by the racial violence, or who were failing to attend school out of fear. Other therapists reported seeing adult clients who were likewise anxious, depressed, or worried about their children's not attending school. The staff reached a consensus that the Klan- inspired racial hostility was creating an epidemic of emotional breakdown, and that if we did not do something about the social cause of the problem, our caseloads would be swelled by the victims.

Our mental health clinic became very active in establishing a coalition of community service agencies and organizations to fight against the Klan's destructive impact. The coalition demanded that the police act more aggressively to halt the violence, and that the school board act to halt the harassment and intimidation in the schools. Meanwhile, volunteers guarded the homes of black

families who had been attacked. In the process of forming this coalition, the staff of the mental health clinic established better communication with the various community service agencies and organizations, and more trusting collaboration evolved in other aspects of servicing low-income clients. At this writing, the coalition's struggle against racist violence continues.

Meanwhile, there were repercussions in the clinic itself. I was leading a therapy group with white and black clients. As racial hatred flared in the community, group meetings became tense. One black woman charged a white man in the group with being "one of them." "I think Mike is glad they're burning those crosses—he always acts like there's something better about him because he's white." I suspected that several members were displacing onto Mike hostility they felt toward me, the white group leader who could do nothing to halt the Klan's violence; perhaps they preferred to attack Mike because they were not feeling secure enough to attack me. I did not share my suspicion. Rather, I commented on the parallel between the racial tensions in the community and the tensions in the group. We discussed the way racial tensions divide a community and prevent blacks and whites from uniting to struggle for more jobs or better housing for all. And we examined closely the reality of the woman's fantasy that Mike acted out of racial hatred. By the end of the session, all the group members agreed to phone each other if any were threatened with violence, and to come immediately if called by another member for help.

There is no way for poor people to separate what is political from what is therapeutic. The distinction may be an interesting abstraction for middle-class therapists. The public therapist serves as a role model for the public client. If the therapist ignores social realities, passively accepts obstacles set up by the mental health system, becomes disinterested in work and numb to clients' plights, is isolated from other therapists, and fails to grow as a practitioner, then the clients are presented with a model that cannot alter their own feelings of personal failure, powerlessness, isolation, and numbness.

A Brief Reading List for Public Therapists

Many books contributed to my approach to public therapy, too many to list here. I will mention a select few merely to help the public therapist enter a rather vast literature.

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