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Impasse, Intrigue & Inspiration: Effecting Change Through Psychotherapy

Founded in 1964 by John Warkentin, PhD, MD and Thomas Leland, MD

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Journal of The American Academy of Psychotherapists

VOICES

THE ART AND SCIENCE OF PSYCHOTHERAPY

When you have exhausted all possibilities, remember this — you haven't.

—Thomas Edison

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Editorial

When the Therapist is Stumped

Our theme, *Impasse, Intrigue, & Inspiration: Effecting Change Through Psychotherapy,* explores those times when the therapy seems stalled, at an impasse, and the therapist feels at a loss as to how to unclog the process and effect the change the client (or part of the client) seeks. People come to therapy to change — or do they? — yet clients often seem to resist that very change. Therapists sometimes attribute these stuck places to client resistance or ambivalence. Nothing the therapist says or does seems to break the impasse and motivate change. Sometimes ambivalence seems present from the start, the client has one foot in and one foot out. Other times, an impasse is reached after productive work, when a steady client hits a plateau and just can't seem to move forward. Some impasses reflect a rupture between client and therapist. Any of these scenarios can lead to a frustrated client, headed out the door, and/or to a discouraged therapist, feeling helpless or inadequate.

Therapists are also sometimes stumped in other ways. Have you ever been intrigued about the topics your clients talk about — or don't talk about! — wondering why they're paying to talk about *that?* Are you left wondering just what keeps them coming? What about those surprises when your patient buries the lead or drops a major revelation while walking out the door? *What?!* Or those moments when you hear, too late, how your own words landed on your client's ears with a heavy thud, threatening a conflictual impasse, and know you need to back-pedal, fast? Any of these moments can leave the therapist struggling to find solid footing again.

I developed this theme at a time when I was sitting in impasse or confusion with several clients: Why is this

person paying me to talk about *that?* What are we doing here? What is she *not* talking about? And why does this trauma client keep repeating the same struggle? Just when we seem to have worked through part of the cycle, we're back at the beginning, often as if it is new, without an obvious retriggering. Am I helping, making a difference? Do I need a new technique? And why did that new client suddenly disappear? She seemed to be working hard and we seemed to be connecting well…but she quit. Perhaps fresh insight for some of these scenarios would come through submissions on this theme. Or at least I might find myself in good company.

When trying to find my way through such moments of therapeutic impasse, I sometimes think of ways that I have found myself in stuck places of my own: perhaps staying too long in a relationship, job, or situation that wasn't working for me, or losing the same pounds over and over again instead of making real lifestyle changes and reaching my goal. I think of the repetition I find in my own therapy journals; I, too, sometimes had to rehash the same struggles. Those old scripts are hard to rewrite! When I can recall my own stuck places, I can shift out of frustration, back into empathy for my client's struggle. When I can get in touch with my own ambivalence — whether realizing that while one part of me may want one thing, another wants something else, the two in conflict, or identifying a fear underlying my resistance to change — I can sometimes see more clearly how to better help a client explore theirs. Sitting with clients in that process feels a lot better than my frustrating efforts to fix what they aren't yet ready to change, which only strengthen resistance and possibly lead to a premature, dissatisfied ending of the therapy. Sitting with them in their stuckness, with understanding and curiosity, when others in their lives are frustrated and pushing for action, can be a gift — and the therapeutic path to growth and change. One of the hardest lessons to learn is that when the client disappears, absent an obvious rupture, it may not have anything to do with me: important to self-reflect, see if there are things I need to be doing differently, but equally important to separate what is mine from what is theirs. Their leaving may not be a reflection of my inadequacy — though it still leaves me frustrated, questioning my purpose — but about something of their own.

For this issue of *Voices,* authors considered their most challenging moments in psychotherapy: the times they felt stymied, not sure what to do next, or were caught off guard by something that changed their formulation of the case or threatened a rupture. What inspired breakthrough? What were their successes and struggles in motivating change? What would they do differently, given a do-over? Authors considered, too, how such moments of impasse impact their own sense of self as therapist, confidence in their abilities or impact. And sometimes it is an impasse in the therapist's own life that poses a challenge in the work, and the therapist has to work first on self.

Linda Buchanan's reframe depathologizes client resistance as the guide to the pain and fear underlying the ambivalence that often accompanies change, absent which clients could likely make their desired change without seeking our help; resistance shows us where the heart of the work is. Tali Silver gives us a poignant vignette of how the angst of one client's abrupt departure led to the therapist's continued self-work. Marilyn Schwartz offers her own experience with an abrupt ending, reflecting on both the impact of rupture on the therapist and the healing that comes with separating what is the therapist's from what is the patient's part in the rupture. Jerome Gans shares several

clinical experiences in which humiliation could have ended in impasse or rupture and how this was, in most cases, avoided.

Blake Griffin Edwards narrates an early career experience of feeling stuck with a client; when none of his training in techniques seemed to help, he learned the power of the therapeutic relationship. John Rhead tells how recent plumbing work in his home led to fresh insight about structuring a therapeutic container so that it is less vulnerable to a clog. Grover Criswell explores the ubiquity of obstacles and impasses in therapy (and life) from both the chair of the therapist and the couch. Likewise, Paul Shultz recounts his personal experience as both patient and therapist with resistance to change in psychotherapy.

Shirley Tung shares her experience with a client in the aftermath of the Uvalde school shooting, exploring how impasse can enter the therapy room through events in the larger cultural context to which both therapist and client have a reaction. Ellen Schiff relates how an impasse within herself impacted decisions about her practice. Penelope Norton explores how two very different client responses to new adult recognition of repressed childhood sexual abuse triggered her own reflection upon the personal costs of her history of repeated, difficult work with such abuse.

A selection from the *Voices* archives, taken from a 1968 issue (Vol 4, No. 3) similarly themed "Therapeutic Impasses," fills out the issue. In their editorial from that issue, John Warkentin and Tom Leland use the obstacles encountered in producing their issue to explore the ubiquity of impasse, in life as in therapy. (I am grateful to their issue for material to overcome the impasse of receiving too little new material to fill the current one. Glad, too, for their good company in the struggles of production.) Carl Whitaker's guest editorial further highlights the ubiquity of impasse, in therapy and in politics — which certainly rings relevant in our own times. In "Symposium: Significant Patients," Richard E. Felder, Richard E. Johnson, Stanley Lipkin, Richard L. Miller & Lawrence I. Bloomberg, Vincent F. O'Connell, and Arthur L. Rautman present snapshots of challenging patients and therapeutic impasses met with boldness, innovation, and relationship. Bernard J. Somers offers an experiential encounter model for addressing therapeutic impasse, reminding us that they are both co-created and co-resolved, in relationship. Leonard I. Stein presents perhaps the scariest of therapeutic impasses for therapists: when the client threatens suicide. Cartoons by Severin illustrate various impasses with humor, reminding us to not take ourselves or our struggles too seriously.

Our Spring 2023 theme, *Psychotherapy and the Arts,* will explore how these two disciplines impact and reflect each other. It may even bring us some additional inspiration for breaking impasse, as sometimes art can take us into lives and worlds beyond our own lived experience or give us insight into our own in ways that may open up the process of a stuck therapy.

If you read something in *Voices* that speaks to you, let the authors know. Keep voices connecting. ▼

YOU'RE NOT LOST
YOU'RE HERE

Articles

Resisting Your Client's Resistance

Linda Buchanan

Dr. Linda Buchanan is a psychologist with over 30 years' experience, primarily at the Atlanta Center for Eating Disorders that she founded in 1993 and sold in 2017. She has written a book titled *A Clinician's Guide to Pathological Ambivalence* and three client workbooks. Dr. Buchanan consults and trains clinicians in dealing with resistant clients and writes a blog called *From One Therapist to Another*, writing about experience gained in her years of clinical practice.
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In 2020, I wrote an article for *Voices* titled "One Therapist's Journey in Understanding Ambivalence to Change," in which I shared how I had dealt with my own struggles with ambivalence and how my ideas regarding resistance developed through the process of helping others with ambivalence (Buchanan, 2020). Therefore, I was very glad to see that the focus of this issue of *Voices* was going to be on motivating stuck clients. I have spent decades focused on this topic. This journey has resulted in my conceptualizing resistance as ambivalence and writing a book on the topic. In this article, I would like to share a couple of my favorite stories of moments in therapy when I've utilized strategies to help someone harness and resolve ambivalence (sometimes only after making woeful mistakes in my attempts to get them unstuck).

Steven Pressfield (2002), internationally bestselling author of *Last of the Amazons* and *Gates of Fire*, states in his non-fiction book *The War of Art: Break Through the Blocks & Win Your Inner Creative Battle*:

> Like a magnetized needle floating on a surface of oil, Resistance will unfailingly point to true North — meaning that calling or action it most wants to stop us from doing.
>
> We can use this. We can use it as a compass. We can navigate by Resistance, letting it guide us to that calling or action that we must follow before all others. Rule of thumb: the more important a call or action is to our soul's evolution, the more resistance we will feel to pursuing it." (p. 12)

If Pressfield is correct, our clients resist because of the importance of what we're doing together. This implies that if there's no resistance, we might not even be focusing on the most important things! Let that sink in. But

when I encounter a client's resistance, I often have an automatic reaction as if something is wrong. I think it is only natural as a therapist to become frustrated when we meet resistance in our clients. It is confusing that people would show up week after week and spend good money just to resist doing what we know would help them. Therefore sometimes we resist our clients' resistance. That sounds like it could get pretty confusing, and it does. Resisting our clients' resistance can slow down the therapeutic process. Like in a game of tug of war, all that gets resolved is which side is stronger at the moment. If we win, the client might reluctantly follow our advice, but that doesn't sound like the best way to help our clients bring about change. Conversely, it can be very unpleasant when we're the one overpowered. This often leads to us feeling ineffective.

I've learned through the years that if the client weren't resistant or ambivalent, they might not even need me. One of many self-help books would do the trick. Consider the following statements:

- The very thing that brings the client to therapy is the thing that they are most afraid to change.
- Resistance exists on a physiological level due to neurological development. What fires together wires together, neuronal strength and all that stuff.
- Resistance shows us where the pain and fear are. We need to fully understand this before pulling against it.
- Resistance may be a reaction to a therapist who is trying too hard to help (or not doing enough).

Therefore, it becomes necessary for us to be comfortable addressing resistance early in the process rather than hoping that if we are sufficiently patient, helpful, or caring, it will just go away. Resistant/ambivalent clients need their therapist to help them understand and resolve the resistance.

Even the most seasoned therapists find themselves resisting resistance from time to time. There's nothing more natural than wanting our clients to see themselves the way we see them and wanting to instill hope. But the thing that separates the savvy therapist from others is how quickly we catch ourselves resisting resistance and then change direction.

Addressing Resistance

When a client is resistant, we often feel like it's focused on us as the therapist or what we are suggesting. It is important to recognize that when a client is resistant to change, it's because they are opposing themselves; one part of them is asking for change and another part is resisting. Therefore, we need to help them recognize their own battle rather than take it on. My favorite strategy for dealing with resistance is to relabel and conceptualize it as ambivalence. I begin with some psychoeducation about what ambivalence is and how humans are capable of experiencing ambivalence due to the complex nature of our personalities. I talk about how all people have parts (such as inner child). I usually provide some education on brain development and how we can have opposing beliefs about ourselves or others coming from different parts of our brains. A person may believe they can't trust anyone when utilizing their emotional centers but know in

their prefrontal lobes that some people are trustworthy.

Therefore, the first objective when encountering resistance or ambivalence is to be fascinated by it and share that fascination with the client. Some of my favorite responses when I encounter ambivalence are:

- When client doesn't follow through:
  "Is there another part of you that is afraid to change?"
  "Where does that fear come from?"
  "Tell me about the part of you that believes you can't _____."
  "Is there another part of you that wishes you could believe _____?"

- If client states a negative belief such as *"I'm not lovable":*
  "When I say you're worthy, where does your mind go?"
  "Is there any small part of you that feels differently? Or wishes you could?"

- With a client that feels that they have to be perfect to earn love:
  "Is there a part of you that wishes you could have more freedom?"
  "What does that part need from you?"

Avoiding the Power Struggle - Case Example 1:

One of the most uncomfortable feelings I've had in conducting psychotherapy is finding myself in a power struggle with a client. Often when clients are ambivalent, they may voice only one side of their ambivalence at a time. For example, if the client says, "I am never going to get better," a caring therapist naturally wants to instill hope. However, when therapists voice hope at this time, the client often reiterates their lack of hope. I conceptualize the person as ambivalent in that one part has no hope but another part has hope (or they wouldn't have come). So if I offer hope, I'm taking the side of their hopeful part which can result in the hopeless part feeling misunderstood and compelled to speak up even louder. The power struggle develops as the therapist tries harder to win the argument for hope, leaving the client to struggle to maintain their lack of hope. This can be exhausting, leaving both sides frustrated. In other words, as strange as it may seem, instilling hope may be ineffective when a client is voicing a lack of hope. Instilling hope is an important therapeutic strategy; however, the timing is vitally important.

Tracy's story will help illustrate this point. Tracy was a young woman struggling with severe panic disorder, substance abuse, and an eating disorder. She had been in several treatment programs with multiple relapses. Part of her history involved being sexually abused by a former therapist about 5 years earlier. She had pressed charges and testified against this man in court. He was found guilty and was currently in prison.

Tracy often vacillated between expressing anger and feeling shame. These two emotions are diametrically opposed. Anger implies the right to be treated well and the need for protection, while shame implies the opposite. She spent about half of her time in sessions expressing anger regarding people who had let her down and the other half in shame, as if she deserved being treated badly. She would swing between the emotions, sometimes so much so that she asked me if I thought she was crazy. For several sessions, I tried to take the voice of hope and help her see her worth and reject her shame over the abuse. When she would express her anger and I would attempt to validate it, she would swing to feeling shame. But when she was feeling shame and I tried to dissuade her of

the feeling, she would switch to anger. It felt to me like we could never stay in sync and that she would discount anything I said. A typical conversation might go something like this:

Tracy: I am so angry that someone who was supposed to take care of me would actually harm me.
Me: He did harm you, and it makes sense that you would feel angry.
Tracy: No, it was my fault—I was an adult; I should've known better.
Me: It is common for people to feel shame after situations like this, but it's important for you to see that it wasn't your fault (although true, this was my value and was expressed at the wrong time).
Tracy: But why would I feel shame when I am so angry that he would do this? I thought he cared about me.
Me: You have a right to feel angry, because your trust was betrayed.
Tracy: No, you don't understand. I was an adult. I shouldn't have let things happen.
Me: I don't fully understand, but I do understand that it is normal for people to feel shame and anger in these kinds of situations.
Tracy: How could you possibly understand my feelings? It didn't happen to you, and you weren't there. [Now she really had me! She wins!]

There were moments when it appeared that I had won the power struggle, convincing her that there was reason to believe that she had worth. And she would say something like, "I guess you're right, but I can't feel it, so something must be wrong with me." This was not a very satisfying win, and it definitely didn't change anything.

In these conversations, I felt powerless, ineffective, and at times frustrated with her. Why wouldn't she let me help her? Was she ever going to heal from this thing that, although horrible, happened so long ago? Was there something about me that kept her from trusting me? One time when I tried an object relations approach, I asked her that question. She actually told me it had no f'ing thing to do with me! That was one of those moments in life when you just wish the ground would open up and swallow you. But now, I look back at that moment and smile with fondness. She taught me so much!

Finally, after several sessions of feeling stuck with Tracy and realizing that she and I were both leaving sessions feeling frustrated with each other and with ourselves, I decided to totally go with her resistance. Frankly, this occurred more out of desperation than any wisdom on my part. On this particular day, when she started to express her shame about the relationship with the former therapist, I asked her, "Okay, what percentage of the situation do you think was your fault?" She stared at me and paused for a few minutes. My heart was beating faster than normal. I had no idea how she was going to respond. I was afraid that she would think I was blaming the victim, something that I was loath to do. Until this point, I had been forcefully holding on to the position that it was not her fault.

When she finally spoke, it was with a soft voice, as opposed to the defensive or argumentative tone that she typically used. She said, "Well, if I think about it, I believe it was about 20% my fault." So we talked about the 20% that she perceived was her fault. This became an amazingly empowering session for her. It turns out that there was a small part of her that was very afraid that she might let herself get into that kind of situation

again. Trying to talk her out of feeling that way was not helping at all. Being afraid to address this with her was neglecting a very hurt, scared, and childlike part of her.

I believe that Tracy's eating disorder was functioning as a communication from a part of herself that believed she had to be sick to protect herself from abuse and that she deserved punishment for the responsibility she perceived was hers in the situation. Talking about the 20% that felt like her responsibility gave her hope that she would be better able to protect herself if a situation like this ever happened again. Additionally, she began to explore things from her childhood that she thought had contributed to the 20% for which she felt responsible. She and I had been unable to delve into those issues when we were focused on rejecting the blame. I realized that I had been engaged in a power struggle with Tracy based on my own value of never blaming the victim. This was not in her best interest, and one of us always lost. When I put this aside and joined her resistance, it became a turning point in her recovery.

One caveat here: I did not bring up the idea that part of the abuse was her fault. It was only when she was saying so that I asked her how much she thought was her fault. This helped us both move from all or none thinking to allow all parts of her to be heard.

As part of Tracy's process for termination, she wrote a letter to me summarizing our work together. She wrote,

> You helped me find strength within me that I never knew existed. You helped me to find my 'voice' and to begin to listen to and trust my inner wisdom. You helped me to discover the balance ... to find the middle ground of nonjudgment. You never attempted to wrestle the disorder away from me [I guess she had forgotten those first few sessions] ... instead you helped me to find the will and desire to let go of the symptoms and to face what issues emerged over time. (personal communication)

I think I did these things by getting out of the way and helping her understand her ambivalence. I'm happy to say that she was still doing fine the last time I heard from her years later.

Avoiding Advice-giving - Case Example 2:

As we sometimes take the side of one part of our client's ambivalence, we can also take the side of our client against someone else in the client's life, often without having ever met them. During Lauren's first couple of sessions, she repeatedly said that she didn't want to be in therapy. I would gently remind her that she didn't have to be since she was an adult, to which she would respond that she just felt hopeless. As I tried to help her see that she could change, she seemed more resistant. She talked about her boyfriend and said that she wanted to break up with him. She talked about how he mistreated her. She reported that he had been sober for a year and she had just learned that he had a slip without telling her about it. It sounded like breaking up was coming from her wise mind. I was eager to help people get out of toxic relationships, and although a noble goal, I have at times been misguided in my attempts to help.

After a few sessions of not following through on goals she had made about the relationship or any other goals, she was feeling embarrassed, and I was confused. That's when I said what I wish I had said in the first session, "You seem to be torn, like one part of you wants to break up with your boyfriend, but another part of you isn't convinced. She agreed and rather than feeling shame that she hadn't followed through on any of her

goals, she became interested in her own ambivalence. I asked her, "Would you be willing to try an experiment with me? It's a little odd, but it can be very revealing." I introduced a particular form of empty chair technique that I often use to help people understand their own ambivalence (and get me out of the middle of it). In this version of empty chair, the person speaks from one part of themselves to the other part of themselves. I can then get out of it and help them work among themselves, in a manner of speaking. In Lauren's case, the part that wanted to break up with the boyfriend spoke to the part that didn't want to and then vice versa.

During this exercise, Lauren recognized that she really did want to change, but she had a voice in her mind telling her that she shouldn't have hope and that she wasn't good enough. Then she realized that she hadn't wanted to come to therapy because she was afraid that I was going to tell her to break up with him (I had teetered very close to doing just that). I told her that I could help her access her own wisdom rather than tell her what to do. We continued the exercise as follows:

Lauren: (At this point, the part of her that doesn't want to break up is talking to the part that does.) I don't want to break up with him because he's all I have. It's not that big a deal that he had a slip; it happens to everyone. If you (speaking to the other part of herself in the empty chair) break up with him, you will be alone and even more depressed. You should take into account his feelings and not be so selfish.
Therapist: (I gave Lauren sentence stems to complete to help her examine each side fully). When you tell me that I should break up with him, I feel...
Lauren: When you tell me that I should break up with him, I feel mad because you are naive, you always want things your way, and you act like the world should be a perfect place. You dwell on the negative. You aren't even thinking about all the things he does for you. You can't make it in the world by yourself.
Therapist: When you act that way, it reminds me of...
Lauren: When you act that way, it reminds me of when I was little and wishing that Dad would spend time with me. He didn't care about you when he was having affairs. You can't always have everything you want. You need to appreciate what you have rather than focus on your unhappiness. You won't find anyone better than him and you'll be alone.
Therapist: If I listen to you, I'm afraid that...
Lauren: If I listen to you and do break up with him, I'm afraid that I will become even more depressed and suicidal (Uh oh. That was where we might have been heading if I only heard her complaints about him and kept subtly aligning with her goal of breaking up).
Therapist: What I wish you'd do differently is...
Lauren: What I wish you'd do differently is accept that life is hard and stop being so depressed all the time. You need to toughen up!
Therapist: What I wish you understood, that you just don't get, is ...
Lauren: What I wish you understood is that I am trying to help you.
Therapist: Is there anything else that this part of you wants to say to the part of you that wants to break up with him?
Lauren: No.

At this point, Lauren switched seats. She was instructed to get in touch with the part of her that wanted to break up with her boyfriend and to respond to what she had just heard the other part of her say.

Lauren: I need to break up with him because he was dishonest by trying to keep this a secret. He knows that I can't tolerate secrets. If he's keeping this a secret then I don't have any idea what to trust. If he really loved you (speaking to the part sitting in the empty chair), he would have let you know that he was struggling. He knows that I can understand about a slip, but not about dishonesty.
Therapist: When you tell me not to break up with him…
Lauren: When you tell me not to break up with him, I feel trapped, unimportant, and weak. I feel like what I want or need doesn't matter.
Therapist: If I do what you want…
Lauren: If I do what you want, I'm afraid that I will never truly feel important. I need to know that I'm strong and don't have to depend totally on someone else for my happiness.
Therapist: What I wish you understood is…
Lauren: What I wish you understood is that I should have a right to my own expectations and to have my needs met.
Therapist: When you don't validate that, it reminds me of…
Lauren: When you don't validate that, it reminds me of Mom telling me to stop complaining and get over it. She was upset with Dad too and would never let me talk about it. She just put up with it! (long pause)…I wonder if part of her wanted to leave him.
Therapist: What I wish you'd do differently…
Lauren: What I wish you'd do differently is pay attention to my feelings every once in a while.
Therapist: What you really don't understand is…
Lauren: What you really don't understand is that I have rights too and I'd rather be alone than settle for less.
Therapist: Is there anything else that this part of you would like to say to the other part?
Lauren: You sound so mean when you talk to me! If you want to help, you should start by treating me nicer.

Next, Lauren was asked to imagine that her adult self or wise-self had been listening to the entire conversation. This part of her understood exactly why each part felt the way it did and knew the way out of the dilemma. Lauren was asked to imagine what this part would now say.

Lauren: I need to know that it is okay to have needs and wants, and that I am lovable. There's actually no real reason to believe that I'll be alone, and the most important thing is for me to know that I'm worthy of being treated well. I will listen to and validate my feelings and not allow myself to just stay in bed.
Therapist: How does this wisdom help with your decision regarding your boyfriend?
Lauren: I'm not sure what I'll do yet, but if I'm feeling stronger, I will be able to talk with him about his slip without feeling unlovable and afraid of being alone. If I'm stronger, I can see that his behavior is not a reflection on me but does affect me…. And be able to

make a choice based on what's best for me now rather than the fears I developed growing up.

Lauren and I realized that this wisdom was within Lauren the whole time but she was unable to access it because she was trying to figure out which side of her was right. By listening fully to both sides of her dilemma with compassion and openness, she was able to apply her inherent wisdom to her own ambivalence.

In summary, when working with people who are resistant, it is usually more effective to consider that they are ambivalent. You can then disentangle yourself from the conflict which is actually inside your client and enable them to find their own wisdom. When someone is resistant, it's important to recognize that there is wisdom on each side of their ambivalence that must be harnessed before the resistance can be resolved. ▼

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Sometimes "Just Do It" isn't enough of an answer. Figure out WHY you're not doing it, THEN fix it.

—SonjaFoust.com

Patience is, in and of itself, a great challenge and it often holds the key to breaking through a seeming impasse.

—Daisaku Ikeda

Tali Silver

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Resonance in Blue
An Unfinished Case Completes with Self Discovery

Some things we have only as long as they remain lost, some things are not lost only so long as they are distant... The blue is the light that got lost.
—Rebecca Solnit, *A Field Guide to Getting Lost*

It may be true that we are most haunted by what we didn't get. A good-enough mother will be mourned and laid down in peace, eventually. But a missing-in-action parent will very likely become an internal unrest, an old hunger that will not be quelled. Similarly, failed treatments sometimes leave a mark that only etches more clearly with time. This paper lays out such a case, leaving theory aside and focusing on symbolic imagery, feelings, and the lens of time.

A young woman slunk into my office and collapsed into a chair, rag-doll-like. Tall and lean and dressed like a teen, gaze averted, heavy mascara, veils of dark hair draped over a pale face. Her limp, almost flaccid, muscle tone contrasted with the intense juvenile goth makeup. I name her Girl.

"What made you call?" I asked.

In a feeble, high-pitched voice, Girl replied, "Last week I was at a Celine Dion concert. Everyone around me was in ecstasy. All I could do was cry." She cried. "It's been years since I had joy like they were all having." She sighed. "I'm so tired. You work in dreams. I had a weird dream. That's why I called."

It is uncommon for a new patient to walk in and immediately upon taking a seat reel off a dream. It made me do a double-take on my initial impression and wonder what else Girl's appearance masked. Encouraging her, I said, "Great, tell me the dream."

"I was in my parents' bedroom. A scorpion with an oversized claw dropped from the shade to the floor. It scuttled about, left the room, came back, and then disappeared. I had to find it but couldn't. I was so scared. I woke up in a panic."

What scared her so, what compelled her so, why the panic? I sensed such a storm inside her, tremors of noxious air. The room swelled with a tide of whipping waves and shrieking gulls. Body trained in stillness, I secured my heart to the spine, mouth softly shut as in meditation, ears open wide. All this to allow the imagination to swim out freely and nibble at dreams, crumbs on the water.

I asked Girl to show me the scorpion's claw and pointed to a pad and a box of crayons on a stool beside her. She apologized, "I can't draw," but agreed to try. "It was a giant lobster claw," she said, and sketched a tiny little outline of a tiny little claw at the bottom corner of the paper. She proceeded to fill it in with the brightest blue from the box, an electric ultramarine.

"What does this color remind you of?" I asked.

She instantly shot back, "I don't know."

Apparently, there was not going to be a call-and-response with Girl. I was on my own with the questions. Convention has it that blue represents depression, and it is as subtle as the longings that fuel jazz. In contrast, Girl's blue was a loud in-your-face neon that insisted on prime-time. The blue claw was a powerful image, let alone for an initial dream in a first session. It dozed in the background while we talked, a screensaver.

I wondered if the scorpion was a helper, since it was so essential for her. Maybe it came to mobilize Girl out of her parents' bedroom and jump-start her heroic journey of individuation. Perhaps it possessed hydration, withheld by her parents. Or was it the chase itself that it offered? In any case, it might be lethal.

Girl told me how as a child she used to while away the after-school hours next to her drunk mother on the parents' bed. Bathed in the quivering TV glare, both were lost in an alienated universe. Girl talked about wanting to sleep all the time, no wonder. Her unconscious traveled very far in order to fetch an exotic scorpion from the scorching south and dress it in a familiar local northern lobster's claw, a hybrid of hot and cold, desert and ocean life.

I take a ride on the scorpion's back. It has a dinosaur's exoskeleton, two hundred million years old. It can survive up to 6 months without food; its enzymes dissolve almost anything into soup. Girl might be beyond starvation. A scorpion inflicts unbearable pain or a deadly sting. I wonder if the blue claw carries a hurt so profound that it threatens Girl with annihilation.

Imagine a frigid room awash with bluish haze from a bulky box TV. The curtains are drawn over two inert scorpions lying side-by-side on a queen size bed. One is larger than the other. The little one wants to play with her friends, but she has to watch over her comatose mother. An empty bottle of wine glints in between them. It soaks the flickering lights of media wasteland and fills up with the two creatures' unmet needs.

According to the law of preservation of psychic matter, the wine bottle fills with their mute anguish. It attaches to baby Girl's arm and becomes an oversized, hermetically sealed, invisible vesicle. It follows her wherever she goes. It becomes the claw that replaces the hand for reaching. It mitigates all her interactions with the world. Stimulated by Celine Dion's sentimental music, the pent-up feelings erupt at the concert and spill out with Girl's tears.

Girl revealed some of her abusive relationships. I was reassuring and kind as could be, and yet she felt closed-off. The distance between us brought to mind the icy parental bedroom. I offered her water in a cobalt-blue jug from the Armenian quarter in Jerusalem. No thanks.

Did she know I am from the Middle East? What if the claw attached itself to my right arm, my tool for doing everything? It would be so debilitating; I might give up. I've had my share of scares and traveled far to evade the sting of memories. I well understand Girl's storm and unspoken fears. I remember myself at her age, 21.

The air is boiling hot and dry, the glare of the sun is blinding. I'm on Mount Sinai, outward-bound, supposedly free and doing whatever I want, tripping with strangers. Actually, I am on the run from the hurt of having been kicked out of home by my mother. I am just beginning to separate and encounter my blues. Haunted by double-binds and dead-ends, heatstroke, snakes, and scorpions, I am afraid of everything. Danger lurks in the rugged cracks of the reddish rocks, yet I am riveted by their energetic power. Then I notice it, the bluest water I've ever seen; why the hell is it called the Red Sea? It is so blue! Nowhere on the face of the planet is the contrast between earth, water, and sky so stunning as it is in the Sinai Desert.

That trip may have seeded my obsession with blues, but it also propelled me to seek healing. I found a wonderful therapist and stuck with her for years. She made all the difference in my life. I wanted to make that difference in Girl's.

Our therapeutic mission was to develop a recipe for transforming the poisonous past into a digestible soup, so that we could process her memories, dreams, and reflections, together. In order to regrow her human hand, we needed a lot of time, patience, and a strong, trusting, loving bond. I waited for the right opportunity to discuss all this with her.

A few months into our work, Girl missed her appointment. I followed up with the usual text, a phone message, and lastly, an email reminder. There was no response. I got a sinking feeling that I had become the one chasing, and she, all too soon, scuttled away. We had barely started to work in earnest. If only she would return, we'd formulate an understanding and dive in. We'd weave together her initial dream, her disappearance, her childhood hurt, and what it all means.

Weeks passed in silence. Eventually, Girl left me a message. After dumping her last abusive boyfriend, she lost her means of transportation. She said she could not reach my office. This was before telehealth, and so it came to pass that her dream predicted the end of treatment; she was not going to be found. Perhaps the scorpion set the trajectory of our work. Despite the dream's forewarning, I was surprised and upset by her exit. Years later, I am still intrigued by Girl and her blue claw.

Why do I have so many blues in my paint box?

Even though I pass by the same lake every single day, it always takes my breath away. After Girl's disappearance, I resolve to capture the view once and for all. To prepare, I lay out all my blues: acrylics, gels, pastels, powders, glitters, and sprays. The paints huddle together, eager for the job. The brushes shimmy impatiently in the direction of the waters. I cut and prime a canvas 6 feet long and 2 feet wide. I stretch it taut, an immaculate horizon.

Maneuvering my car around the bend, I swerve towards the shimmering expanse on the right side of the road. A dark force lurks in the depths of the basin. Its taste arises in

my mouth, cold and metallic. Beyond it, blues from above clash with blues from below along a perfectly straight line. I halt to search the point from which the blues spill out to fill the entire expanse.

The canvas fills up with deep blues, purples, and neon green. Narrow strips of rough terrain in brown and ochre materialize on opposite sides, inching towards each other but not touching. That's how we were, Girl and I, so much encapsulated feeling, so much need, but no outlet and no connection. A brief encounter. Will she do the work with someone else? I have done it and facilitated others; she is the one that got away.

Girl's blue claw itches and awakens my blue claw. Unlike Girl, I let the blues gush into paintings of skies and waters, their interrelationship, reflections, and moods. The itch leads to dozens of renditions of the mysterious razor edge of meeting/non-meeting, where above and below have a conversation.

I practice both painting and therapy, two mediums as different as air and water. They merge in the creative gesture. Standing where they meet, I try to make the stuff inside the claw legible. Try capturing distance itself; there is no recipe. It flickers. It impregnates jazz. It becomes a calling for emotional repair.

Perhaps sometimes, healing, for someone who did not get good-enough mothering, is unattainable, like the color of air. From a distance, it seems blue, yet up close it is transparent, for it has no pigment. Blues only approximate an ungraspable void. Water bodies reflect the sky, and therefore they too appear blue. The ocean is perceived as a symbol of the great mother, yet its blue is merely a reflection of a lack, of the sky's hue of distance.

Finally, I get it; it took a few thousand words. Because Girl's case was incomplete, because of the resonance between us, and thanks to the haunting image of the blue claw, my own incompleteness was tapped. Most cases offer gifts. The boon of this case was reigniting my love of the ocean and chasing blues, thus boosting the never-ending project of self-healing with art. It seems that the distant lost mother drives my creative flow. I am truly blessed.

The claw is a safe that stores what feeds creativity. It is my wasteland, my wilderness, and the zone of scorpions. I turn towards it, enter, swim in it. It becomes art and regenerates life. The blue pain of distance inspires dripping layers of diluted washes and careful strokes of dry brush, leathered thickly and smeared with a spatula, gouged with nails and smoothed with hands. In time, this is how Girl completes. ▼

Marilyn Schwartz

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You're Fired! Intractable Impasses

As Freud (1937) warned, the analyst deals with hazardous materials that require special precautions, lest the handler be gravely injured (Freud 1937/1964, p. 249). Rarely is this truer than when a psychotherapist is fired, dealt the blow of an unexpected, unilateral, precipitous termination by a client who has been in long-term therapy with them. I imagine any therapist who has been in practice long enough has had this shocking, bewildering, and painful experience. I certainly have.

I recall a dinner spent with a very seasoned therapist who spent the entire evening horribly upset about her long-term client that day, who announced as she was going out the door that she did not intend to come to any more sessions because, in her words, "I am done." The therapist was shocked and could hardly get the words out of her mouth, "Let's schedule a session to talk about this." In response, the client firmly said, "No, I'm not interested," turned away, and walked out of the room. The therapist subsequently reached out to the client by calling, emailing, then sending a letter, but the client never responded to any of these communications. As the therapist later shared with me, she was surprised by how deeply hurt she was by this client's sudden exit and especially by how her deep caring for the client and efforts to help her were met by this seemingly heartless treatment in return.

Worth sharing is a story of mine that similarly illustrates the painful, even traumatizing effect of being summarily fired and ghosted by a long-term client of 20 years and my struggle to metabolize and heal from this experience. Ms. D, age 36, began therapy with the stated goal of "wanting a life." As she described the problem, she had no

life from her 20s until then other than working non-stop in an organization on the path to becoming a partner in the firm. She had no social life or, for that matter, any significant relationships or involvement in activities outside of work. Learning about herself in terms of what she wanted around connection with others, including me, and engaging in activities other than work was the first phase of treatment. The second phase was learning how to be in a relationship, especially in a partner relationship, which led to her marriage and becoming a mother of two.

As is often the case when clients start their own families, Ms. D began to reflect on her upbringing and her relationships with her parents, not wanting to repeat unhealthy patterns. In this phase of therapy, what became foreground was the client's early experiences of neglect and lack of emotional attunement with her mother, who was an active alcoholic during her first few years. This pattern of her mother's lack of emotional availability and support continued into her later years. She had a closer relationship with her father, but he was an unreliable presence as he had bipolar disorder. Ms. D questioned continuing in her marriage as she struggled with a similar pattern of feeling she was not getting her emotional needs met there. After her husband lost his job, he became, by default, the full-time parent at home and not a very effective one at that. He was subsequently diagnosed as being on the autism spectrum and struggling with ADHD.

Therapy continued, as the patient seemed to benefit from exploring how she could better meet her needs in her marriage, be a more effective parent, achieve a better work-life balance, and deal with health issues, including breast cancer. As it appeared that her life was going well, it seemed that we were heading into the home stretch of completing her therapy. However, an event soon occurred that, in hindsight, now strikes me as leading to the rupture of our relationship, an unraveling of the therapy, and my being summarily fired.

What occurred was that Ms. D missed an appointment and, unlike her, hadn't called me in advance to cancel it or see if she could reschedule. When I called her to confirm the next scheduled session, she reported that she had missed the session because she had to take care of her children, who had the flu. As it was the end of the month, I sent the patient a bill for sessions that month, about $1,400 in total. That included billing her for this missed session, which was my policy since she didn't call to cancel or reschedule. And then—radio silence from the client. She didn't show up for her next session, pay her monthly bill, or respond to my numerous attempts to reach out to her. To say the least, I was stunned and confused by her actions.

To address this situation, I immediately sought consultations from colleagues whose clinical judgment I respected and whose support I badly needed. What was reinforced from these consultations was my own belief in the importance of trying to repair the rupture of my relationship with Ms. D. As we've come to recognize (Goldsmith, 2013), the work of repairing a rupture of the therapeutic relationship is a goldmine for fostering growth and change in clients. For this reason, I reached out to Ms. D through various means to offer a session or sessions to process her decision to end therapy with me. Still radio silence.

Serving at that time as chair of the Ethics Committee of the American Academy of Psychotherapists, I was keenly aware (or maybe, even wary) of how to address this situation with regard to ethical and risk management considerations. One relevant ethical principle is that we have a responsibility to provide a proper termination no matter how

the patient leaves therapy. Even with a sudden, precipitous termination like my client's, we are obliged to offer a session or sessions to process the termination and, if appropriate, make recommendations for further treatment and offer referrals to demonstrate our providing continuity of care. Also important is to document the termination process in the client's record and include a termination letter, sent by email or snail mail, to confirm that you are no longer the client's therapist on record.

Unfortunately, Ms. D did not respond to any of my overtures to meet with her to discuss the reasons for her termination, nor did she ever pay me the $1,400 balance due. Not paying her bill felt like a sting that lasted far too long and a carrier of whatever message she intended for me to get. Although I was tempted to turn her unpaid balance over to a collection agency, I chose not to because I've heard numerous times from my malpractice insurance company lawyers that this is risky business, even if you state this as policy in your patient informed consent form. But the downside of not doing so is collusion with the client in avoiding the reality of expecting them to act like a responsible adult and fulfill their therapy contract with you. Also, I wondered, in my not pursuing my client's paying me what she owed me, was I afraid of her anger and further retaliation against me? Was I being bullied and afraid to claim what was rightfully mine? And worse, was I afraid of expressing my anger and aggression towards Ms. D?

Fast forward 5 years, and, to my surprise, Ms. D. reached out to me by email to report that she was bereft over her mother's recent death and wanted to return to therapy to work with me to address this and other matters. I suggested we speak by phone to understand the situation better. As you can imagine, I was extremely curious whether she would explain to me her sudden termination and the reasons for her non-payment of her last bill. To my surprise, Ms. D did not mention the earlier ending of her therapy or her unpaid balance.

What was clear to me during our phone conversation was that Ms. D was horribly grief-stricken by her mother's death and in no emotional state to deal with how she had ended therapy with me. As she gave me an out, asking if I were retired or retiring soon, I chose to tell her that as I was on the path to retiring soon, it would be best if she saw someone else with whom there wouldn't be any time limits around the work. What I didn't say to Ms. D was that I was choosing not to work with her because I couldn't imagine stepping aside from first addressing my feelings about how she ended her therapy with me. It was my clinical judgment that this focus wouldn't be helpful to Ms. D and might even be harmful as she was genuinely suffering, grieving the loss of her mother. I then told Ms. D that I would check with a colleague I felt would be a good fit for her and then would get back to her about their availability.

This turn of events led to my learning what I believe is often a critical dynamic in situations involving a long-term patient's sudden termination and their inevitable need to inflict pain on the therapist. In making the referral to my colleague, I did feel, for purposes of ensuring continuity of care and the success of the client's subsequent therapy, that I should disclose to my colleague about Ms. D's sudden termination with me, her unpaid balance, and the lack of resolution of this situation despite my efforts to arrange a meeting to process this. As per my habit, soon after I made the referral, I checked with my colleague to see if Ms. D. followed through with the referral. Ms. D called my colleague, and I was absolutely shocked to learn that Ms. D had a very different recall of the end of her therapy with me. Her memory was that her treatment came to a natural end-

ing, and we had a proper termination. Also, to my surprise, she sang my praises about what a wonderful therapist I had been for her and how deeply disappointed she was that I couldn't work with her again. What!?!

As I've thought about this case, I've come to appreciate the old saying about therapy that any client can defeat any therapist at any time. Perhaps, this is the definition of an intractable therapeutic impasse when the therapist missteps and triggers in the client an early trauma and related set of feelings that have not been adequately or completely dealt with in the treatment. In the case of Ms. D, I think my billing her for the missed session set off an explosion of repressed rage around my not taking care of her, similar to her alcoholic mother's not adequately caring for her in her earliest years. Maybe she expected me to waive my fee for the missed session because, unlike her mother, she had shown up and cared for her sick children when they needed her. Also, the situation may have been complicated because the one piece of advice I repeatedly offered Ms. D for her children's safety was that she should never leave her children's medical care up to her unreliable husband. In this case, she had left it up to him to get her children their flu shots, which he failed to do, resulting in both children getting a severe case of the flu. I imagine the patient had rageful feelings towards her husband over his neglectful behavior and felt guilt over leaving it up to him. I suspect I was the safest depository for these feelings.

Transference, projection, and projective identification are likely factors leading to therapeutic ruptures and impasses. But in the case of intractable impasses, like that which occurred between Ms. D and me, projective identification may be the mental mechanism or defense mechanism more at play here. Projective identification is a defense mechanism first introduced by psychoanalyst Melanie Klein (1946, p. 102) that refers to the infant's directing or projecting hated parts of themselves onto the mother. According to psychoanalytic theory, the patient projects onto the therapist qualities about themselves and feelings that are unacceptable to the self, disavowed. Projective identification is regarded as a two-person process whereby the therapist internalizes the projections, i.e., believes themselves characterized by these projected qualities. In the case of Ms. D, her summarily firing me led me to question the caliber and effectiveness of my work with her and stew over and be held hostage to my anger and hurt over feeling badly treated by her. I wondered whether these feelings mirrored the repressed rage that Ms. D might have felt over her lack of agency and her neglect at the hands of her earliest caretakers. Also, as further evidence of Ms. D's projective identification, it was astonishing that 5 years after ghosting and reconnecting with me, her feelings of rage were so split off from her consciousness that she had no recall of how she left therapy.

Having the opportunity to later learn of Ms. D's positive regard for me as her therapist was healing in addressing the confusion and hurt that I had been carrying about her sudden termination. It also helped to explain to me the possible dynamics of why certain clients go the distance to hurt their therapist by suddenly and unilaterally terminating a long-term therapy. I was fortunate to have this reparative experience, which I imagine is rare in these situations. In keeping with Freud's saying that our work is hazardous, I believe this requires that we have compassion not only for our clients but for ourselves, especially when we find ourselves injured in the line of work. ▼

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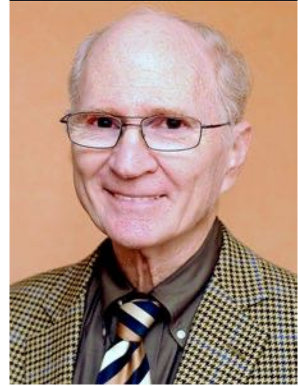
> Empathic failures are the gold mines of psychotherapy.
>
> —Heinz Kohut

> Between what is said and not meant, and what is meant and not said, most of love is lost.
>
> —Kahlil Gibran

Jerry Gans



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The Therapeutic Potential of Humiliating Experiences in Psychotherapy Groups and T-Groups

Given that powerlessness and humiliation are two of the most intense and debilitating feelings that a human being can experience, I imagine that more than a few readers will do a double-take at the title of this paper: "Something therapeutic about humiliation? You must be kidding; you can't be serious." And you would be on solid ground feeling that way. If there is anything that research into human well-being has shown us in recent years, it is that social connectedness is one of the most powerful determinants of human happiness and sound physical health. Since humiliation tends to rupture connectedness, it would seem logical to conclude that humiliation would have a negative, not a positive, outcome. In this paper I describe and comment on instances where that has not been the case, when instead benefits have accrued to the successful resolution, in one way or another, of the humiliating event.

Don't get me wrong, I'm not advocating for the humiliation of our patients. That being said, because of the complexity of psychotherapy, the variety of our patients' inner worlds, our own blind spots, and the vicissitudes of our personal lives, the best of us will make mistakes and humiliate our patients, or be humiliated ourselves. Given the messiness of human interaction, we should expect that humiliating experiences will find their way into our treatment rooms, and we should lean into them when they occur. We can't keep humiliation out of our therapy sessions—nor would we want to. While the examples of humiliation I offer can be viewed as mistakes, they are inherent in human relationships and, thus, the stuff of psychotherapy.

What follows are three examples that involved my own humiliation and two examples of my humiliation of patients. I will discuss the valuable learning and resolutions that resulted from each experience.

The Humiliation of Patient Suicide

My first example of humiliation that I suffered did not occur in T-group (training group); rather, the prospect of being in T-group 4 hours after a traumatic event contributed to my feeling of humiliation.

It was the beginning of June 1969 — I was 28 — and I was finishing up a very successful first year of psychiatric residency at the Mass Mental Health Center in Boston. I received a message to go immediately to Dr. Semrad's office with my chief resident. Dr. Semrad was a revered teacher of psychotherapy and the clinical chief of the hospital. A straight talker if there ever was one, he said, "This morning at 8:20, your patient Mary Smith jumped out of a 7th story window and killed herself."

I immediately felt a mass of undifferentiated feelings in my body. I experienced nausea, a wish to cry (as in feeling sorry for myself), dizziness, tightness in my shoulders, arms, and testicles, and a literal sense of not being able to see straight. Cognitively, a dense fog of disbelief enveloped my mind. I felt distanced and abandoned by my chief resident who reacted as if I had leprosy; at least, given my devastated condition, that is the way I experienced him. I had virtually no thoughts about my now-dead patient. I left with a very hazy remembrance of advice Dr. Semrad had offered.

A few minutes after I left Dr. Semrad's office, an overwhelming feeling of shame and humiliation overtook me as I realized that in a few hours I would be meeting with my fellow residents in our weekly T-group. Despite the fact that my patient had just killed herself, I felt an instantaneous and deep hatred for the grievous and unfair act my patient had committed against me. I felt a sense of being crushed, of having my cherished career threatened if not ruined, and of feeling defenseless and lost in uncharted territory. I projected onto my dead patient a sense of rage that obscured any sense of personal failure. I experienced her as the powerful perpetrator, myself as the underserving victim, about to be humiliated in front of my peers.

Time and the support and concern of friends, my T- group colleagues, and my wife helped me regain perspective. My fellow residents were able to both support me and admit relief that it was my patient and not theirs that had suicided. Residents who had a patient that suicided were particularly sensitive to the feelings I was experiencing. My patient's unconscionable act uncovered personal shortcomings and vulnerabilities that I had been successful in avoiding or denying up to this point in my life. Despite having gone to Harvard, my self- esteem had always rested more on athletic achievement than intellectual competence. My college experience, which exposed me to so many class valedictorians and to fellow students better prepared academically than I was, served to accentuate my feelings of academic inferiority with its attendant feelings of shame. In addition, the suicide, occurring as it did near the end of my first year of psychiatric residency, mobilized doubts of my ever developing into a competent psychiatrist.

Some good did result from this traumatic experience. I recalled and took to heart two things that Dr. Semrad said to me that morning: "Try to keep your mind open about this happening and keep learning from it," and "One of the hazards of treating sick peo-

ple is that, once burned, you may stay away from treating such people again." This advice proved extremely valuable in my career. I developed a reputation for treating difficult patients and even wrote a paper on the topic.

My patient's suicide resulted in my entering psychoanalytic treatment that fall, something I may have put off if not for this traumatic event. In the beginning of treatment, I had the opportunity to notice how concern for my devastated self-esteem had eclipsed my regard for my patient — something that in retrospect I was not proud of. Gradually regaining my equilibrium and my self-esteem, I have had years to think more deeply about my patient's delusional state and chief complaint upon admission to the hospital: "I buried my twin children alive." If nothing else, she succeeded in getting me to experience the pain, mortification, and humiliation that must have been embedded in her delusional state. I also had the opportunity to recall that I was very threatened and disturbed by her psychotic presentation on admission. She threatened my belief in my own sanity. She was just a few years older than I and had attended the same college; maybe I didn't have any more immunity against being crazy than she did. And finally, I slowly came to realize that all I could legitimately expect of my patients is that they do the work of therapy — and pay their bill. It is not their job to be grateful for the hard work and caring that I put into the treatment.

T-Group Humiliation

My second experience with humiliation occurred when I was 55 in 1995. That year, Massachusetts General Hospital merged with McLean Hospital and the new training director was not supportive of T-group. There was a woman in the T-group who had a lot of trouble with my leadership. She also, as it turned out, had a lot of difficulty with her father, whom she described as very narcissistic. Midway through the year, she announced that either she stayed in the group and I left or visa-versa. She complained to the training director about me. Instead of sending her back into T-group where her complaints could be processed, the new training director essentially said, "You say Gans is Hitler; well, we'll need to look into that." He hired a consultant to come in and meet with the T-group for two sessions, in my absence. I felt unsupported, hung out to dry, furious, and, yes, humiliated.

The consultant concluded that, essentially, I was doing a good job. He also had a few suggestions. He helped me to see that I was treating as resistance what actually was the group members' sense of feeling lost. I hadn't sufficiently appreciated how little psychodynamic thinking the residents were exposed to. When I was a resident back in the Neolithic period, psychodynamic thinking was the only game in town. Now, residents were mostly taught CBT, DBT, behavioral therapy, and a heavy dose of psychopharmacology — with only brief exposure to psychodynamic thinking.

I resumed meeting with the T-group and modified my style somewhat. I spoke to their ego more than their unconscious. I introduced some psycho-education when I observed that they were more lost than resistant. I thought that the modification of my approach had gotten things back on track until about 3 weeks after the consultation when a resident politely asked me, "Dr. G, if the group leader changes, can the group still have a positive outcome?" I thought he meant if the leader changes his/her approach as I had. But no, that is not what he meant. Bloodthirstiness was apparently still alive and

well. What he meant was if a new leader were to replace me, could the group still have a positive experience? I felt that this was a moment of truth for me. I could modify my approach up to a point, but I could not sacrifice my integrity by avoiding the educational and emotional work. I took a deep breath, fastened my metaphorical seatbelt, looked the resident straight in the eye, and said, "Joe, in my clinical experience, in almost all cases, patricide is not a good idea." The group became very upset and basically said, "There he goes again, making those interpretations we don't understand." But one member said, "You know, he's got a point; if we kill him off, we're going to have a lot of guilt to contend with." Someone else said, "Another leader might not be a bargain either." By late in the second year of the T-group, its members were talking about how sometimes they weren't such bargains either.

What I learned from this encounter is that much can be learned from deep pain, if only one can stay with it and processes it. The consultant had something to teach me that proved important and useful. The occasion provided me with an opportunity to model courage. I emerged from this occasion with enhanced self-esteem and self-confidence.

My Humiliation at AGPA

In the early 1990s, I ran a 2-day Specific Interest Section Institute on "Money and Psychodynamic Group Psychotherapy" at the annual conference of the American Group Psychotherapy Association (AGPA). In those days, participants signed up for events and received tickets in their registration packets that had the name of the event and in what room in the hotel it would be held. Without such a ticket there would be no way to know where a particular event was being held. The 12 institute participants met over 2 days for 13 hours.

Ten minutes into the institute, a woman, let's call her Susan, entered the room and asked, "Do you have room for me?" I asked her if she had a ticket. She said yes and handed me the ticket, which, uncharacteristically, I put in my pocket and didn't look at because I was already quite involved in the happenings in the institute.

About an hour later, I noticed that the chair Susan was sitting in was situated conspicuously outside of the circle. I called attention to this possible non-verbal communication and tried to foster group discussion about it. What emerged from the discussion was that a subgroup, consisting of four women in the group who were friends of Susan, had said to her earlier in the morning, "Why don't you come to Gans's institute, it will be better than the one you are signed up for." They told her where the event was being held.

I became privately excited by this revelation. What more could a leader giving an institute on money and group psychotherapy want than living, pulsating examples of dishonesty and corruption in the here-and-now? One could only imagine the chaos around registration that would occur if more people disclosed to those not registered for an event where it was taking place. I looked forward to the eventual processing of this fraudulent transaction as a powerful learning opportunity.

The subgroup had a different read on my intentions. They believed that I had called out Susan to humiliate her.

I discussed this situation at the luncheon table where institute leaders along with two

members of the Institute Committee discuss any issues in their groups. At this point, there was no way of knowing how the institute was going to turn out. The table group was sufficiently concerned and suggested that I bring the situation to the attention of the Institute co-chairs, which I did. The co-chairs, after hearing my take on what had transpired in the institute, concluded that I was handling the situation well and were not concerned.

A half hour into the afternoon session of the first day of the institute, there was a knock on the door. It was the institute co-chairs, who called me out of the room. They had thought more about what I had told them and wondered if I wanted Susan removed. I felt humiliated, like a bad boy who had been visited by the school principal and who had been asked to leave class. I told them that I was fine with Susan staying in the institute. I explained that l was confident that issues raised by Susan and her subgroup could be processed successfully in the remaining day and a half.

If only that had been true. The subgroup proceeded to mount an assault on my leadership that continued for the 2-day Institute. Other members of the institute, who had been made aware that the five women involved were lesbians, were reluctant to confront them about their behavior. They were afraid of being seen as anti-gay and/or homophobic. As a result, it became impossible to process the boundary violation and corrupt behavior and relate them to the topic of the institute. Instead, the focus became my inept leadership.

The institute took on a deadened feeling, and I received the lowest rating I had ever received. This was the last institute I was to run for 10 years because I was about to become a member of the Institute Committee and eventually one of its co-chairs.

What did I learn from this humiliating experience? It surprised me to learn that it wasn't the low ratings that bothered me the most although, obviously, I wasn't happy about what occurred in the institute. What bothered me the most was that the co-chairs, the folks who were there to provide safety and advice, had failed me. Their behavior stirred up strong feelings from my childhood when I felt that my parents weren't there for me when I really needed them to be. This realization led me to productive work in my own therapy, which made it easier for me to assume my Institute Committee responsibilities without mixed feelings. It also helped when a year later a woman who had been in that institute came up to me and apologized for letting me swing in the breeze and for not having the courage to confront the lesbian subgroup. I had tears in my eyes as she spoke.

Patient Humiliation—Henry

My first example of a patient I humiliated is Henry, a poignant soul whose father ran off with the babysitter when he was 5, leaving him and his five siblings with his medically-compromised mother and in poverty. He was one of my first patients in my psychiatric residency and someone whom I treated in both individual and group psychotherapy for almost five decades. Over that period of time, we worked in the transference on the rage he felt toward his father. We also spent much time discussing the deep emotional wounds he sustained at the hands of his peers who taunted him about his obesity, a chronic condition that persisted into adulthood. I essentially became like a surrogate father and every Father's Day received a card from him. In short, ours was a

very meaningful relationship for both of us, not an unusual outcome for therapists with one of their first patients.

One afternoon in 2017, I received a phone call from Henry saying he wouldn't be attending group that evening. There was something about the vague, apologetic reason he gave for missing the meeting that sounded very unconvincing. Partly because I had such a solid, long-term relationship with Henry, and partly because there was more to his phone call than the fact that he would miss the group meeting, I made the following announcement. "I had a call from Henry that he would not be attending tonight's meeting, but the reason he gave sounded like bullshit." This was a very, very uncharacteristic type of announcement for me to make. Henry attended the next meeting, and when no one referred to my announcement of the previous week, I called the groups' attention to their avoidance. When Henry learned what I had said, he was furious and said that I had humiliated him. When the group asked why he was so angry, he refused to provide additional information. Later in the session and with encouragement from the group, he disclosed the following information: He missed the group because of gastroenteritis that was causing him to pass a lot of gas. He worried that if he came to group he would be farting the whole time he was in group. Noting silently to myself that I had occasionally farted in the group, I asked the group if Henry were alone in having such concerns. There then followed one of the more disclosing and humanizing discussions about bodily functions that I have ever had the privilege to witness. Stories of embarrassing erections, untimely menstrual flow, premature baldness, excessive body hair, and unwarranted convictions about bad breath filled the room. Henry clearly felt joined by the rest of the group. The group's honest sharing allowed Henry to make the following statement in the closing minutes of the group: "I guess what this topic reveals about me is the fear that I stink as a person." Group members' responses made it clear that Henry was a person whom they highly valued. Several weeks later in an individual session, Henry told me that he felt a lot better since that session. What meant the most to him was my willingness if not determination to welcome into the therapy hour those parts of him that he was most ashamed of.

My Humiliation of Edith

The other example of humiliation that I caused also involved a patient with whom I felt I had a very solid, long-term connection — but this time the injury I inflicted took longer to repair. Edith was a 45-year-old, single woman whose major psychological difficulty was internalizing inaccurate negative projections from her peers. This problem had its origins in childhood and adolescence, in her relationship with her critical father and her highly competitive and jealous younger sister.

An attractive woman with many personal strengths, charisma, and vocational accomplishments, Edith was well liked by the other group members. I viewed her as one of the healthier members of this long-term, very cohesive group that had worked through many negative feelings with each other and had achieved an impressive degree of maturity and intimacy.

One evening in the group in which she had been a member for 10 years, Edith described a man she dated whose ex-wife had a restraining order on him. She also shared her disquieting feeling, resulting from things he said on the first date, that he could be

a pedophile. Edith went out on four dates with him before cutting off the relationship. The group, judging from their comments about Edith's relationship with this man, felt that that she could have been in danger. Edith was someone who wanted very much to be married but seemed to get involved with men whose passivity and narcissism were deal breakers.

Shortly after Edith's account of this brief relationship, I told the group that somehow her story reminded me of the joke about the single woman in Florida who lived in a condo and knew everyone. One day she saw a man at the condo pool who clearly was a newcomer. Striking up a conversation with him she learned that he had recently come to Florida from Pennsylvania. She inquired about what he had been doing in Pennsylvania. He said that he had been in jail for murdering his wife. To which information the woman replied, "Oh, so you're single."

The instant look on Edith's flushed face made it clear to everyone in the group that I had humiliated her. Edith rightly felt that the joke suggested that she, like the woman in the joke, was pathetically desperate for a relationship with a man. My remark would have been shaming enough if I had made it in individual therapy; shaming her in front of the other group members inflicted an even deeper wound.

Why on earth did I respond in such a hurtful and unempathic fashion? In retrospect, I realized I felt attracted to Edith and took personally the barriers she had erected early in her life to protect her from her narcissistic father. From time to time over the 10-year period she was in the group I would check in with her about our relationship — as is my wont with all my group members. Her response was always the same — that nothing had changed. I felt connected to her and wanted her to feel more connected to me, something that was still difficult for her because of her well-earned deadened feelings toward her narcissistic surgeon father. Rather than exploring this repetitive pattern that was getting in the way of her own happiness, I enacted her relationship with her father with a narcissistic response of my own: The joke was clearly for my benefit, not hers.

After sorting out my feelings, and when asked by Edith why I had behaved in such an uncharacteristic fashion, I explained the dynamics underlying the injury that I had inflicted. I told her that, without realizing, I had taken personally her inability to feel closer to me after all the hard work I and the group had put into her treatment. In telling the joke, I acted like a jilted lover who wanted to hurt her back. In retrospect, I realized that her unwillingness to feel more connected to me had given me a deeper appreciation of how dangerous it must have felt growing up to feel closer to her self-absorbed father and, by extension, other men as well. I acknowledged that I had told a joke at her expense and had punished her for a deep limitation that she had come by painfully and honestly. I also gave her credit for speaking up and refuting the implied comparison between herself and the woman in the joke. I cited the impressive progress she had made in not taking on negative projections. Owning my contribution to this interaction and my apology heightened group cohesion and trust. For Edith, having someone in authority take responsibility for their behavior and apologize, especially a man, was a new experience and helped her gradually feel more attached to me. Having regained my therapeutic equilibrium, I could enjoy the fact that 8 months later, Edith met a wonderful man whom she married the following year.

My Harmful Humiliation of Eva

As my last example, I want to make sure that my readers know I am quite aware that humiliation usually has detrimental if not destructive effects.

Eva, a member of my group for 4 years, seemed most connected to two cherished beliefs: that people didn't like her and, when, not if, subjected to criticism, she would not be protected. These beliefs clearly had their origins in her father's relentless and vicious criticisms of her and her mother's failure to provide her any protection. Eva had been in individual psychotherapy for 15 years before joining my group, and insurance paid in large part for both therapies. When I went off all insurance panels, Eva asked for a fee reduction which, after a thorough discussion in the group, I agreed to on a temporary basis should her finances improve.

Two months after the fee reduction was negotiated, Eva announced that she and her husband were going on an expensive, 4-week vacation. Her bill for the month prior to her vacation was unpaid. It was my custom to announce at the beginning of each group session any information I was privy to that the group couldn't know about, including unpaid bills, to ensure there were no secrets. While Eva was away, I nursed my grievance that she was a big spender with my money. It crossed my mind that it would be the better part of discretion to wait until her second week back in group to make the announcement about her unpaid bill. I didn't wait. I made the announcement on her first week back. In her mind, I immediately became her vicious, critical father bent on humiliating her. Even with owning my part in her humiliation and despite the group's best efforts to have a fuller discussion and offer support, Eva left the group soon after.

Conclusion

Humiliation is a difficult emotion to experience. It is unfortunate when it occurs in psychotherapy, but, given the complexity of human relationships, we can expect it to happen. As I hope the examples I have described show, the successful processing of humiliation has the potential to be an important and sometimes profound learning experience for both patient and therapist. ▼

Blake Griffin Edwards

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Mikey's Homecoming

Back in my 20s, I spent some time working with homeless teens in residential treatment, in the Seattle area. A couple of weeks prior to meeting me, Mikey had stepped off a Greyhound bus from Boston, a rebel and a runaway. Coolly dispirited, with both hands tucked into a black leather jacket over a grey hooded sweatshirt, he just rode along that long haul between coasts, with little to eat. When Mikey screeched his way into the bus station just 3 blocks from the Westin downtown, he had only about 20 bucks in his pocket, maybe. He hadn't the faintest idea of where he would go when he got there or why he had even chosen Seattle of all places.

He was surrounded by people yet completely alone in the world and hurting from pains inflicted onto others, stemming from the impacts of those that had been inflicted onto his much younger self. That afternoon—he had travelled all night—Mikey strolled up Stewart Street in search of a miracle. Eight blocks later, he turned right on Yale and spotted a large name sign on a building: the name of a local non-profit that provides, among other things, education for homeless teens. A month later he'd be a student there, and 3 months later he'd have a steady job at a local grocery store. But we'll come back to that.

That day Mikey just chatted with a young receptionist he thought was cute, snagged a brochure, and was on his way out the door. He headed down the road, flipping his hoodie up in the drizzle, bewitched a bit by the enchantment of the Emerald City. But not too bewitched. He was from Boston, after all. Mikey headed downhill, as anyone in his position would have done, toward the waterfront, older buildings, and a better view of ships.

That night, Mikey worked his way back to the guise of safety, the plaza outside of Westlake Center. He didn't realize that in the glimmer of Macy's and Starbuck's he'd be fending off sexual assaults and struggling to keep one eye open on a hard metal bench before being yelled at by a cop. Mikey barely slept that night, and he barely ate. I know all this because he told me in that booming Boston accent with all his smug "whateva's."

I didn't like Mikey at first. He was hesitant to receive me into the fold at the boys' shelter because I was the new guy. He'd been there, what, 2 weeks!? And I was this new guy that needed to be tried and tested? Whateva. Mikey was a loner. He would disappear and come back a couple of hours later smelling like smoke, or we'd have to go on special missions to find him.

But I got to know him, and he got to know me. He didn't let me off easy, called "bullshit" every time I started talking like a "pissant shrink wannabe." I wasn't just his therapist. I was his shelter case manager too. Which means I'd be shooting the basketball with him and a few other guys one minute, eating pasta and drinking Sunny D the next, and then meeting in private for an hour, hoping he didn't notice me slipping in and out of Robin Williams:

> I can't learn anything from you I can't read in some fuckin' book. Unless you wanna talk about you, who you are. And I'm fascinated. I'm in. But you don't wanna do that, do you, sport? You're terrified of what you might say. Your move, chief. (*Good Will Hunting,* Van Sant et al, 1997)

Mikey would sit there, slumped, looking down, swiping his nose, glancing past me, and, in a fury of my own discomfort, I'd extol him with a weakened dose of positive psychology. I was pretty sure he could literally see through me. Every once in a while, Mikey would look directly into my soul and call out at me like I was a quarter-mile away—"Hey, Blake man, you should write a book." I'd retract and squint a bit toward him questioningly.

Again and again, I would take time alone before these sessions to breathe and consider Mikey as a person, and in our moments together, I would reflect to him what I thought I might be witnessing in the attitude I detected in his behavior, his sarcasm and rule-breaking, and what I perceived to be his feelings, from themes heard underneath periodic anger outbursts.

In our best moments, I would quiet my own anxieties, and in the spaces of my own curiosity and concern Mikey would occasionally just begin to talk with me. He would make wise cracks about other guys in the shelter, and he'd speculate about ways to make a buck or meet a girl. Sometimes he would tell me he was fed up with all this "bullshit." He would not define bullshit. And he'd tell me that he felt trapped or sad or tired or chill or hopeful or whateva.

Once Mikey had been in classes for a few weeks, I felt like he was doing well enough that I should give him more space, so I'd shorten our sessions. I didn't communicate with Mikey about why our sessions were shortened. I'd just open the door and yell for Joel, who ran the shelter, to ask what was next on the house agenda. Looking back, I realize that I was not sure of the next step, and I was fearful of daring to just be in relationship with Mikey. I had looked for a therapeutic schtick to move to some higher goal, some elevated level of functioning to pursue, but I could not find it.

I tracked change data on a functional assessment tool, staffed his case at monthly

psychiatry consultations, tried on theoretical models for fit, and wrestled to come to grips with Mikey's history. I consulted with residential counselors at the shelter, sought clinical supervision from a mentor, and read portions of books that illuminated considerations related to developmental theories of evolving teen consciousness and underlying causes of deviant behavior. But I was at a loss as to how to help him.

I felt and was in many ways, I confess, inadequate. I had never walked a mile in Mikey's shoes. I could not remember, or figure out, how to best apply all the developmental and theoretical insights I had so enthusiastically learned. I was uncertain of the accuracy of his file's diagnostic categorization and, thus, questioned the basis for my every attempted intervention. I sometimes found myself jealous of those practitioners who chattered on about their clients with apparent diagnostic precision and therapeutic conviction. If only I knew which way was up.

Joel wasn't such a head case as me. He would pick the guys up from school, take them to the library to complete homework and check their email, make them a snack, shoot the basketball and maybe goof off on a skateboard, play video games, and end up chatting about their latest love interests. I envied Joel's ease with my clients—therapy clients, psychotherapy clients, mental health therapy clients—I tried on these labels to see which best bolstered my sense of professional pride. I would sometimes try to explain either psychodynamic or systemic rationales for the difficulties they were facing. Not this day. I was becoming lost in my own need for validation. I knew I had to try something different.

That day I drove Mikey to a nearby trail. As we walked hilly terrain through misty forest, he told me about his aunt and uncle back home that cared so much for him. He told me about a few close friends—one in jail, one addicted to heroin, and one who betrayed him by sleeping with his girlfriend. As he did, he would stop occasionally and continue storytelling as he karaoke-stepped a few paces to the left, a few back to the right, all the while holding eye contact through a glazed sheen of tears. We would walk further, stop again, and this continued even beyond a brief moment in which he caught himself in a moment of meta-awareness, chuckling as he wiped his eyes, "Yo, Blake, I don't know what kind of spell you're putting on me, bro. I've never shared all this…all the emotion behind it. Thanks. You suck."

I gut-laughed. And we both experienced a kind of mutual fullness in that moment. By "we" and "mutual," I am making a massive assumption. As we walked on, Mikey directed: "Let's go home, boss." We did. Something important changed on that walk. And although I believe it involved primarily Mikey, a shift in experiential understanding was taking place in me as well. After that, I remained as odd and awkward, quirky and clunky, as ever, yet I began to loosen up a bit and lean into something of relationship, with Mikey and with the other boys in the shelter. I more vulnerably and openly acknowledged my own frailties, questions, and hope around how we were going to see positive changes take place for their lives.

Mikey got himself into some more trouble. Joel and I infuriated him by taking away his cigarettes one day. Mikey stayed up later than he was supposed to that night debating the meaning of life and playing video games with Christian, our night monitor—another extraordinary mentor for these boys.

While working toward credits through his school, Mikey was required to keep a part-time job, and he landed one at a local grocery store. I visited him there a couple of times.

That first time I caught eyes with him from across the produce section, he lit up in a way I didn't think he was capable of. "Yo, Sammy, get on over here! This is Blake. He's the one I told you is helping me." He introduced me to his supervisor, whom I would speak with weeks later after Mikey was late one too many times. He got his job back, only to quit soon after.

One day, with Mikey's permission, I called his uncle, whom he had told me about through a half-verbal trail of cryptic mumbles riddled with pain. I figured he meant something to Mikey and that, likewise, Mikey probably meant something to him. And, the reality was, Mikey had to go. Shelter care for teens is a difficult world stretched into that thin space between foster care and homelessness, and there are rules. Mikey had already been granted more extensions than our grants would cover, and he had dropped out of the nonprofit school's program upon which our grace hinged. Mikey's uncle spoke through tears and told me of the hurt Mikey had caused during the couple of years he and his wife had taken him in before he ran away.

After that call, I had a long and difficult conversation with Mikey. In the midst of it, Mikey initially expressed feelings of guilt, anger, and fear on hearing what I had to say. Yet he did so in the space of an established relationship, a therapeutic alliance built on empathy and trust. Nonetheless, I confess that my words that day were inadequate. The words that mattered most were the ones spoken hours later by speaker phone when Mikey's uncle and aunt pleaded tearfully and convincingly for Mikey to know their unconditional love for him and to come home.

Before he left us, we celebrated. Mikey did not leave broken-spirited and alone as he had come. He left with full belly laughs, playful glances, trash-talking, acknowledged regret, and a clear-as-day sense of hope reflected through the retelling of story after story, recounting not just memories but meaning, gratitude, and a sense of belonging. Further, he left with a sense of worth that would be transferable back home.

I learned from my experience with Mikey something I couldn't pull from the books of what it meant to be a therapist. After all my efforts to find the right technique, I discovered that in the least, the therapist has power to offer empathy, and empathy—when combined with warmth, genuineness, and freedom from judgment—has power to re-shape experience. Once a client experiences himself feeling, thinking, or behaving differently in therapy, he has a chance of experiencing himself feeling, thinking, and behaving differently in life.

In *Critique of Pure Reason,* Immanuel Kant (1781) illuminated the conflict between "reason" and "understanding," warning that reason devoid of experience risks false understandings. He claimed there can be neither true knowledge nor true understanding apart from experience. Humanistic psychology has traditionally understood this as well. C.S. Lewis's (1970) essay, *Meditation in a Toolshed,* provides an instructive anecdote here:

> I was standing today in the dark toolshed. The sun was shining outside and through the crack at the top of the door there came a sunbeam. From where I stood that beam of light, with the specks of dust floating in it, was the most striking thing in the place. Everything else was almost pitch-black. I was seeing the beam, not seeing things by it.
>
> Then I moved, so that the beam fell on my eyes. Instantly the whole previous picture vanished. I saw no toolshed, and (above all) no beam. Instead I saw, framed in the irregular cranny at the top of the door, green leaves moving on the branches of a tree outside and

> beyond that, 90 odd million miles away, the sun. Looking along the beam, and looking at the beam are very different experiences....
> The people who look at things have had it all their own way; the people who look along things have simply been brow-beaten. It has even come to be taken for granted that the external account of a thing somehow refutes or "debunks" the account given from inside... We must, on pain of idiocy, deny from the very outset the idea that looking at is, by its own nature, intrinsically truer or better than looking along. One must look both along and at everything. (p. 212-213)

If a psychotherapist's technique is too technical, his efforts to help may be worthless. Therapy in this case may be little more than a poor excuse for scientific experimentation. The mechanisms of some psychotherapies undermine their therapeutic value. If a therapist is not fully present as a warm, accepting, genuine, caring, and appropriately vulnerable person, the power center of therapy remains turned off. Whatever insight may come along the way, meaningful, sustainable change requires transformative experiencing, with emotion replacing emotion and identity recast in the removal of unnecessary defenses and an increasing capacity for secure attachment.

Analysis without encounter constitutes, to borrow again from Lewis, "all the apparatus of thought busily working in a vacuum" (1970, p. 214). It is our responsibility to stir hope and catalyze strengths rather than to stew history and analyze at length. Far from data to be interpreted or even a patient to be treated, we are heart and soul, of the same essence, both facing existential predicament. It is in the context of authentic relationship and therapeutic alliance that I can most truly hope to be an active collaborator and witness to therapeutic change. ▼

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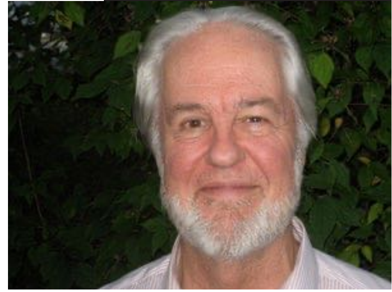
John Rhead



Psychotherapy Lessons About Impasse Learned From My Plumber

John Rhead seems to have been born with two lenses through which to view life—the geek lens and the mystic lens. Attempting to create a worldview that includes the input from both lenses has been a challenge for him and for friends and family who have to put up with him. Mystical pursuits with and without the help of psychedelics have made him less afraid of death, but he will still miss his chainsaw.
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When you live in an old house with 1/2-inch diameter iron water pipes and you have them replaced with 3/4-inch copper pipes, there are some interesting results. First, of course, it now takes much less time to fill the bathtub on the second floor. When I had this done in my home the magnitude of this change was dramatic enough to prompt me to ask the plumber some questions. His answers to these questions seem to have a good deal of relevance to psychotherapy, at least as I practice it. The plumber's truth is that the rust that accumulates on the inside of relatively small iron pipes over the years can greatly reduce how easily and quickly water can flow through them. What had been a 1/2-inch diameter iron pipe can be reduced to about half that size by rust accumulation. Compared to the rusted 1/2-inch iron pipe, the new 3/4-inch copper pipe can be expected to allow nine times as much water to flow through it and to maintain this capacity even as it ages, since it does not form rust.

I like to conceptualize and structure psychotherapy in the 3/4-inch copper pipe model from the very beginning. This helps to prevent future impasses. We often talk about creating a safe container for psychotherapy. We can now add to that container model the idea of a pipe adequate for the flow of healing and wisdom to the client. This therapeutic pipe must be large enough to allow healing and wisdom to flow freely and must be constructed in such a way that it can contain and transmit such things without bursting, leaking, or corroding.

I approach all of my psychotherapy work in a framework that includes the transpersonal or sacred. I don't usually say that explicitly when a referral is made or in the first appointment, but many people who are referred to me have been warned in advance by the person making

the referral. Most people expect a therapist, other than one that is strictly behavioral, to help them explore their personal unconscious and perhaps the collective unconscious. I like to include in each of these realms of the unconscious the spiritual or transpersonal dimension of reality. The exploration of this dimension or reality requires a pipe adequate to the task.

One implication of this framework for psychotherapy is that my relationship with the client is much more important than any technique I might use or any presenting complaint that the client might bring. I make this implication fairly clear by telling people that the first appointment is all about a mutual exploration of compatibility between them and me, rather than taking a history or making a diagnosis. However, I do make a point of asking them in that first appointment about any beliefs or practices they have that relate to existential, spiritual, or religious domains. Again, this feels like fair warning (truth in advertising?) about what they may be getting into if they choose to work with me. Only if we both feel like we are a good match will I go ahead and schedule any additional appointments.

If we do proceed, at the next appointment I offer one more piece of structure that may make clearer how I approach things. I invite people to come to each session with the question in their mind: "What is the most important thing to talk about today?" I make it clear that this topic for the day can be anything from the past, present, or future and that it can be related to the mundane, the sublime, something painful, something joyful, or anything in between all of these. I also make it clear that I am not asking them to talk about what they most want to talk about but rather that which is most important. By using the word "today" in that question I mean to imply an existential connotation in terms of our never knowing if today might be the last day of our life.

As we then dive into the work, I gently weave into the conversation my outlook on human nature. To varying degrees, I make it clear that I believe we all have a desire to feel deeply connected with one another and even to know that this transpersonal connection to all others is a fact. I also make it clear that I believe we all have a deep desire to live a life that feels meaningful and purposeful. Again what I mean to imply is that each life has a meaning or purpose and that a part of what psychotherapy does is to provide an opportunity to discover and live that purpose. I place great emphasis on acquiring knowledge about the kinds of things that bring deep fulfillment and those that bring regret. I tell people that the only fear I will unequivocally support in their therapeutic journey is the fear of deathbed regrets. I emphasize that some paths to finding deep fulfillment and avoiding regret are universal, and some are unique to each of us. The knowledge that is acquired about these things I label as wisdom.

Sometimes I bring up topics in therapy that are meant to stretch or enlarge the therapeutic pipe. I may suggest that concerns about how a client's child is doing in school or in social situations may be based on less than conscious concerns that their child's life may be shortened by climate or political catastrophes. Feelings of despair that do not seem to have any obvious cause in the client's life may be examined in the context of the collective unconscious. Such examinations are not limited by time. I sometimes invite people who feel unexplained despair to ask themselves if they might be feeling the despair of people in the past during times like the Holocaust. When someone reports having a feeling about something in the future, I suggest taking seriously the possibility that they may have some way of knowing something about the future, whether they call

it intuition or clairvoyance or they simply believe that beings in the spiritual realms are communicating with them. Such beings are sometimes called compassionate helping spirits in books and workshops on shamanism, and the exploration of such topics seems to be increasingly popular.

Also increasingly popular is the use of psychedelic medicines. Although I am sometimes frightened and judgmental when clients report using these medicines in ways that do not include what I was taught (50 years ago) to be adequate preparation and support, I have to admit that many of the reports of these young whippersnappers are quite positive. Particularly positive are the reports of transcendental or mystical experiences that completely change a person's outlook on life. In my plumbing model it seems that these experiences either flush out the rust or expand the size of the therapeutic pipe. Either way, the capacity to experience deep joy, love, gratitude, ecstasy, fulfilment, and hope is enhanced. Such experiences bring into the ongoing psychotherapy the part of the traditional psychedelic-assisted psychotherapy model that is known as integration. I invite people to find ways to integrate such transcendental experiences into their ongoing lives, resisting the tendency to diminish, trivialize, or even forget such experiences. Occasionally someone reports having had such an experience spontaneously, without conscious intention or psychedelic medicine, many years ago. Although they have not forgotten it, they have been reluctant to tell others about it and have been struggling on their own to make sense of it. I tell them that making sense of such as experience is what I would think of as integration and invite them to use the therapy process for this.

There are also physical versions of the use of psychedelics to flush out rust or expand pipe size. These can include traditional psychotropic medications for depression, anxiety, and the like. They can also include more historical physical interventions like lobotomy and electroconvulsive therapy (ECT), as well as more modern physical interventions like transcranial magnetic stimulation (TMS) and cold exposure therapy. For some people it is easier to think about such things in terms of the concrete physical framework of the nervous system rather than my metaphorical pipes, at least initially. There is a little question sometimes about the validity of the experiences in question, since they can so easily be assumed merely to be experiential epiphenomena of physical processes in the nervous system of the body. This is an assumption that I often suggest be challenged.

Of course I, as a therapist, have my own plumbing work to do. My framework for therapy has to be large enough to contain and take seriously all the material that comes up in my work with clients. If I do not have the capacity to accept and process larger possibilities, I will not provide a safe container for my clients. One such possibility that became popular some years back was the idea that some psychotic experiences are actually not signs of psychopathology but rather manifestations of contact with larger spiritual realities. John Weir Perry (1974) talks about such possibilities in his book *The Far Side of Madness*. About the time his book came out an organization named the Spiritual Emergency Network (SEN) appeared on the scene. It sought to help people who were having what appeared to be acute psychotic episodes work through these experiences in a kind of depth psychotherapy rather than be hospitalized and medicated to suppress the experiences. As things evolved the E in SEN became Emergence rather than Emergency, more clearly reflecting the idea of a positive connotation.

While profound transcendental or mystical experiences may flush out rust, as noted above, intimacy seems to serve as a rust preventative. Whether a person develops inti-

macy with themself through an inward process like meditation or psychedelic journeys or develops intimacy with others through deep interpersonal sharing, it can prevent rust. In psychotherapy this intimacy can be between therapist and client in individual therapy, between family members in couples or family therapy, or between members of a therapy group.

Some years ago, a friend who is a therapist told me of an awkward and unexpected moment of sudden rust removal or pipe expansion. At the close of an individual therapy session he had an irresistible urge to invite his client to go to lunch with him. She too was a therapist and was quite horrified that he would suggest such a violation of boundaries. He explained that he was horrified himself by this impulse, especially since he could offer no explanation as to why he felt this powerful urge to take her out to lunch. Nevertheless, he insisted that they must go to lunch, and she finally capitulated. They had a rather unremarkable lunch, talking about fairly mundane matters. When she came in for her appointment the next week, she reported that she had intended to go home and commit suicide at the end of their previous appointment. That plan was derailed by his insistence that they go to lunch and then was discarded. The source of his impulse/inspiration to take her to lunch remains a mystery to him, but clearly something larger has opened up in terms of what he allows to flow through his own therapeutic pipe.

Many times I have wondered if I am a mystical geek or a geeky mystic. Writing the above suggests to me that both may be true. Or perhaps I am a just a geeky mystical psychologist and psychotherapist. ▼

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> Sometimes you put walls up not to keep people out, but to see who cares enough to break them down.
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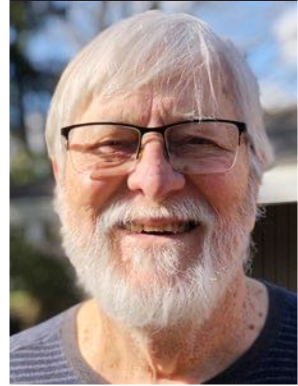
> —Socrates

Grover E. Criswell



Grover E. Criswell has functioned as a psychotherapist and supervisor in Dayton, Ohio, since 1968. He retired for the last time in 2018. His academic education was at Phillips University and Yale Divinity School. His training as a therapist took place at Albany Center Hospital and Hartford Hospital, various Gestalt Institutes, Bioenergetic training groups, and 7 years in training with the Institute of Integrative Psychotherapy. He joined the American Academy of Psychotherapists in 1974 and has been active ever since. He is both a past president and Fellow.
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Stuck in a Rut

The splendid television series *1883* (Sheridan & Linson, 2021) is about a wagon train laboriously heading west in that year. The recurrent theme is how often they are derailed and get bogged down in a situational crisis. Just as the wreckage of one problem gets cleared, they unexpectedly fall into another. Not only do they have to deal with getting stuck in the mud, but they have to cope with rivers, snakebites, storms, raucous gangs, angry Indians, disillusioned companions, and numerous deaths, to name only a few of the situations they end up facing on their journey. Some are defeated by the calamities visited upon them. Others build a depth of character grappling with the disasters. A compelling feature of the series is how many of them negotiate the stuck places and keep moving on toward their distant goals.

Great as this series may be, what does it have to do with psychotherapy? While our setting is not the catastrophic background of the Wild West, we do enter on a journey with our clients and not occasionally get stuck in a muddy impasse. Similarly to the plethora of obstacles they encounter, we may time and again find ourselves confronted with situations that block the therapy and threaten moving forward. Some might even say that if this never happens, we are not doing in-depth psychotherapy. Our ability to work through these difficult places often plays a significant role in the success of the therapy.

All impasses are, of course, not equal. Some are a mud puddle on the therapeutic road, while others present as complicated labyrinths taxing our skill to negotiate. The *impasse* was a French word that meant a “blind alley” or “dead end,” coined by Voltaire as a euphemism for *cul de sac*. That is how it sometimes feels.

Some of the early impasses we may encounter in the therapeutic relationship have to do with the assumptions, expectations, and projections concerning the therapeutic culture itself and the personhood of the therapist. Those who don't know much about therapy often come looking for the quick fix, a simple plan, or an easy answer. They may project onto the therapist the image of the all-knowing shaman who can tell them what to do related to their problems of living, giving them immediate relief for their social and psychological wounds. Sometimes even clients who identify themselves as fairly sophisticated about what therapy involves harbor some of these same expectations. They want the therapist to be the perfect parent with a map to a better life. Therapists who are too eager to be helpful or who think their role is to give cognitive explanations about the therapy process will miss the dynamic issues that give us glimpses of the deeper levels where the client may need to go. As the client and we relate to each other in those initial sessions they will learn what is involved in therapy. We, as the therapist, will come to know who they are and how their assumptions about therapy may reflect hidden issues. Not infrequently, these projections about therapy and the therapist pop up in myriad ways throughout the course of the therapy because they are frequently rooted in the shadowy stuck places of the past.

Ironically, every time I entered into my personal therapy I found myself surprisely stuck. Being a devout student, I would read extensively about the system I was stepping into wanting to get, of course, a good grade. It took me a long time to learn that my highly valued asset, my major coping device, was also my persistent liability. My first investment in therapy, I am sure I approached as a course on counseling. I believed that I didn't have any personal issues and that I understood myself fairly well. Was I ever wrong! When I was honest with myself, I knew there were feelings I was avoiding and issues with my father I had never resolved. I was stuck in a rut, dealing with it by denial. The lid was not that tight. During those first years, there were numerous moments where I would get bogged down trying to be aware of my feelings and give them expression only to slip into an embedded habit of detachment and rationalization. With the different perspectives of the various forms of therapy in which I have since been engaged (psychoanalytic, bioenergetics, Gestalt, and integrative) I have found new awareness and the ability to be more fully myself. Each framed my impasses differently, but facing those uncomfortable stuck places has been the focus of my therapeutic work.

Unlike my initial excursions into therapy, many clients enter therapy because they have encountered some impasse in their lives. They have suffered a loss and don't know how to deal with the emptiness. They have been diagnosed with a physical illness and are living in fear. They feel trapped in a marriage and don't know how to make changes. They are dissatisfied with their job but are afraid to move in another direction. They are ruled by addictions and feel they can't stop. They feel the spectrum of being unhappy or anxious or sad or angry and want to feel differently. The list goes on and on. For some, the feeling state accompanying a particular impasse may seem problematic but not horrendously threatening. With others, they feel in the middle of a crisis that is significantly upsetting. With these impasses, the therapy begins. With some clients, when the impasse that brought them to therapy has been worked through and resolved, they are ready to leave therapy. For many others, in the process of dealing with the initial issues, they discover additional therapeutic concerns that promote their staying in therapy. This decision point of whether to leave therapy or stay may become in and of itself

an impasse to be addressed.

So let us bring onto the stage a client radically enough disguised that even he would not recognize himself. We will call him Kevin. Kevin came into therapy very dissatisfied with his marriage. Many were his complaints about his wife. High on a long list of what was wrong with her was how critical she was of him. She refused couple's therapy, and he was at an impasse related to how the marriage could be improved. He didn't want a divorce, but he was very unhappy. Nothing he tried seemed to work. He found himself angry at her most of the time. Making the case for how she was wrong about him, he rambled on and on about how successful he was, what an esteemed leader he was in the community, the many friends he had, and how much money he made. He didn't see her as very grateful for the good life he provided. The intersections where the therapy began to shift were when he recognized that he was as critical of her as he felt she was of him and when we explored his assumptions about marriage and what his parents had modeled for him. Magically, the marriage began to get better. In Kevin's therapy, the focus became less on the marriage and more on his personal issues. Two significant impasses in the therapy were when I observed that he seemed very dependent on her and when I wondered why he worked so hard to impress me. Both times, his initial response was denial and resistance. Both times we worked through to pivotal issues related to his dependency and narcissism. Ironically, after working together for several years, when I announced that in 3 months I was retiring, Kevin claimed he was okay with that. The next week, he let me know that was our last session because he had already gone to a new therapist. He resisted the suggestion that we might need more time to process the end of our 3-year relationship. Here was a sample of resolving an impasse by dumping it on the therapist's doorstep. Not an unknown tactic! I had not anticipated this response and voiced my disappointment that our work would end in this abrupt manner. It left me with some doubts about how far we had come in the therapy. On one level I saw it as a momentary regression, but my hurt feeling was still there. Looking back, he was probably acting out some of my own ambivalence about terminating my practice. Dealing with my own impasse, I might well have presented my decision in too detached a manner causing him to feel some rejection. I'll never know.

In the course of the therapy these seemingly intractable moments may present themselves in a variety of ways. When this happens, a dilemma is presented to the therapist. How to respond? Most of the time I have taken an experiential approach. Have they fallen into the impasse in their daily lives? Is this a historical rut? Are they bogged down in the therapy? As the therapist, have I focused on an issue that needs attention? I will want to know what they are experiencing, whether it feels familiar, what feelings they are aware of, and how they are registering in their body, what might be the meanings, how does it affect their lives and relationships. Mostly I am guided by intuition as when to be silent, when to offer an observation, and infrequently an interpretation. Sharing my own experience of the moment is probably my biggest contribution to the process of working through the impasse.

In the case of Kevin, he was often stuck around issues related to being self-centered and his defenses against seeing himself in that way. Exploring these issues took us from his difficulties in current relationships into his childhood experiences of being doted on as the favorite son and prescribed rules for good behavior. Kevin had a hard time connecting his childhood to his present distress. When I would focus on his issues, he

would almost always feel that somehow he had been "bad" and he would see me as the critical father. During these sessions he attempted many short cuts into feeling better and making his familiar system work. Some moments of impasse were created when I did not give him a response he was expecting or when I pointed to his inconsistencies. Frequently Kevin would bring up in the session how much money he had made the previous week. I would greet this with indifference and take us back to one of his unresolved issues. Some ruts are invisible, at least for a while. Kevin had a hard time dealing with the boundary issues relevant to our relationship. When he wanted to take me out to lunch or give me stock market advice, and I told him I couldn't do that, he was always disappointed. By exploring these stuck places, we tried to acknowledge the graciousness of his intent, while examining what other dynamics were being played out. While these rocks seemed to be blocking the flow of the therapy, they often became the stepping-stones supporting progress.

Impasses in therapy may present a challenge to the therapist. When the client feels anxious or uncomfortable, the immediate temptation may be to help them feel better. Sometimes this is the wrong response because the client needs to face the issues contained in the impasse. That may take awhile. When I was first in therapy with Howard Fink, I would come to the sessions giving a report of what my previous week had been like, and Howard would casually listen and mostly read his mail. Finally I had had it and angrily told him I wanted him to stop reading his damn mail and to be there with me. He never again read his mail during our sessions, and I was more emotionally present. If we as therapists are too quick to give relief, we may be complicit with resistance to exploring deeper issues. We also can't ignore our wanting to avoid our own discomfort when one of our clients is upset. Being a supportive presence while facilitating the client staying with the work they need to do, even with intense feelings, takes therapeutic skill. Being caring might look quite different given the situation. When I first began seeing Howard I was working as the director of a counseling center as well as having a private practice on the side. Howard engaged me around whether I was reducing fees in both situations with the notion that I was being helpful. I didn't totally agree with him, but it got me to examining my definitions of "helpful."

Another difficult role for the therapist is when we know we are the creator of the impasse. This may happen in a number of different ways. Withholding a response or giving an unexpected response may nudge or sometimes catapult the client into feeling stuck, not knowing what is happening. I remember two other moments in my therapy with Howard. One session I was sharing with Howard my realization of how depressed I had been. His response, which tripped me up for a while, "You are much more depressed than you think you are." I initially felt really more depressed. I had not gotten my secretly wished for approval. In a later session when I was quite upset about how lonely I was feeling, especially in my professional organizations, Howard reached into a drawer and gave me information about joining the American Academy of Psychotherapists, saying, "Here is a place where you may feel at home." Even though I had never heard of the Academy, I was quite surprised and hopeful. Not all impasses are negative. I look back on that as a pivotal event in my life. In the course of therapy, the client may run into their own impasse: an incongruity, a conflict, an inconsistency, a disruptive habit, a learned response, a detachment, or buried characterological structures. Often the task for the therapist is to frame these issues. Because this involves an exploration

of the unknown, uncomfortable feelings may be attached. The therapists may also trip over impasses of their own. When we have the trust of our client, these impasses can be endured as an essential part of the process.

What we know about any therapy of depth is that there will be those times when we have to pull on our boots, jump down out of the comforts of the wagon, and help push it out of the mud so we can continue on our journey together. ▼

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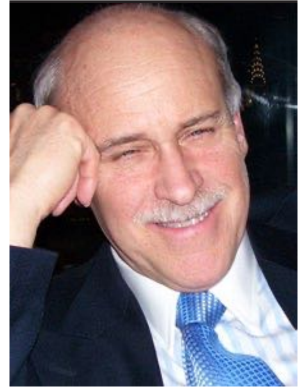
> Sometimes it's necessary to go a long distance out of the way in order to come back a short distance correctly.
>
> —Edward Albee

MOUNT PEARL

Paul Shultz



While teaching school for 9 years, Paul Shultz earned his master's degree in humanities, then left teaching to achieve his master's in psychiatric social work. He then practiced combined individual and group psychotherapy in his private practice for 45 years. He loves to ski, sail, hike, paint, and study jazz guitar. He sees the therapeutic process as a creative adventure, perpetually leading to new discoveries not just about his clients but himself as well.
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Effecting Change Through and Beyond Psychotherapy

After almost 45 years practicing combined individual and group psychotherapy, I have grown wary of "change" seen in my patients. Too many times change was merely apparent, a figment of my own imagination, or a product of the patient's unconscious adaptation to external pressures with no real integration of the change. I myself am a prime example of the latter, I left therapy after 6 years at the age of 30, believing I had conquered my demons. Hardly. Although I had made huge changes in my life, my self-image, and my self-esteem, I had barely scratched the surface of my pathology.

Before Therapy

My mother was an alcoholic given to violent outbursts. As a boy, I watched my father wrestle my enraged mother to the floor and pin her arms until she settled down and went to bed. Dissociated, I felt like I was watching a film. She came screaming into my bedroom once when I was about 9, and I stood on my bed, literally trying to crawl up the wall to escape. She didn't hurt me physically, but I was terrified all the same. Small wonder that I had monster fears that sometimes kept me up at night, sitting at the top of the steps waiting for my older sisters to come upstairs to bed, or that I had sadistic fantasies, sometimes so brutal I felt like a monster. I wasn't always that scared, but in between my mother's violent outbursts there was an ongoing uneasiness knowing an explosion could happen at any time. Ashamed of the family skeleton, we did our best to ignore and hide it from others.

My father was a source of safety and mothering for we

three siblings, but he was a musician who worked in the evenings and ran his real estate and insurance business during the day. We experienced him as our savior, but didn't see him often enough. I yearned to live only with him, but in those days the kids in a divorce almost always went to live with their mother. Dad took that one off the table.

As the youngest in the family I was often infantilized, and being timid I liked the special treatment. I was very bright but a lackluster student. Neither of my parents pushed me toward excellence, telling me instead, "Do the best you can." I never did, and they accepted that. As a teen, I was socially awkward and had great difficulty getting involved with girls. My college days were lonely, my social contacts confined to the dorm or the Union Grill where I worked as a busboy. In my freshman year, I almost flunked out with a 1.09 GPA. Socially and academically, I was dead in the water and wanted to quit school. In a rare forceful move, my father told me I could quit, but he wouldn't let me live at home. Had he let me do that, I could easily have been stuck for years in a regressed state. Back at school, my roommate was seeing a Rogerian therapist at the counseling center and encouraged me to go.

Short-Term Therapy

At long last, I called the counseling center. As expected, my therapist said very little to me, often repeating what I had just said. I don't remember any great insights or growth in self-understanding. But this man looked deeply into my eyes and listened like no one else in my life had ever listened. We met for only 10 sessions, yet as far as I can surmise after 43 years of practicing psychotherapy myself, the curative element was just that: He truly listened and heard what was in my heart. He took me and my life seriously and that helped me do the same. By the time I graduated, I had improved my grades significantly, had a girlfriend, and was on my way to a career in public education. But my troubles were far from over. I was unable to develop a fully intimate relationship with my girlfriend and felt profound shame about that.

Group Therapy

After teaching school for about 3 years, I found myself in much the same spot I was in when in college. My social world was very limited, and relationships with women were short-lived and lacked intimacy. Indeed, I ended several relationships because I felt so ashamed of my sexuality. Meanwhile, the younger of my two sisters had begun her own psychotherapy with a psychiatrist she thought was unusually good. After encouraging me again and again to call him, I finally did. On the day after Thanksgiving, I began a relationship with Dr. T. that was to develop over the next 31 years.

In my search for peace, I had been reading about Zen Buddhism. So, after going over some of my history and my chief complaints with the doctor, I decided to check him out. I asked, "What do you know about Zen Buddhism?" His reply cemented me to him: "Zen is crap. Why aren't you getting it on with women?" It was clear he didn't want to waste time with philosophizing but wanted to get to the nitty-gritty and get there now. Soon I was attending therapy groups three times a week and seeing him occasionally for individual sessions. Like my first therapist, Dr. T's eyes looked deeply into mine and he really listened to what I was saying. However, unlike my first therapist who was largely

passive, Dr. T. was active, telling me things I didn't want to hear and confronting my evasions. I often felt anxious and quite vulnerable, but it was clear he had my best interests at heart. But whatever insights I may have had, what sticks with me most—even after all these years—is his insistence that real change lies in one's actions, not in their intellect. If doing something helps you grow, but you're scared to do it, then you must do it anyway. That is, if you want to get better. This attitude played out in the way groups were conducted. Despite my shame in talking about my impotence in the group setting (with some pretty girls present) I did it, having accepted the value of pushing myself beyond my own limits. Unlike my parents who let me coast, this guy pushed me and others to pursue goals we were afraid or just too lazy to attempt. It wasn't clear to me at the time, but Dr. T. had become my transferential "good father" whom I wanted to please. I didn't realize I had learned what to say in the groups so I would come across as a senior patient who knew the ropes. But I also did make real changes in my life that I knew would be good for me, even though difficult. Over the course of my therapy, I earned a master's degree with a 3.93 GPA. After 5 years of therapy, I finally formed a lasting relationship with a woman I was able to be intimate with and could talk with about my sexual shame instead of running away. Having learned in my therapy that I had to push myself in spite of my feelings and stick with things even if difficult, I stuck with this relationship and eventually married her and built a family. It's been 49 years since our first date and our relationship continues to get better and better. Even during those years when we had ugly fights and I considered leaving, neither one of us saw divorce as a viable option. We worked it out as I had learned to do in therapy.

There is no question that the positive transference that developed over 6 years of therapy helped me make huge changes in my life and that I borrowed courage from my identification with Dr. T. He was a very forceful, outgoing man, unafraid to express even a most unpopular opinion. In my wish to overcome my fears, I emulated his manner. At the time, I was unaware of how provocative that kind of force was and even less aware of how intimidating it could be. As I later learned, Dr. T. sometimes unnecessarily made enemies with his strong-arm ways. For all that, I did discover power in my person I never knew I had. I decided to pursue another advanced degree, this time in psychiatric social work.

Mount Olympus

A major element of my development was a result of something many readers may judge unethical, or at least clinically unwise. A few months after I terminated my 6 years of therapy, Dr. T. invited me, a budding therapist, to attend the weekly seminars he held in his office. I felt like I had been invited to Mount Olympus to sit with the gods! Many of the people I met at those seminars were well known in the field. Some had even known Freud and Reich! We discussed people like Otto Kernberg, Jim Masterson, Al Lowen's "Bioenergetics", Perls's Gestalt therapy, and others, learning about cutting edge theories of the '70s. I had been hungry for this kind of intellectual stimulation. Beyond the positive transference thrills, these experiences nurtured my under-developed abilities.

Scarcely a year went by before one of Dr. T.'s co-therapists drew me aside to explain that she had been a social work field-instructor at my university. Soon, I was doing my

second-year internship in psychiatric social work in my former therapist's practice! Now I was no longer just a visitor, I was part of the team! But the glory of being invited to Mt. Olympus paled as new responsibilities faced me. I often sat quietly through groups, only to be admonished after the group for not speaking up and making myself a presence; I didn't have to make correct interventions, I just had to overcome my fears and actively involve myself with the patients. So, I tried to do that, winning the respect of the patients even if I was wrong. And of course, I was afraid of disappointing Dr. T. so I tried to please him. This clearly helped me develop talents I scarcely knew I had, even if it was at the expense of ongoing transference confusion.

At the end of my academic training, I felt honored to be offered a place in Dr. T's practice. He and his co-therapists were excellent clinicians who managed a large practice with 16 group sessions a week, most patients also seen individually at least once a week. An exhausting, demanding schedule, but what a rich environment in which to learn and grow! We were all constantly attending workshops and lectures: self-psychology, Gestalt, bioenergetics, object-relations theory, Tavistock, etc. We had many meals together, traveled together, got to know each other personally; Dr. T. was now Herb. Everyone was expected to write for publication, my first article being published in my second year of practice. What a major adjustment to my self-image and self-esteem! While positive transference was a motivator, the real-world results were my own. I had finally begun to develop talents others had told me I had, that I'd not had the direction and discipline to develop until the therapist who became my boss expected that I do it. I wrote a couple more papers, produced teaching videotapes, and gave multiple presentations at state and local conferences. And yet, during the years I worked in Herb's office, the positive transference wore thin, not only for me, but for him also. Much about me he still didn't know. In fact, in my final year of therapy, he had written a poem: "To Paul." The poem describes "Paul" as an insecure man who wishes to be a "superman" (a' la Nietzsche), but instead he becomes a "man," and isn't that "super." He was unrealistic about how far I had come. I believe he idealized me. That didn't last.

Mount Purgatory

Many of my character weaknesses and primitive defenses had been obscured in my 6 years of therapy. When anxious, I was given to disordered thinking and sometimes surreptitiously might drift into daydreaming. I suffered from insomnia and got into nasty power struggles with my wife. But I was also pretty good at hiding this at the office, being smart enough to figure out what I was expected to say and saying it. At times, I acted like a sycophant. I was highly adaptive and had a well-honed as-if defense. As this began to show itself more and more in my professional and social interactions with Herb, he was more and more annoyed with me and told me I was regressing in an effort to be again his patient. It was worse than that. I believe it more accurate to say the real Paul was becoming more apparent and it clashed with his idealized image of me. What made matters worse was his tendency toward temper tantrums, although at the time I couldn't have labeled them as such. On occasion, he would simply blow his stack at me (or someone else), and I would regress emotionally to the dissociated little boy I had been with my explosive mother. I could sense it happening but was powerless to do anything about it. It was a humiliating process. Suddenly my competence seemed to

vanish. Even my facial countenance became that of a little boy, and he then became even angrier and disgusted with me. These were times I became familiar with *split object-relation units* on a personal level. I found myself sleepless for hours either obsessing over my short-comings or having bloody and sadistic fantasies of what I would have liked to do to Herb. And yet, when things were good between us, I felt good about myself and loved him. It was easy to recognize this cycle of good me/good mother—bad me/bad mother for what it was, a borderline defense. Yet understanding this gave me no power at all to overcome it. The pattern slowly became more and more pronounced over the years I worked with him, finally reaching a point where I was desperate. As when a boy, I had a chronic sense of vulnerability.

Opening my own office in 1991 helped. In my own domain, there was no risk of that awful transference reaction to Herb. Yet I was still heavily invested in the stimulating professional community Herb had built around himself, continuing to participate in his seminars and case conferences. Furthermore, I had continued to work in his practice part-time, doing one group a week, which helped financially as I built my own practice. Additionally, for all his faults, he was generally an exquisitely sensitive and gifted therapist I continued to learn from. And yet, this physiological negative transference continued to haunt me. I wanted to fix the damned thing!

I began looking for a therapist. But this was problematic. Herb was well-known in town, and his unsavory qualities—which I was so reactive to—were well known. Where would I find a good therapist who wouldn't treat my complaints simply as reality-based? That he had offensive temper tantrums wasn't the problem; my uncontrollable regression was the problem. I suspected I would handle his tantrums completely differently if I didn't regress. After at least a year of searching and exploring other possibilities, I hit upon a novel plan: I would ask my boss, my clinical colleague, and former therapist if he would make a place for me in one of his groups. There, for sure, my regression was likely to show, and maybe he could help me with it. And perhaps I unconsciously wanted to force him to finish my incomplete therapy.

"Absolutely not," was his reply. "I don't want you as a patient." Meanwhile, nutty as it sounds, I was simultaneously working with him quite effectively as a fellow co-therapist and more of a true colleague than I had ever been. It seems that when I was treating others, I was at my most competent. Taking care of myself was the problem. Over the next year I approached him again and again, and being rejected, asked him where else in town I could go. He never could come up with a name we both didn't reject, being pretty sure the therapist would over-identify with me and miss the deeper problem. Finally, he relented. We set up a date for me to start group.

Therapy #3

On my first day back in a group, 25 years after I'd left therapy with him the first time, I took off my necktie and sportscoat and sat in the waiting room with my new group-mates, most of whom I knew from my role as therapist in the practice. It was, to say the least, a very weird situation. And yet, after just a few meetings, I was accepted as a fellow patient by the others, who respected my effort to continue working with myself. Soon enough, I had in that group the same regressive experience I had in my everyday interactions with Herb. When he spoke to me, I averted my gaze, tilted my head to one side

and responded in a squeaky voice as if my balls were being squeezed. I even dissociated a few times. I told him I felt like he was very impatient with me, experiencing him as my angry, shaming mother. But that didn't stop my bodily reactions. The other group members said that he sounded very patient. He asked me to explain what was happening to me, and I did, but either he couldn't understand what I was talking about or couldn't allow himself to believe it. So, as he often did, he sought help, asking people in the group if they understood. Carl, a particularly articulate fellow successfully explained the situation. From that day forward, Herb, my colleague and now again my therapist, worked with me in a way he never had before. Throughout the 30 years of knowing me, he had never realized or maybe didn't want to know how scared I was of displeasing him and how disoriented I became when he was angry. Nor did he see the profound shame I felt in being regressed.

Much of the work was behavioral in nature, since the genetic roots had been explained ad nauseum. The needed change was not intellectual, but physiologic/neurologic. Much like a victim of PTSD, my early life experiences had encoded very primitive defensive reactions to somebody exploding. These reactions were reflexive, beyond voluntary control. Once Herb understood this, he patiently and persistently worked with the manifest bodily fear reactions to him. Slowly I began to realize he wasn't going to dismiss me with disgust.

"I want to hear what you have to say, but straighten your head first." I might straighten my head but avert my gaze. "No, look at my eyes." I would but then immediately look away as I began to speak. "No!" he would interrupt. "Look at me." I did it, but my head would tilt. "No, straighten your head." When at long last my head was erect and gaze steady, my voice became high-pitched and plaintive. "No," was his patient reply. "Lower your voice." I would, but then my eyes would look away again. My lack of control over my body was embarrassing, but I was making progress.

So it went for many months, until I was able to settle my body and speak to Herb in a settled, dignified manner about my transferential fear of his anger or disapproval and the shame I felt in having no control over my reactions. As these advances became consolidated, I felt an immense sense of relief. Clinically, I became much more sensitive to the fears of my patients and how fear can surreptitiously lead a patient to unconsciously present himself as healthier than he is. Herb's work also changed for the better, as he became more sensitive to patients' fear of displeasing him. Unfortunately, Herb died suddenly. I stayed in the group for a while, mostly mourning, but without him there was little reason to stay.

Back to Therapy

After Herb's death, his daughter, a psychiatrist herself, kept the practice going. I saw myself as being able to pass on what I had learned over the years to the several younger therapists who practiced in that office. But it wasn't Herb's practice anymore, and I found myself growing dissatisfied with what I got back from continuing there. Meanwhile, interpersonal challenges arose that proved unsurmountable. Finally, I stopped working in that practice altogether and worked exclusively in my own. Scheduling was easier, and I made a little more money, but I was knocked off kilter by the loss of what had been my professional home-base for almost 35 years. After struggling for months,

drinking too much and needing medication to sleep, I sought another therapist.

So, at the age of 74, I began therapy for the fourth time in my life. While early sessions consisted of tearfully mourning the loss of my professional home, eventually the process evolved into looking at my characteristic way of living, emotions springing from my early history, and trying to integrate the crazy-quilt of experiences that had been my life. Indeed, the writing of this paper is part of this integration process, further clarifying transferences that have clouded my vision over the years and resolving the conflicting feelings of love and rage I have felt toward Herb and toward my mother.

Over the last 46 years, I have often wondered how my life might have played out had my involvement with Herb ended when I left therapy with him in 1974. Clearly, those 6 years of therapy helped me make dramatic changes. Yet, the serious pathology and character flaws that remained surely would have limited my life. Much of my change was what I'd call "imitative change," as opposed to "integrated change." Imitative change is just that: I imitated the behavior of others so as to fit in and be accepted. Based on fear of disapproval or abandonment, such changes contrast sharply with integrated change, which is not fear motivated, but a natural development of one's existing personality. As such, it is well-integrated into one's sense of self, while imitative change I had always experienced as a garment I wore to conceal my true character. Over 50 years ago, I first learned about the authentic versus inauthentic self, and I see them here illustrated in my own story.

Throughout most of my history with Herb, I felt like he wanted me to be like him, and since I wasn't content with myself, I believed that to be like him would bring me contentment. I learned a lot and made many changes in my life under Herb's tutelage and whip, but contentment with myself was slow to come. And yet, in a herky-jerky, patchwork fashion, I did get there, in part because of Herb's help. Perhaps, if instead of post-therapeutic involvement with Herb, I had found my way to another skilled, less confrontive therapist I might have fared better. Who knows? What I do know is that I am content with where I find myself today. Where I once saw Herb like a jazz expert of psychotherapy I tried to imitate, I now see him as a very talented player I borrowed some licks and chord changes from and made them my own. I plan to practice psychotherapy for a few more years, until I am 80. But I don't know if I'll be able to stop then. There are so many changes still possible for my patients. And maybe more for me, too. ▼

ENTRY
PROHIBITED

Shirley Tung

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Interior Impasse

It was in the days following the Uvalde school shooting that my psychotherapy client, Rebecca, told me she intended to leave the country. She had two school-age children and could not go on kissing them good-bye in the morning, wondering whether they would come home at the end of the day. Worse, her older son had become nonchalant about his school's active shooter drills, accepting them as ordinary safety protocols, like fire drills.

"In what universe is this normal?" Rebecca demanded. "I spoke to an immigration lawyer earlier today about what would be involved in relocating to Canada."

My mind drifted back to a conversation Rebecca and I had some months ago when she wondered aloud whether the divisions in our country might lead to civil war. Although this possibility would have seemed remote several years ago, it no longer struck me as implausible.

"What would you do if things reached that point?" Rebecca asked. "Would you flee?"

"Well… I wouldn't rule it out," I responded. "But, obviously, I'm not doing anything about it yet—I don't even have a current passport."

"Where would you go?"

I hesitated, wondering how helpful it would be to my patient for me to share just how seriously I had considered the prospect of immigrating. My son-in-law is from England and his parents still live there, and my husband has extended family in Toronto. My spouse and I had discussed the advisability of going to a place where we had family, perhaps even starting some exploratory conversations with them, laying some contingency plans while we still had time.

“Probably Canada,” I replied. “I’m picturing the northern border besieged by American refugees.” The visual image struck me as slightly comical. “Do you think they’d want us?”

Rebecca wasn’t amused. “How do you know when it’s bad enough to leave?”

I thought about Timothy Snyder’s viral Facebook post in the days following the 2016 presidential election, outlining twenty lessons from 20th century countries that yielded to fascism, Nazism, or communism. Lesson number 17 reads as follows: “Watch out for the paramilitaries. When the men with guns who have always claimed to be against the system start wearing uniforms and marching around with torches and pictures of a Leader, the end is nigh.” *Shades of Charlottesville and January 6…*[author’s note]. “When the pro-leader paramilitary and the official police and military intermingle, the game is over” (Snyder, 2016).

I recalled Freud’s reluctance to leave Vienna, when he underestimated the danger posed by the Austrian Nazis. It wasn’t until March of 1938, when Anna Freud was arrested and questioned by the Gestapo, that her father declared that he wanted them all to flee Vienna at once. The tortuous leave-taking process stalled, mired in lengthy and expensive negotiations with government officials. If not for the help of friends and followers, including Princess Marie Bonaparte, the Freud household might not have escaped in time (Young-Bruehl, 1988). He almost waited too long.

I didn’t say any of this to Rebecca. What she wanted to know was what I would do.

“I don’t think I would leave. I think I would stay and fight.”

Rebecca pounced. “What do you mean, ‘fight?’ Do you have a gun?”

“No, I don’t have a gun.” In fact, I grew up in Kansas where my father taught me how to shoot a rifle and shotgun; on weekends he took me out to shoot skeet. As an adult, though, I have never been tempted to own a firearm. Rebecca was raising a good question: What did I mean by fight? March in demonstrations? Engage in civil disobedience? Provide sanctuary to the vulnerable? I actually had no idea what fighting would look like or whether it would do any good.

“I don’t have a gun, either. I think I would stay and fight, too… whatever that means,” Rebecca replied.

“But you have kids. My children are grown. Wouldn’t you take your children to safety?”

Rebecca was silent for a long time before saying, “I don’t think I can do that. What kind of example do I set for my kids if I run? I think I’d have to stay.”

But that was months ago, discussing a hypothetical civil war. This was now, trying to make sense of another massacre of the innocents. Now there had been one school shooting too many. Now the threat to Rebecca’s children seemed more immediate than it ever had. Now she was ready to go.

Therapeutic versus Societal Impasse

When we think of impasse with our patients, we are ordinarily referring to some impediment to the treatment caused by an irreconcilable difference between therapist and client. Perhaps the patient has an active addiction that is interfering with the therapy and refuses to commit to abstinence; perhaps the client is making demands the therapist cannot ethically accommodate. Sometimes the clinician becomes incredibly frustrated by the patient’s resistance to change, which can “feel as though a duel to the death is taking place” (Maroda, 2022, p. 22). Or the patient becomes infuriated with the ther-

apist's inability to fix his life and storms out of the room. Most of us will consider the possibility that the problem is not simply that the client is obstinate or the therapist incompetent, but that something deeper may be at work, having to do with transference, resistance, or countertransference. Our willingness to work with these underlying issues, rather than simply writing off the relationship, is what distinguishes therapy from friendship. Sometimes this work pays off, the impasse is resolved, and healing begins, but not always. Just as all surgeons carry within themselves a small cemetery, where they must look for an explanation of their failures (Leriche, 1951), we psychotherapists have our own inner hidden chamber, populated by patients we failed to help when the impasse could not be resolved.

Another kind of impasse occurs outside the consulting room: The patient has an angry, withdrawn spouse who will not talk about what is wrong in the marriage, or a young adult son or daughter with a substance abuse problem who refuses treatment. The client has tried everything: couples counseling, interventions, accommodating, tough love…nothing has worked. He or she is finally coming to therapy alone, perhaps secretly hoping for a miracle but more often ready to settle for some sensible advice and emotional support. Sometimes all we can do in such cases is explore options: Your loved one is not going to change; will your life be better or worse without this person in it? That is the nature of impasse.

If I were writing about impasse a decade ago, my paper would have fallen into one of these two categories. But in recent years, impasse has taken on a broader definition in my work with clients as more and more of them have expressed feelings of helplessness and despair about their ability to influence the course of national events. Such conversations between therapists and patients have become so common that Kerry Malawista (2022) has proposed adopting a new diagnosis: "Democracy Anxiety Disorder." Mature adults in my caseload express guilt about the damaged ecosystem they are handing down to their progeny, and young adults have decided not to have children, so pessimistic are they about the destructive effects of climate change and the inability of our government to minimize the damage. COVID-19 has exposed the weaknesses in our health care system, and although most of my clients have heeded the CDC's advice to get vaccinated, almost none of them trust our government to ensure their well-being. Divisions in our country, especially since the January 6 insurrection, have become so profound that many of my patients have given up trying to persuade anyone with a different political opinion to consider an opposing point of view. And nowhere are the divisions in our nation deeper than between proponents of gun control and defenders of second amendment rights.

"Nothing is going to change." This is what I heard repeatedly after the Uvalde massacre. "If Sandy Hook didn't inspire change, if Parkland didn't inspire change, why would Uvalde inspire change?" I see this hopelessness everywhere, every day. Just this morning I read a letter in an advice column from a person who suddenly realized, while at a neighborhood pool, that there was no obvious escape route should a mass shooter enter the premises and start firing. "I find myself doing this over and over in random stores and locations. I know I can't be the only one," the writer says. "I also feel helpless because our government won't do anything to even remotely help stop these events from happening" (Hax, 2022). Opinion polls show that up to 90% of Americans nationwide support universal background checks (Hulse, 2022), yet efforts to legislate the will of the

majority at a federal level consistently hit a brick wall. Roxane Gay sums it up succinctly:

> The greatest of American disgraces is knowing that no amount of rage or protest or devastation or loss will change anything about this country's relationship to guns or life. Nothing will change anything about a craven political system where policy is sold to the highest bidder. (Gay, 2022)

This, dear reader, is impasse. It is this sense of futility that many of my patients are voicing in their sessions now — a hopelessness, I confess, that I share. While it is one thing for irreconcilable differences to end a therapeutic relationship or a marriage, it is quite another for them to end one's relationship with one's country. Nothing in my training has prepared me to address this kind of impasse in my clinical work.

The Charlie Brown Effect

The weeks following the Uvalde shooting presented my clients with a dizzying array of events: The Supreme Court overturned Roe v. Wade, rolled back the EPA's authority to regulate carbon emissions from power plants, and struck down a New York law that placed strict limits on carrying guns outside the home. At the same time, Congress passed the first gun control legislation in years, a move which some hailed as long-awaited progress and others decried as too little too late. There were glimmers of hope: Ketanji Brown Jackson was sworn into the Supreme Court. Cassidy Hutchinson's testimony before the January 6 commission inspired even some cynics to entertain the possibility that the insurrectionists might be brought to justice. But my patients, in general, found little reason for optimism. Jeremy expressed fears about going into Philadelphia for a doctor's appointment because of rising gun violence, even in Center City. Abigail was distraught over the current heat wave here and in Europe: "This is just the beginning," she said grimly. Henry and his husband, who worried the Supreme Court now had same sex marriage in its sights, discussed the prospect of leaving the country and ultimately rejected this option, not because they thought things might get better but because they felt they had no good alternatives. Everyone who expressed these concerns was confident that nothing would change and seemed afraid to hope that it might. "I've had the football pulled away one too many times," Rebecca remarked, invoking Lucy's annual tradition of leaving the too-trusting Charlie Brown flat on his back.

So have I. Getting my hopes up about proposed legislation that inevitably dies on the Senate floor has proved to be an exercise in futility. Did anyone feel differently, I wondered? Mary Pipher, author of numerous psychology books, including *Reviving Ophelia,* recently wrote an essay about coping with her despair at the world. Pipher references some of the plagues of our era—the ongoing pandemic, mass shootings, and climate change— describing how being pummeled daily with traumatic information causes us to shut down emotionally:

> America isn't eastern Ukraine, Afghanistan or Yemen, but nonetheless, we are a lonely, frightened people who have lost hope in the future. Any psychologist knows that is a dangerous place to be. We risk losing our ability to think clearly or experience life completely. We lose our vitality and sense of direction. We cannot help others. We cannot fix anything. (Pipher, 2022)

If we, the clinicians feel this way, how can we possibly encourage our patients?

Pipher finds comfort in her grandmother's teachings to be the best person she can

be and leave the world a better place, psychology's teaching to face suffering head on and take action, and Thich Nhat Hanh's teachings to stay in the present, as well as his example of working for peace and a sustainable planet. "Most of us cannot be great heroes. However, we all have the capacity to be ordinary heroes" (Pipher, 2022). We cannot single-handedly halt global warming, but we can work with and support local environmental groups. This is not a new idea—I think of the aphorism, "It is better to light a candle than to curse the darkness"—but it is a good idea.

Can I have the heart to do this, even if I believe deep down that I am fighting a losing battle? I see my professional organizations putting out position papers on a woman's right to control what happens to her body and organizing political action to promote gun safety laws, and I wonder if I'm wallowing. No sooner had the Supreme Court struck down limitations on carrying weapons than did the New York State legislature pass a new law placing significant restrictions on the carrying of handguns into most public spaces. Some elected representatives are doing more than complaining; they are fighting back.

I don't think I would leave...I think I would stay and fight...

Defying Impasse

It occurs to me that responding to impasse doesn't have to be limited to either winning over one's adversary or ending the relationship. I often talk to my clients about the importance of not feeling trapped, of knowing, even if they choose to stay in a bad situation, that they could leave if they needed to. Conversely, they need to know that physically leaving does not guarantee relief, given our tendency as humans to bring our distress with us. Irreconcilable differences do not have to result in impasses if the patient (or the therapist, for that matter) experiences a sense of internal freedom.

Cory Booker, when interviewing Ketanji Brown Jackson during her confirmation hearing, used his allotted time for questioning to salve the wounds inflicted upon her by some of his colleagues, to correct the record, and to express his deep understanding of what they both had experienced as African Americans in this country. He brought Judge Jackson to tears as he recounted a Black woman stopping him as he jogged, breathless, just to tell him what it meant to her to see Jackson sitting where she was sitting. "You are a person that is so much more than your race and gender," Booker told Jackson.

> [But] it's hard for me not to look at you and not see my mom, not to see my cousins... I see my ancestors, and yours. Nobody's going to steal the joy of that woman in the street, or the calls I'm getting, or the texts. Nobody's going to steal that joy. (PBS, 2022, 13:40)

The musician Jon Batiste expressed a similar sentiment regarding his decision to marry his long-time partner, Suleika Jaouad, when her leukemia roared back after a period of remission. When Jim Axelrod couched their decision to marry in terms of hope—"And, something like getting married can be an act of optimism, an act of declaration, an act of 'we have a future'"—Jon Batiste replied, "Yes, it's an act of defiance. The darkness will try to overtake you, but just turn on the light, focus on the light, hold onto the light" (CBS, 2022, 4:44).

An act of defiance...not an exercise in denial or resignation, or even an expression of hope, but a choice to stare down fear and hopelessness with quiet joy and courage; death may indeed triumph in the end, but despair will not.

My patients and I all experienced a similar stuckness that has less to do with whether we win the fight for our cherished values or leave the country in defeat than it has to do with our paralysis, rooted in our deeply held belief that no effort on our part would make a difference. That may indeed turn out to be true, but my paradigm shift pivots from winning or losing to embracing a sense of freedom emanating from transcendent truth and unwavering love. Thich Nhat Hanh created the Youth for Social Service in the wake of war in Vietnam to help his ravaged country. This group aided the homeless, set up medical units, and rebuilt schools. He traveled to the United States and Europe to call for the end of hostilities in Vietnam and met with Martin Luther King in 1966. As a result of this mission, Vietnam denied him re-entry into his country; thus began a long exile of 39 years (Plum Village, 2022). The impasse with his country could not be resolved, but through his school of Buddhism his teachings about peace and the interconnection of all life on our fragile planet have reached millions of listeners around the globe.

I cannot ask my clients to resolve their internalized impasses until I resolve mine, and I have much work to do on that front. A results-oriented mindset that breaks down along dichotomous lines will surely only dig me deeper into my despair. "Nothing is going to change" is a specious argument. Everything is changing, at an alarming rate, and that is scary. And fear is paralyzing. The impasse, between the part of me that wants to make things better and the part of me that despairs of trying, cannot be resolved by a cost-benefit analysis. It can, perhaps, be transcended by moving beyond the zero-sum game of American law and politics and embracing the counterintuitive examples of those who have turned from the darkness to hold onto the light. ▼

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Letting Go

Sitting in the mahogany leather chair, my hands rest on the well-worn arms as I take in the calm and quiet space of the office. I look around. The walls are painted a light neutral taupe, providing a comfortable and soothing holding space for the decades of stories that have been shared here. My eyes land on the large 3' x 3' fabric rendering of a phoenix, framed and hung between two chairs. I breathe in deeply, and the tears of grief and sadness accompany my exhale. The phoenix, an early acquisition in the office, represents renewed life that can arise from the metaphoric ashes of the work in psychotherapy. This phoenix is a treasured symbol of the healing process, richness, and lifegiving work that has taken place in this room for 36 years. I wonder, how can I give up this office?

I continue to look around: my licenses dutifully hung in an unobtrusive corner, overshadowed by a 3' soft sculpture doll, a jester, sitting on a stool in my line of vision. The jester was a symbol of honesty and common sense in the king's court, relaying information that others dared not. This symbol, purchased so many years ago by a 35-year-old beginning therapist, was an ongoing reminder of the need and commitment to be honest and to take risks in the service of facilitating growth, change, and healing. When I really let in the reality of letting go of this space my jaw clenches and my fists tighten. I want to hold on. The tears come. I begin to weep and feel my body relax as the holding on loosens.

The depth of my emotion surprises me. Yet, as I open, the memories become clearer, and the people and souls who have shared themselves in this space feel more present, reminding me of their vulnerability and mine. The

memories move, like a movie, through my awareness. I remember the stories: the client navigating a life-threatening illness and finding in herself the courage to fight and endure painful treatment in the service and hope for a cure; accompanying a woman who entered therapy to deal with her fear and mistrust of becoming a mother, given her experience with her own mother; joining the journey with a woman courageously dealing with the pain and betrayal of incest in her family; and helping a man live through the disappointment and anger of a failed marriage and his wish to understand why the relationship didn't work…wanting so much to be able to have a better relationship in the future.

I am filled with respect and appreciation for these people and their resilience and courage as they deal with their lives' challenges. Joining with my clients as they explore and open to themselves in an effort to understand their dynamics and feelings is a complex and extraordinarily privileged journey. In my professional life I have chosen to provide long-term, in-depth psychotherapy, and the years have provided me with a richness and connectedness with people that I couldn't have imagined. Navigating personal and interpersonal terrain that wanders through both the known and the unknown, always in the quest for a person's truth, is an intimate and special experience.

The rich experiences of life in this office make it so difficult to imagine letting go of my space. Paying for an expensive office while not being able to be there seeing clients during the pandemic went on far longer than I had anticipated—2 years without using the space. But, characteristic of me, I held on. Now, repairs in the building which necessitate jack hammering in the garage become another obstacle, making it impossible to see clients in person in the office for another 6 months. This is what brings me to this time of letting go.

I begin to explore other options that would be less expensive but still provide the space and the opportunity for in-person work. Zoom has been wonderful in that it made it possible to continue the work of psychotherapy during the pandemic, but truth be told, it does not replace meeting face to face. I locate an office in the same building, on the 10th floor, far from the drilling, to sublet from another therapist, and I begin to make those plans. I would continue to Zoom with some people from home and see others in her office. I visit her office and feel myself in the foreign space around me. It is hard to imagine seeing people there. There is none of me or my energy in this office… no familiar pictures, no familiar chairs. I wonder if I could grow into this space. I gently ask if I could bring some small mementos into the office, wanting to be respectful of this being her space but trying to feel more of myself there. She is kind and accommodating. She smiles warmly, nods her head, and says "Of course you can." She invites me to visit the office in her absence so that I can sit alone and get a sense of what it would feel like to use the space. I was touched by her understanding of the profound challenges for me in making such a move.

I began to clean out my office, starting with the desk. I discover notes from people with whom I worked, souvenirs, and mementos…36 years' worth of experiences and files. I even discover the original lease for the office, signed in 1986 for $2,000 less per month than what I am paying today! Fifteen boxes of books are packed up for donation, as well as a dozen trash bags and boxes filled with old files for shredding.

Sitting in my partly cleaned out office, I am aware of the intensity of the sadness and loss. I have to remind myself that I am not retiring. I am not giving up the work. My

head understands that reality, yet the feelings do not change. My effort to try to minimize the loss is futile. I leave my office feeling anxious and uncertain, questioning what I am doing.

That night I have a dream. In it, I am checking into a hotel. The person behind the registration desk asks me for my ID, not an unusual request. I reach into my bag, feeling for my card case, and cannot find it. I feel a bit of panic. I look down at my crossbody bag to look and search further and realize that I am standing there naked…no ID and no clothes.

I love dreams. I believe they bring our unconscious thoughts and feelings into a more conscious state and, as a result, make them more accessible. The following morning, I awaken with a clarity that is absolutely freeing. I understand from my dream that I am not ready to make this move. Letting go of my office is clearly premature. With fresh eyes I change direction. With certainty, I make a new decision to re-establish that Suite 122 is still my professional home. ▼

> Whoever cannot seek the unforeseen sees nothing for the known way is an impasse.
>
> —Heraclitus

Penelope Norton

Penelope Norton, PhD, practices psychology in Ormond Beach, Florida. She provides psychotherapy to children, teens, adults, couples, families, and seniors. Her 35 years of practice have brought her increasing confidence and humility. She is inspired by Ralph Waldo Emerson, who wrote, "What lies behind us and what lies before us are tiny matters compared to what lies within us."
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Shadowed

Last winter two men sought my help at the behest of their mothers. Over time, I have had quite a few adult clients who I saw when they were children, and these two were among those. As adults they are sometimes curious about their earlier stories. Since I have seen so many traumatized children, they frequently ask some version of "Did that really happen?" Perhaps they inquire after having glimpses of memory, or even dreams, which invite them to revisit their past. The psychologist Mary Pipher posits, "...without stories, we are without a self" (Pipher, 2022, p.7). Yet, discerning when, and how much, of an old story to disclose to a particular client has been an unanticipated challenge from my long-term practice. Sometimes, I found that I was not eager to re-burden myself with my own pain and anxiety connected to the stories I know about them.

The first of the two men of last winter, Sean, was headed to college out of town and was seeking a letter of support to help him obtain medical marijuana for his overwhelming anxiety. Thirteen years earlier, his parents had brought him for therapy following sexual abuse by his teen babysitter. His parents discovered the abuse on their nanny-cam, making the assault clear, real, and prosecutable. Due to Sean's anxiety, his mother sent him back to my office "because she is on our insurance." Sean did indeed have debilitating anxiety; he had homeschooled for high school because he could not tolerate the anxiety of sitting in a classroom, much less going on a date. However, his bags were packed for college 3 hours away; he would not be returning to therapy with me.

I decided to take his history, as I would any new adult client. Girlfriends (or boyfriends)? He had none. Sleep?

Regularly disrupted by anxiety. History of any sort of trauma? He reported, "None." He stated that he vaguely remembered my play room, so I asked what he remembered. He reported that he remembered that he had been having "school problems when I was in elementary school," but that was all. So, taking a deep breath, I began to talk about the benefits of therapy for anxiety and the referrals I knew of in his college town. He became irate, stating that he only wanted a medical marijuana card. We ended with my encouraging him to find a provider in his college community who could monitor him more closely than I and hoping he would reconsider therapy as a means to being able to enjoy more aspects of his life.

Later that week his mother called me. She, too, had gently inquired of him his ideas about the origins of his anxiety. "He doesn't remember anything," she said in disbelief. "Should I tell him?" I recommended that she encourage him to get therapy in his college town. If he had a relationship with a therapist, the decision could be re-visited. "That's what I thought," she said. The potential to further de-stabilize him at this transitional juncture did not seem to be a good strategy; we decided to hope for, and trust, his future readiness. Although I could do nothing more for her son in that moment, I continue to hold his story and his mother's worry and sadness. His mother and I are at an impasse of unknown duration with Sean.

Around the same time that Sean re-surfaced in my practice, another former client, David, sought an appointment. I had also seen him when he was about 5 years old; he was now in his late 30s. David's parents divorced when he was 4. I had first seen his mother for supportive therapy after David's father left her. The mother was resilient and, after a protracted court battle, returned with her children to her former home in Pennsylvania where her parents and siblings resided. Prior to the move, however, I had seen David for an intellectual assessment.

David went to a preschool, attended by many of my clients, where sexual abuse was known to have occurred. Although I had no way of knowing which clients may have been abused, with the help of an attorney I had drafted a letter to clients whose children had attended the school, notifying them of the possibility and potential symptoms of abuse. Some who received it were grateful, others angry, as the letter reverberated through this community over many years:

> *Since I last saw [David] information has come to my attention that sexual abuse of children occurred at [name of school]. Several of my patients were also enrolled at this school. The information is reliable enough to justify warning you that, as a parent, you should be on the lookout for symptoms in your child that may demonstrate a need for special care or counseling. This information may be helpful as part of your child's history to a health care professional providing treatment at a present time, or in the future. I am enclosing, for your information, an inventory of symptoms a child might exhibit if they have experienced abuse.*

David's mother had received my letter, nearly 30 years earlier, after she relocated to Pennsylvania.

David was, as an adult, still in Pennsylvania, living alone. He wanted a video consultation with me because his mother told him that there had been sexual abuse at his preschool. "Was it true?" David queried.

I was cautious with David, legally, ethically, and therapeutically. First, I told him I had no license in Pennsylvania and no authority to provide a professional service to him while he was there. (Florida has yet to participate in PSYPACT.) Two months later he

re-contacted me, stating he was coming to Florida and wanted an appointment while here. I agreed, provided he had a therapist to see on his return to Pennsylvania, since I would not be able to follow up with him.

Per my earlier letter, I had no way of knowing for sure whether David had been one of the victimized children. When I met him in my waiting room, however, my gut knew. David was attractive, fair-haired, and blue eyed, the widely held preference of pedophiles. Once again, I inquired of his history.

David had a successful trade, though he refused college. He reported a failed marriage and needed help with a new relationship; he had full blown panic attacks, including shaking and sweating, at the initiation of physical intimacy. I told David what I knew, encouraged his therapy, and offered hope that he would progress to some resolution of his symptoms. Understanding the possible genesis of his symptoms allowed him to feel greater compassion for himself. As he left, I felt both sorrow and hope for him. He was grateful for our meeting and reported a renewed hope for himself as well as a commitment to therapy. He was ready for the story I had told to his mother 30 years before. I believe he left my office having recovered a bit more self than before. In reflecting over the return of David and Sean, the different ways the two responded to revisiting their earlier traumas, and the memory of so many other young clients over the years who suffered such abuse, whose painful stories I have held and carried, I too have needed to recover a bit more self.

I sometimes believe I became a therapist due to my love for stories. What better life than to spend one's days with the infinite variety of stories, both historic and currently unfolding? Both the joy and weight of longevity in private practice is to be entrusted with clients' stories. Over more than 40 years, I have gathered and held both client and community stories. And yet, some of the stories I have heard have made me sad and afraid — and, sometimes, burdened. As I approach age 70 and face inevitable changes of aging, including losses of important relationships, retirements, and health changes, I think a lot about the overall arc of my life, especially as a therapist. Have I fulfilled my mission, have my efforts mattered? As with many closing chapters, I have been thinking of the shadow of this work I have loved. What have been its costs to me?

My long-time friend and mentor, an academic clinical child psychologist, retired at age 62 after 35 years of teaching and training in the psychology clinic at a large southern university. She said, "I have seen every terrible thing that can happen to a child, and I need to do something else." She only lived 10 more years, but she filled them with happier pursuits: art, nature, travel. Her story affirms some of the burden I have felt and that "stories that rise from deep suffering can provide the most potent remedies for past, present, even future ills" (Estes, 1993, p.5).

As a child, my favorite story was *Little Red Riding Hood*. In it, a young girl dutifully follows instructions to deliver treats to her grandmother. As she proceeds through the woods, she encounters evil for which she is unprepared. She doubts her own intuition, and the Big Bad Wolf, posing as her grandmother, gaslights her in response to her confusion. There are many versions of this story, popular for centuries throughout Europe. In some versions, Red dies, in others she is rescued by a woodsman who happens by, and in still others she rescues herself by unraveling her hat made of yarn along the journey, so that she can follow her own thread back to safety. I think my love of this story has something to do with identifying with Red's being unprepared, especially for unfore-

seen confrontation with evil in the face of responsibility.

My paternal grandmother was, like me, an eldest daughter. She boarded with and cared for a family of children so that she could finish high school, a goal her family could not support emotionally or financially. Her first job was teaching at one of Michigan's boarding schools for Native American children, i.e., children who were removed from their families and culture to be educated. These schools have been much in the news recently for their abuses of these children, in addition to the abuse of being stolen from one's family or culture. My grandmother was a cog in the wheel of an evil larger than she, at 17 or 18, could either see or confront. But in the photo I have of her with her class, she is responsible for 20 children, her emotional big shoulders part of her legacy to me.

Others' stories have indeed been a reservoir of wisdom. But now I turn to reflecting on my own story, in response to the two men whose return to my office after many years began this narrative, in hopes that "the power of story is to heal and sustain. And, if we are brave enough to tell our own story, we realize we're not alone, again and again" (Jouad, 2022, p. 307).

I opened my private practice in 1984, having moved to the greater Daytona Beach community 6 months prior. I had focused my training on working with children and families, and my skills were much needed. My available hours were filled relatively quickly with the variety of challenges faced by children and families everywhere: school performance, behavioral issues, and children's traumas (car accidents, dog bites, medical traumas, and a number of bizarre and unusual accidents that inevitably occur in families' lives). I had a welcoming playroom and a consultation room for adults and felt I was hitting my stride. By the late '90s I had two young children of my own and a practice as busy as I wanted.

However, I was floored by the sheer volume of child abuse cases with which I was confronted. The impact of the relatively new child abuse reporting laws was just beginning to be felt when I left my training. I had had a smattering of child abuse cases throughout my case load in practicum and internship. But the percentage in my practice seemed higher. As my case numbers grew, and my reporting numbers grew as well, I began to be questioned about the reliability of my perceptions and diagnoses vis a vis child abuse. As one of the few psychologists in an underserved community, I felt very alone in what seemed to be an endless flood of children and families in pain.

One sample story is multi-generational, involving a grandmother (Barbara), her son (Art), and her granddaughter (Ami). Barbara brought Ami to see me after Art's death by suicide at age 40. Barbara was an important caregiver to Ami and on good terms with Ami's mother, Art's ex-wife, Dana. Barbara and I had known one another through our mutual involvement in a charity for children. Barbara wanted Ami to have therapy to help her process her parents' divorce and Art's suicide. Ami made good use of play therapy and gradually unburdened herself, through play, of self-blame and loss. She was oddly relieved by her father's death and eventually disclosed that he had sexually abused her. Barbara had indicated that she feared that Ami might have more need for therapy than the loss of her father, but neither Barbara nor Dana could tolerate further discussion of what else might be troubling Ami. Barbara blamed herself for not having sought help for Art. By helping Ami, she was resolving some of her grief and guilt over Art.

But I held another story about Art that Barbara did not know. Art had attended a local playschool for children of the volunteers in Barbara's service organization. Several

of his classmates had been my clients and had disclosed that the playschool had been the site of a child pornography operation during Art's preschool years. Other clients had been able to provide news clippings of the discovery of this criminal operation. Had Barbara known this, it might have helped her understand Art's abuse of Ami as a re-enactment, or it might have added to her distress and guilt over Art. It felt like such an unwelcome burden to withhold what I knew from Barbara, to hold the horrible secret about her son, a secret that might only add to her despair. I kept that story to myself and chose to focus with Barbara on the many factors in a child's life (Art's or Ami's) that are beyond parental control, to reduce the weight of her guilt, and focus on the hope of her contribution to the good in Ami's life.

When I was in my mid-30s, near the end of the 1980s, I attended a church sponsored event on healing at the diocesan cathedral of my mainline protestant (Episcopal) church. I attended with a group of women friends, mostly health professionals, interested in the intersection between faith and health. At the time, my private practice focusing on children was established for a few years in my smallish community, and I was raising my two young boys. As I knelt at the altar rail for the old bishop's blessing, he placed both his hands on my head, then jumped back suddenly as if struck. Recovering his decorum, he returned his hands to my head saying, "You are surrounded by a great evil," gave me a blessing and the anticipated prayer for healing, and moved on along the line of attendees. Though he did not know me, the bishop validated my embodied distress.

The pain of those stories is hard even now. I saw children who had been sexually assaulted, who had witnessed torture and killing of animals, and even a few who had witnessed actual murder, whose silence was assured by threats that their loved ones would be killed if they revealed what they witnessed and experienced. Most of these children were wary-eyed and numb, as they replicated their experiences in play therapy. At one point, I was in a small room with three state law enforcement officers, explaining to them that three preschoolers, all of whom attended the same preschool but none of whose families knew one another, had all told through play the same story of sophisticated child abuse that I had reported. All three reported having been given drugs, having been abused, and having been filmed. Even if law enforcement discounted one such report, it was hard to ignore three with the same specific, lurid details. I had regular supervision with a specialist in sophisticated child abuse. My supervisor, an Ivy League-trained, experienced psychologist, had a break down and left the field altogether, moving to a different community, taking up a different line of work. She had helped me stay strong and sane, but her endurance broke her. In a group workshop with other therapists, one therapist became nauseated and ran out of the room saying that she could not hear this story, my story. My therapist encouraged me to give up my anatomical dolls.

My community had, at that time, a disproportionately large child pornography industry of many years' duration. There were through the 1990s and early 2000s enormous efforts by local, state, and federal law enforcement to disband these operations. During that time, in addition to my practice, I did many training programs for mental health providers and the community at large on identification and treatment of child survivors. I sponsored a community-wide workshop, bringing my supervisor as the keynote. Nonetheless, there were many who could not or would not accept the horrendous stories. I was accused of having "lost it," "barking up the wrong tree," and "hating men." Before I knew the term *vicarious traumatization,* I recognized that I was tired and

stressed. I had a short fuse at work and at home, and I was continually (at work, at home, and in my sleep/dreams) preoccupied with the child abuse stories I was hearing. One night, while putting my eldest son to bed, he asked, "What's wrong, Mommy?" It was a moment of insight in which I realized that I might be hurting my own family. Back at the office, I gave away my anatomical dolls.

I reduced the volume of children I was willing to see, and I found that I was particularly good at understanding the children inside my increasing volume of adult clients. These inner children, however, were less burdensome to me than the actual children I had been seeing. I began to see fewer of the severe cases I had seen in the late '80s. I focused more on my own survival and the real enjoyment of my own children and family. Entering midlife, I was strongly influenced by the work of Jungian Allen Chinen (1992) whose wisdom about midlife was a practical guide to my becoming content with avoiding evil and protecting my own life. I found a new therapist, a very senior, retired child psychologist who as a World War II veteran and a widower was no stranger to personal trauma or working with traumatized children, including his own. He was generous and real in helping me re-vision the beauty in my own life. Even now, so many years later, I tear up in gratitude for his wise guidance. And, when I recently received a call for help for a child who the caller suspected had been sexually abused, although I felt some guilt, I felt relief in refusing and referring the case. And still, occasionally, I wonder about my 30- to 40-year-old self, "Was all that worth it?"

Underneath my anxiety about seeing David and Sean again, I found a deep sadness. In fact, around the time of these two returns, I wept frequently. In exploring this bit of myself, I was reminded of a time from my college years when, as a nanny for three children, I saved the life of the youngest by grabbing him by his pants waist and jerking him away from an oncoming car. After we fell safely on the ground, I shook, and I cried. The memory is an anchor to remind me that after one is safe, emotions are able to flow. My younger self had been a good soldier when faced with so much child abuse. She had been both naive and courageous in the face of this particular evil. But I do not believe I had mourned the emotional cost to her, to me. Containing so much sadness, outrage, and frustration had left some part of me numb for many years. Sean reminded me of the barriers of ignorance and denial I had faced with great frustration. Sean, David, and the many other wounded children from that time in my life had left me with a heavy heart. I am sad, too, recognizing that the work I loved so much, in spite of the cost, had given my own family a partly numb wife and mother.

Recently, following my grandmother's example, I have been making quilts for each of my children, enjoying the meditation sewing affords, thinking about both personal and professional bequests and the meaning of legacy. In this perspective-taking journey, I realized that from childhood through middle adulthood, I thought a lot about others: their needs, their causes, their perceptions of me. In a way, the reflection prompted by these two cases has afforded me the opportunity, like Red, to unravel some threads and follow them home, to a place of greater spaciousness within. The cost of some aspects of my work has opened the door to a kindness toward myself that has eluded me much of my life, a place of greater compassion for myself, either a coming into balance or a greater wholeness or both. A place where legacy is both what I leave for others and the peace I make with myself. My quilts, both actual and metaphorical, created by my work as a therapist, are gifts for others and mandalas for me. I can feel pride, contentment,

and belonging in how I have lived my mission. In relating the stories here, I am not only more connected to myself but to the greater community of therapists and to the shared mission of psychotherapists, including its costs. “And the message of all these stories, the secret that our poets and philosophers have been trying to tell us for centuries is that our longing is the great gateway to belonging.” (Cain, 2022, p.xxvii). ▼

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> Dreams are impartial, spontaneous products of the unconscious psyche, outside the control of the will.
>
> —C. G. Jung

Cartoons by Severin

"WELL, DOC... I THINK I'VE MANAGED TO BREAK OUR DEADLOCK!!"

"... WELL, MISS BELLCHOP... IT'S JUST AS MUCH MY STALEMATE, AS IT IS YOURS!"

"...WE WON'T GET ANYWHERE AT ALL, 'TIL YOU COME HERE BY YOURSELF, MR. BRODSKY!"

Fall, 1968

John Warkentin

Editor, *Voices*

Tom Leland

Associate Editor, *Voices*

Therapeutic Impasses: Editorial Dialogue on Impasses

John: It is a coincidence that our issue on Impasses ran into some publication impasses of its own. It seemed almost as if our topic infected the production effort.

Tom: Impasses are familiar to us, as editors and as therapists. All of life is a recurrent cycle: Tension > discharge > relaxation. Life can be seen as the adventure of a restless wandering through a maze of cul-de-sacs and escapeless predicaments. Our daily lives are literally filled by impasses.

John: This is my own experience. Impasses are not limited to psychotherapy. The very act of awakening in the morning and reluctantly moving from dream life to real life, the morning traffic jam enroute to the office, these are examples of hindered movement. Our chosen profession requires that we often sit impassively hour after hour traveling with our patients into plateaus and log jams. In our colleague relationships also we often find ourselves strangely unable to relate, or at least I do, as if stalled in

the free flow of communication. As editors we have met some impasses as we try to present VOICES as a creative and personal forum for the growth experiences of people. Sometimes these impasses are troublesome enough to make us feel like giving up the effort.

Tom: In addition to the obvious log jams and head buttings that occur in all interpersonal relationships, there also occur within each of us repeated brief plateaus of intrapsychic impasse, such as depression. What we know about the dynamics of the impasse experience fills books, but what we do not know about its real cause and purpose would fill libraries. We are as much in the dark about the cause of impasse as we are about the force that opposes it, the inexorable movement called growth. In fact, this desperate drive to move, to change and to grow is a definition of life. Its cessation equals death.

John: As we risk or push our way past a plateau, we realize that the stalling and the road blocks are not always unfortunate. For example, the frustrated 18 year old son who is angry at the restraints of his parents strikes out on his own, feeling utterly blocked in his development at home. On his own he finds a new growth spurt which would never have been possible in the lap of his family. Similarly, the psychotherapeutic patient who comes to a major stall after years of movement with the therapist may well be simply at the point of a constructive ending. Taking up life on his own is the risky next step. In a sense, psychotherapists are seen by society as impasse resolvers, and indeed most of our patients come to us at the point of some impasse. The psychotherapist then becomes the stranger, the catalyst, who comes into the impassed experience or into the marriage, the impassed relationship. Perhaps one common denominator of the treatment experience is that the psychotherapist is willing to say the awful words, "Take a chance — kill it completely or else resurrect it." It seems that the basic usefulness of the catalyst is to delineate the scope of the impasse, and then to cultivate the hunger, the drive, the inexorable force to grow and to change.

Tom: It is this facet of facilitating growth that makes the discussion of impasses relevant to the psychotherapist. One of the most peculiar aspects of the psychotherapeutic relationship is that it is akin to an artificial second childhood. It is quite strange that reliving childhood experiences can teach the patient to experience how the maze itself can be solved. That is, it is something more than the resolution of one impasse. It is an experience in learning how to unravel all impasses. In our offices we often see the human dilemma to be that we are feeling souls imprisoned in dying human bodies, and that only another soul in another body can ease the humiliation of this brief life and its ultimate impasse, death. It is in the risky sharing experience that growth is released from its plateau. To the degree that human beings can wedge themselves into inescapable predicaments, to that degree another person can relieve the endless despair. Psychotherapists say in effect, not unlike Jesus, "You are the walking dead, hopeless and helpless — let me into you and you will immediately feel new life and have no more despair." Perhaps, as one patient said, it is in the acceptance of the navel as a symbol and as a reality, that the human impasse is resolved.

John: As therapists and as editors we recommend that people should relate to each other at any cost. Thus impasses in living can resolve into new movement. We are pleased to present the many wonderful authors in this issue who suggest detailed ways to do so.

Fall, 1968

Carl A. Whitaker

Dr. Whitaker was born in 1912 on a dairy farm in northern New York. He received his medical training in Syracuse, obstetrical training in New York City, and psychiatric training in Syracuse and Louisville. He is Professor of Psychiatry at the University of Wisconsin and is in part-time private practice, treating families only. He has previously appeared in VOICES and is on the Editorial Board. Three of the Whitaker children are now married and have their own homes, two are in college, and one is still at home. Carl and his wife, Muriel, live on beautiful Lake Mendota and report that they are still turned on by sailing and by their flower garden.
Madison, Wisconsin

Guest Editorial:
The Impasse

Much of the criticism of psychotherapy is in one way or another related to the problem of impasse. One day we say psychotherapy is no good because the patients don't get anything out of it, that is, nothing moves. Another day we say psychotherapy is bad because it goes on forever. Most patients come to a therapist because of an impasse in their living. Somehow they have been stalemated. If it lasts a long time, we call them rigid or burned out. They also come because they are either beginning to break out, hoping to break out, or determined to break out of their impasse with life. Psychotherapy is a microcosm of life. When psychotherapy does not succeed, it frequently is because that also becomes a stalemate — a kind of cold war that locks therapist and patient in a fixed state.

The impasse problem is not just restricted to psychotherapy. There is a cultural impasse in the United States now between the black and the white. Neither is able to move in it and the tension of this lock-step condition becomes more and more frightening. The world agonizes daily over an impasse between parents and children. I'll bet even the caveman faced the one between parent and adolescent. Nowadays, most marriages pass through serial impasses. The ten-year syndrome or the seven-year itch are both indications of our social concern with this kind of lock between two individuals or groups of people or states of being.

There is something about the impasse that is like an unhappy bilateral symmetrical dance. Neither of the individuals is able to change the rules of the dance. It's as though they're locked in and neither one can switch to being creative. It includes a kind of mutual disrespect and somehow the process becomes as they say about a love af-

fair, "bigger than both of us." The 20-year stalemate between Russia and the United States is typical. Essentially, it's a situation such that there is no whole of which each is a part and which transcends them both. It's as though the two units had lost their goal-directed pattern. If the United States and Russia could acknowledge the United Nations they would be out of the impasse and each working for a better world which indeed may be happening. We know about dead marriages in which the partners rest, each in his individual rocking chair, she reading *True Romances* and he reading *Playboy* but positioned back to back. Dr. Shefflin describes them as the "gruesome twosome."

Sometimes the impasse is three-cornered.

> Father H. was fat, soft, petulant, with temper-tantrums like a "seven year old" who was a blustering tyrant but there was no chill in his emotional storm. Mother H. was a tight-lipped fury with every muscle locked ready to spring, yet all was hidden under her idealistic, gentle, agreeable mother image. Impassed with each of these and with their partnership was the 16-year-old son. His lash-back sneer of disdain, his teetering on the edge of delinquency was combined with a derisive and degrading attitude toward father and a sarcastic pseudo-sweet snarl for mother. In this case the impasse had a peculiar quality. No combination of two was stable in this unit. As soon as father and mother got together they would break up and father and son would get together in a fight, or mother and son would get together to discipline father. Thus, the triangular impasse revolved around a constant instability which was in itself very stable.

In the therapeutic setting of a one-to-one relationship the impasse develops after therapy is underway, and after the transference has been established in both directions. The therapist and the patient try to sell *each other* on an image and agree to conceal their personhood behind these images. Once this has taken place there is a kind of mutual enjoyment of the state and the dance goes on and on. The systems theorist would say that the units of which the system is composed are under control of the system, and that the system tends to maintain itself in a steady state.

Prevention

Assuming that we are out to do something about the impasse on a deliberate level the therapist is wisest to deal with it as a problem in prevention. Many aspects of psychotherapy can be set up to prevent an impasse. The early establishment of a deliberate, contrived role structure for the therapist undoubtedly prevents subsequent impasses or tends to, if it's well done. If the therapist is in charge of everything that happens in his hospital operating room, the patient is not apt to tie him up in a bilateral unchanging role status. Once this deliberate therapeutic structure is established the therapist is more free to respect the unique custom-made living style of the patient and not invade his life but only his feelings and his personhood. Prevention of impasse probably is also aided by any secondary commentary; e.g., an objective discussion of the transference. Thus when the existential and peer relationship typical of healthy late phase psychotherapy develops, *it is not* contrived.

It is not new to say that negative affects must certainly be expressed to prevent impasse. Assuming that the impasse is frequently the result of the secretive character of the one-to-one relationship or indeed of much psychotherapy, it follows that the use of a consultant, either early in therapy and later if needed, tends to break up the lock-step. This consultant should be professional but the same result is frequently obtained by

bringing in others of the family, even the extended family, and sharing with them the lock-up in the therapeutic relationship, or just asking them to participate in the relationship. In the conduct of psychotherapy the freedom for the creative flow of communication tends to prevent a game playing lock. Freedom on the part of the therapist to leave the scene emotionally, attention-wise or even physically, also helps. If the therapist dares invade his own role stance he creates a happening, and such a happening makes it very difficult to get into a fixed impasse set.

Techniques of Breaking Up the Impasse

One of the most obvious ways of breaking up an impasse is having a war. When the cold war stalemate is disrupted by a hot war this changes everything. The war may be and frequently is started and won by the patient who ends treatment, walks out, or in some other way breaks up the relationship. Better it should be the therapist who starts so that it can be verbal, affective and made part of the ongoing process of change. This takes a kind of freedom in the therapist to hang loose, because once the patient has him up tight it's a different kind of world and it's very difficult to reheat the cold relationship. However, a deliberate effort to make the impasse a joint problem is aided (as in prevention) by the humiliation of bringing somebody in from the outside. If it's family psychotherapy, one can sometimes reactivate the family romance. If it's a marital impasse, sometimes one can begin the process of decourting preparatory to the talked-of divorce. The decourting may then change to recourting. The biggest struggle with therapeutic impasse is with the schizophrenic. This necessitates a kind of marriage and divorce between the therapist and the patient, as put forward well in "The Jet-Propelled Couch." It's a kind of folie-de-deux.

The Impasse with the Schizophrenic

At the risk of being far out, I should like to postulate how the schizophrenic patient grows in psychotherapy. If the schizophrenic does develop a transference, it's because the therapist is like his mother. His mother was a double-binding person, and so is the therapist. They establish a relationship in which the therapist double-binds the patient, and the patient is able to double-bind the therapist. Gradually this bind becomes tighter and tighter until each of them is locked in step with the other and neither is in charge of any change. Indeed, neither is capable of more than minute quanta of change. This was exactly what he had with mother. We know that when such a patient gets well in a state hospital by some fortuitous and still unknown means and leaves the hospital, it is frequent that mother herself comes into the hospital or goes crazy in some other way. Assuming that this is also true in psychotherapy, our patient dare not get better for fear his therapist would go crazy. On the other hand the therapist went into this relationship deliberately; I assume that for myself at least, my objective for this is to find some more of my own craziness. So at the point where we are impassed in a land of figure eight reciprocal double bind, I elect to experience some more of my craziness (my growing edge) supported by the homeostasis of that relationship. When I do "go crazy" the patient has no other recourse except to be the counter-schiz, if I may use the term, to my schizophrenia. Thus, we are in a pseudo impasse and each of us is capable of forcing

the other, but I as the therapist want to be "crazy" and he is thereby forced to be "sane." Once this reciprocal movement is established the oscillations become wider and wider, assuming all goes well, until we are further separate. One other factor has to be added to this. Once the freedom to oscillate is residual in each of us we are free to love each other, and this is the kind of love that revels in the other's gain, not just in one's own gain. With such love the movement apart, or rather the movement into life on the part of each of us, takes place gradually and with satisfaction in each of us for the life and openness of the other. The love lasts forever, but the freedom is constantly increasing.

Could it be that no impasse in a relationship means no love is developing? So why not go on and break up the impasse with one psychotic after another? — I'll tell you why! My society fights my craziness. Each time I have to defy this pressure for social lock-step, and I get scared each time. ▼

The reasonable man adapts himself to the world: the unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man.

— G. B. Shaw, *Maxims for Revolutionists*

Fall, 1968

John Warkentin &
Tom Leland, Editors

Symposium: Significant Patients

Editors' Introduction: In a continuing effort to increase the volume and number of VOICES heard in our Journal we are once again utilizing the technique of a Symposium as a mode of sharing ideas from a variety of psychotherapists. (Issue Ten contained a Symposium by 27 therapists on "Good and Bad Patients.") The following is a panel of eight psychotherapists who have written about those significant patients who catalyzed their own professional growth.

We want to acknowledge our great teacher, The Patient. In our ongoing professional training we have experiences with an occasional patient who significantly helps us to become a better therapist. The focus of this Symposium will once again be on the experience of the therapist and his professional growth, rather than focusing on the dynamics or pathologies of the patient. To the editors and to the authors of this Symposium it seems appropriate and ethical to learn from our patients, and to share these experiences with our colleagues. We appreciated the panel members' willingness to be brief. We particularly want to thank the patients represented in the following pages for their part in our learning experience.

Richard E. Felder, MD

Atlanta, Georgia

Terror

I have had some difficulty in deciding which "significant patient" to write about for the purpose of this symposium. The one who won represents one of the craziest experiences I have ever had. A little background will help make the story communicable.

The interview took place many years ago very shortly after I had begun to do psychotherapy. I was a full-time teacher then and was permitted to schedule private patients on Saturday. The offices of the Psychiatry Department were in an old two-story building which was separate from the Hospital and Medical School. The Psychiatry Department, of which I was a member, was operating at the time on the basis of a couple of principles which the reader of this article needs to know. We were extremely experimental and were contributing actively to the field of research in psychotherapy. We engaged in therapeutic experiences of enormous intensity, believing at the time that a "therapeutic experience" might be relatively adequate treatment in place of longer term psychotherapy. We were striving to find ways to bring more psychotherapy to more people in the man hours available. We certainly were convinced that any and every patient was curable, and we didn't let any diagnostic category slow us down.

I had seen the particular patient only one time and went to the waiting room to get him for his second, and as it turned out, his last interview with me. He was a freshman in a local college and his history, which he had told me during the first visit, was that of the psychopath. I noticed when I went to get him that there was something frightening about him. We went into the office and closed the door but neither of us spoke. We were facing each other, looking each other in the eye. I then began to realize that I had scheduled this appointment as the last one on Saturday afternoon, at a time when there was no one else in the building but the patient and me. As the silent interview proceeded I became increasingly frightened and finally terrified. The patient had worn a long hunting knife which he menacingly handled from time to time. I was no fighter anyway, and with him armed and me not, I felt trapped and totally vulnerable. He sat between me and the door. He also happened to sit between me and the window. There was no telephone in the room and no way for me to summon help. I reviewed in my mind every possible plan of action should the imminent danger become manifest. No plan was any good.

No word had been spoken. I finally sank into a psychotic terror in which I sort of abandoned myself to whatever might develop inside of me, there being nothing else to do. After perhaps thirty minutes of this eyeball-to-eyeball terror, a strange insight pushed its way with total clarity into my awareness. Strange because it was so unanticipated. I knew at that moment that his life was as valuable as mine, and that each person's life is as valuable as any other person's. Having found this knowledge I began to be unafraid. We sat out the rest of the interview time, and I knew I was saved. As I remember, no word was ever spoken. Nor did I ever hear from that patient again. I have never had to relearn what I learned in that interview; and I noticed that it helped me with my concept of death as well as with my concept of life. ▼

Limits and Cornerstones

Richard E. Johnson, PhD

Family Training Center
Patton State Hospital
Patton, California

I wanted to discover boundaries for psychotherapy during the initial phase of my work. I wanted to discover terminal limits for the therapeutic experience. I felt intrinsic limits would emerge where personalities and relationships had no formal structure. I began work on the back wards of a large state hospital. I worked with anyone who showed signs of life and with many who showed none. A pattern of boundaries did emerge. Specific relationships were the guideposts for these boundaries. The outline was clear but there was no definitive closure. I could not reach the hypothetical turning point. I needed a relationship commitment which would convince me that I had gone as far as possible.

The significant patient in this struggle for closure was a severely troubled young man. He had been in the hospital six months when we met. He had recovered from his initial disorganization and was now rational and coherent. His outward appearance was that of a typical and successful young adult. Yet inwardly he had been out of step with the world around him as long as he could remember. He described imaginative experiences from childhood which seem to have been preludes to his current religious and mystical confusion. He shared this current confusion with me: "You see… I'm a very holy person… and divine… I believe I'm like Jesus Christ… I mean… I believed that… (heavy sigh)… I don't know… (pause)… I believed that I'm… I was the second coming of Christ… and that I was pure and good until my heart was broken." So did he share with me other aspects of his confused identity: "Then I went and surrendered to a woman… and when I got a piece of ass from her that's when my soul changed to hers… and I became like her in body and form and thinking and everything… and now I feel that I am a woman… and that's why I feel homosexual… like with you… I don't feel right toward you… and that is the pool of blood that exists within me." We worked through these varied fears and a useful rapport developed. Still we could not break through the interpersonal barrier between us. We were at an impasse as the fourth month of therapy ended. Then he wanted me to arrange a week-end leave for him. He had been violent and disruptive on the ward. He had broken furniture and smashed windows on his last visit home. I told him I could not in all honesty recommend it. In a sudden rage he struck heavy blows to my chest and face. Then he sat down in his chair with his head hung low. I got up slowly from the floor and sat down close to him. My eyes were flooded with tears. I touched him gently on the shoulder. He looked up at me. We discovered each other in that brief moment. He broke into convulsive sobbing. Then my own emotional pain overwhelmed me. I sobbed openly with him. We intermittently cried and comforted each other until the mood of trauma gradually subsided. The pain we experienced together broke the interpersonal barrier. We shared the venture of a therapeutic relationship.

The intensity of that encounter gave me the definitive closure I had been seeking. The hypothetical turning point was now a concrete reality. I knew for myself the limits and boundaries of psychotherapy. Other relationships would be different, but this would be the prototype for them. I had set the cornerstone for the foundation of my work. ▼

Launching a Thousand Ships

Stanley Lipkin, PhD

Chicago, Illinois

I believe all of us have significant patients when we are personally ready for them and that professional development waits upon the personal reorganization of the therapist as he seeks to make room within himself for another's "being." In this context, I should like to discuss a current patient who has sharpened what has been an ongoing issue for me, but one which I believe goes beyond my own dilemma.

The patient, a married woman of 40, is an accomplished artist, exceedingly shy, highly blocked verbally. Over a long period of time, her behavior in the office might have been described as catatonic. She would sit rigidly, weep silently, tears dripping down her cheeks. There was a constant battle raging within her between father's and mother's value systems. She reported paranoid ideation, jumped levels and spoke so privately that there was a continuous struggle on my part to comprehend, a struggle which frequently left me exhausted physically. We got to the point where there were massive open rages, physical attacks on my person, etc. As time went on, the picture changed dramatically. Recently, she has been functioning increasingly adequately, is better able to deal with her daily tasks, and much of the earlier symptomatology is gone. Now to my difficulty.

Not too long ago, this patient commented to the effect that, while she had changed and she felt that *I* concurred that she had changed, she thought I gave evidence from time to time that I continued to perceive her as she was when she had been frankly "ill," that I was quizzical about her good judgement and the adequacy of her perceptions. Most important, that I denied that she could "read" me correctly.

The issue which this has triggered off for me is a nagging, ever-present one, since on rumination I realize that ever since I became a therapist I have been confronted with the problem of how do you acknowledge the "growing edge" of another who has been dependent upon you? How do you genuinely accept their equality? How do you accept a dependent becoming not only your equal but perhaps your teacher? With a patient who comes in rather adequate to begin with, who is not psychotic, or one who is your functioning equal in social or educational terms, the problem does not really come to the fore. *But the greater has been the dependency,* whether out of neces-

sity as with a child or with the kind of patient described above, I have become aware that you can frequently verbalize "I and Thou" and operate "I and It."

But what about the acceptance of judgment and criticism of yourself on the part of another who but a short while ago was relatively incompetent? It has become clear to me that this very act is what makes for growth in the patient. The reluctance to make room in one's self for another, a former dependent, who has developed different ways of perceiving or being, has for me all the elements of a biological principle. It is the parsimonious employment of energy plus, I think, the hunger for omnipotence on the part of the child within me who will have it his own way. It is also in part the reluctance to accept a competitor for fear of being dislodged as the master. But it is nonetheless apparent that there is a basic rhythm to life to which I as therapist, parent or teacher must bow, lest I risk falling totally out of step with an ever-changing reality, a reality which my dependent-patient-grown-adequate, my child-grown-adult, my student-grown-colleague give me eyes to see.

As I see it, the reward for giving up the "brute" within me and his throne which dispenses nutrition, wisdom, and pronunciamentos is the privilege of being fed by others, learning from them, developing alongside them, keeping my own "growing edge" open and clear. Perhaps another way of saying it is that when I make room within myself for others, I can have the excitement of launching a thousand ships, without having to be captain. But it ain't easy! ▼

Miss Eggplant

Richard L. Miller, PhD & Lawrence I. Bloomberg, PhD

The Institute for Multiple Psychotherapy

San Francisco, California

Although we had been together in a one-week group therapy workshop and had proceeded to work on our relationship the next time we met at the APA convention, we had only been in multiple psychotherapy practice a few days. We met with a couple who were referred by a lawyer. They were in the middle of a divorce, and they mentioned that their 20-year-old daughter was home for Christmas vacation. The couple's interaction was so terribly pathological that we probed them about their daughter and discovered that she had been hospitalized, electro-shocked (20 times) and drugged, after repeated suicide attempts. We consider Christmas to be a high suicide month and, therefore, suggested that the girl come in to see us as a prophylactic measure.

Miss E. arrived, tall, beautiful, and very well-dressed. She maintained a wry, distant smile and was muted as she nonchalantly related experiences worthy of the Shitty Childhood Award. One of us, Dick, got in touch with how he would be feeling had he had such experiences and openly expressed these impressions to Miss E., who responded by degrading him severely. He let out a moan of pain and began to cry. The other therapist, Larry, comforted Dick by holding him closely and hugging him. After a few moments the following conversation . . .

Larry to Miss E.: "We are going to have to work on his rescue fantasies. He thinks he has to be Lancelot to every maiden in distress."
MissE.: (smile)
Dick to Larry: "No one really wants to live where she lives."
Larry: "She has the right to live where she pleases. Who are you to rescue her?"
Dick: "She's lonely and doesn't have to be."
Larry: "She's lonely and she wants to be."

At this point we both rose and hugged Miss E. and each other. She teared up and said her contact lenses were bothering her.

In the second session we brought in a third therapist. Miss E. was silent and the meeting was uneventful, except for her showing some annoyance as she left without hardly a word.

We did not know if she would return, and when she did we were happy and greeted her warmly. She attacked

us for having brought in “a stranger whom she didn’t know” without asking her permission. We had not continued to treat her with the respect we began with.

Her attack brought goose bumps to our skin, for she helped us get in touch with a far greater respect for her than we had been offering her, and with the far greater respect she had for herself than she had been willing to acknowledge or recognize.

We learned from this session that we could expose our innermost feelings to each other and to our patients regardless of the threats, for we as a team were able to stand up against a formidable opponent who could easily wipe the floor with either of us alone. We realized *emotionally* that we have equal rights as participants in therapy sessions and, as equals, we can express ourselves openly and participate actively both as therapists and as patients.

Now, having been helped by Miss E. (which stands for eggplant, the name she gave herself), we are therapists to be patients. ▼

Bless Them All!

Vincent F. O'Connell, PhD

Student Health Services
University of Florida
Gainsesville, Florida

When I think of my most significant patients I give thought primarily to those men and women who have taught me something of loving; and to those who have taught me something essential also of suffering. (At the present time I view these two as polar, as intermingled.) The latter patients — those who bring with them suffering — are, from my side, the ones who are defended against more in the present; and yet those also most prized and appreciated in the later time in the future. That is to say, when I am grown beyond a certain difficulty: Be it (as in my case) the matter of blindness, of deafness, or the fear of giving myself to that point of meeting wherein I am no longer in control of the situation.

Bless them all! They wait in such patience for me to come to meet them here where they are. To meet them there, in the now, in the flesh, in the real world wherein real men and women (and children) grow, and change, and multiply together in this moment. In that is the significance for me. And it is this I remember. As well as the ways I struggled with Sam and Emily and David (etc.) not only to bring into the light his or her particular demon and darkness, but my own (more subtle) attempts also to manage and delay the final commitment in which I am now no longer just myself, but in this moment also the other. One does not approach that moment with a sane, well-ordered mind!

When I attempt to encompass all of this (the kaleidoscopic and ultimately enduring, the crazy and ultimately sane, the researchable and ultimately ungraspable cogency of the lived moment between persons) — when I attempt to encompass this, my Irish tongue is at last unable to find the fitting phrase. It is as if I have been a psychotherapist for all my life (as indeed I have and am); yet, on another level, I know (and the external record testifies to this) that it is a mere 13 years since I have been given the *imprimatur* which says I may make a living in finding out why I am here, and why this person (who sits with me and over against me in the now moment) is here. It is indeed significant! But how is one to say it? How is one to encompass this? I cannot. And I am beginning finally to have the wit and grace no longer to attempt it.

For the patient-therapist combination, or unit, or relationship, or dyad (choose your own particular magic

word) is at once the most precious thing, the most needed and urgent situation, yet the most bizarre and paradoxical way of being together among men that the world has so far perhaps evolved. It is all of these and much more also (namely Etc.) because our age and time is all of these things. And because we are just in our time the bridge, the connection, between a world of individualism and the world of community.

In my longing for and toward community (Does any man or woman stay a psychotherapist for long without this longing?), I spend one-half of my waking life with men and women who begin as strangers, who become companions upon the path, and possibly in time, friends. Only to discover, then, in the moment of meeting, that our need for and of each other is fulfilled and re-directed to where it belongs in reality. Namely to the world "outside," to the real world of suffering and loving, outside the office door.

I spend one-half of my waking life thus, one-half of my waking life, only to find out, so to say, who my patients are, and who I am with them. And then, if I have done my job well, they are gone.

Money alone cannot encompass this; nor vocation; nor dedication; nor "motivation." We make a living, it is true. (What kind of living is that for a good jewish boy? Even for a christian? or a goy?) But money alone cannot encompass this. It seems to be that psychotherapists are lived by a talent, a skill — the possibility, namely, for saying "Hello" and "Goodbye." And without regret, or attachment. As best we can!

We make a living, it is true. But why in this odd, precious, and ultimately paradoxical way? I do not know the answer to that. Do you?

Is it that we are attuned to *voices*, that is to say not merely to the content alone, but to the sounding out also: To what becomes possible, what comes forward into being, when there is attention focused, and when the heart opens? I believe it is so; and that in this is our peace — the tension that is met without conflict.

I have been fortunate, I believe, in the number of significant patients I have had. (Does this then intend merely that I have been "lucky," or perhaps that I have had much need of growing? What say you? How do you allow your patients to become significant for you?)

But just as I have "had" many significant patients in the 13 years since *imprimatur*, it seems now (and is this then perhaps merely the self longing toward community?) that I have been significant for them as well. I have been, so to say, a sign-post along their paths, a quiet place perhaps wherein they could put down the burden of their *karma (neurosis)* for a time. So that we might look quietly, together, and possibly see together, what is, what is there, what can be, and what could be if . . .

In the "if," in the possibility, is, for me, the significance, the magic, the hope, and ultimately perhaps my own redemption. (But in just this can be the loneliness of the psychotherapist.) For many, so to say, knock at the door. And how few also are ready — even in the potentiality — to say that good-bye with a full heart? Being a psychotherapist involves much waiting. And if I am not able to sustain that waiting with a light heart, without conflict, even, so to say, without "needs," I had better find another way to make my bread.

So we wait, and wait, and wait still some more. For what end, and to what purpose?

In the "if," the "what if," is, for me, the significance, the magic, the hope and the redemption. For just as I am bound now to redeem myself and my world each day (that is to say, to renew myself, my world, my hope), so the significant patient crosses my path

and my existence here-and-now. He comes, namely, for a sign, for a signification, for a road-marker along his path. For a sign that touches his heart and redeems his world.

If I touch him in the heart, I become significant for him. If I touch him in the head, I am merely remembered. In the heart is the touching and the meeting. And it is this the Irish tongues, and the Jewish tongues, and the Goyishe tongues struggle to put into words. (We are all dumb in some measure in the face of this. And dummies too — the blocks of wood who need to wake up to who we are — when we do not hear the music of the heart.) For psychotherapists (is it not true?) are at once the hope and the greatest barrier perhaps also to the patient's growth, and the person's salvation. It is this which is paradoxical (when it is seen from the outside, the point of vantage and discrimination), that we seem able to do so much with so little.

At times it seems to me miraculous. But then I'm Irish, and to the "Irish," the miraculous is just another aspect of the everydayness which each man makes brilliant when he loves. ▼

> It took a series of relationships to get you into this mess and it's going to take a relationship to get you out of it.

—Dick Felder

Arthur L. Rautman, PhD

St. Petersburg, Florida

New Vistas

She was an unusual woman. After some twenty years as a beautiful, talented, but prissy unmarried professor in a small Midwest religious college she had, in high adventure, chosen to serve her country as a WAC and thereby also escape the old-maid-school-teacher's occupational disease, the lifelong care of an aged and ailing mother. But in military service the lack of privacy, the lax sexual mores of younger, less dedicated souls, plus the military set-up which permitted an over-conscientious older woman to over-extend herself, led to a decompensation of carefully repressed pathology. When her old mother, whom she had parked with a not-too-enthusiastic brother and sister-in-law, became seriously ill, Miss P. collapsed and was soon discharged as a psychiatric casualty of war.

By the time I met her, almost ten years later, she had made several unsuccessful attempts at college teaching and at therapy, both soon interrupted by periods of hospitalization. Now when her mother finally died, only her brittle repression and self-righteous defense structure stood between her and complete disintegration.

Treating her on an out-patient basis was somewhat like feeding an infuriated wild cat. If I used anything but impeccable English, I was pointedly corrected. Personal questions of all kinds were parried with expert hostility. Since she was not above "accidentally" kicking my ankles in sudden rage, we sat across the edge of my desk, with the lower drawer pulled out a convenient length to protect my shins. Hour-long hostile silences, ending with her stomping out in a huff, were commonplace.

After many weeks she moved from muted silence, through paranoid rages against the world and me, into a phase of depressive behavior punctuated with lacerating self-depreciation.

My own background, combining as it did the academic and "Nice-boys-don't-talk-like-that" point of view with more than a few years of psychotherapy with verbally fluent, often unbelievably profane ex-military psychotic patients, resulted in frequent deep conflicts.

My knowledge of Miss P.'s post-service history and her violent insistence upon exact propriety in speech and diction had all this time prevented me from using any but the most bland of terms.

One day, however, I had just finished an endless hour with an unusually aggressive, outspoken, and demand-

ing, even though ambulatory, schizophrenic man. When, during the next hour, Miss P. continued her oft-repeated whining, self-depreciative recitation, describing once more her complete worthlessness, apologizing abjectly for coming to bother me, and profusely describing her feelings of guilt for accepting the charity of her small pension, for occupying space on earth, even for breathing, I listened in stony silence.

After about twenty minutes of carefully patient "acceptance," I exploded with language quite unbecoming a dignified therapist and an old dowager-type religious ex-college professor of impeccable diction and a mortal abhorrence of profanity. I banged my fist on my desk under her nose and yelled in honest exasperation, "I have listened to your goddam stupid self-evaluation long enough. God damn it, I don't see you that way. If I did, I wouldn't waste my time with you. If I saw you as the useless, inadequate old bat you describe, I would give you a sack full of tranquilizers and tell you to go to Hell!"

By the time I became aware of the horrified expression of amazed disbelief on her face, there was no back door.

I retreated into stony silence; she, into violent and open-mouthed weeping.

But she did not stomp out. She did nothing but weep, the tears rolling down and sopping the front of her dress like a Niagara. She did not pick up the Kleenex tissues which I gently and surreptitiously dropped into her lap. She just wept . . .

After some thirty wordless, if not silent, minutes we had both somewhat re-composed ourselves; and without a word, we both stood up to stare at each other.

Then, quietly but firmly, she said, "No man has ever used such language at me or in my presence."

I was about to apologize when she added, "Nor has any man given me a finer or more sincere compliment."

Then, with her blotched and tear-stained face held high, she turned on her heel and marched out of my office.

Our next meeting was on a solid foundation, and therapy was on its way for the first time.

Now, years later, I still work under her paintings in my private group-therapy room.

Sometimes I see a tear-stained face behind her beautiful seascape, and she once more gives me the courage to be myself — in life, and in therapy. ▼

> The monstrous thing is not that men have created roses out of this dung heap, but that, for some reason or other, they should want roses. For some reason or other man looks for the miracle, and to accomplish it he will wade through blood. He will debauch himself with ideas, he will reduce himself to a shadow if for only one second of his life he can close his eyes to the hideousness of reality.
>
> — Henry Miller: *Tropic of Cancer*

Cartoons by Severin

"... BUT, DOCTOR ... YOU CAN'T RETIRE FROM PRACTICE RIGHT IN THE MIDDLE OF A SESSION!!"

"THERE'S ONLY ONE THING LEFT TO TRY, MR. SEABORN... **PRAYER**!"

"MOTHER SEEMS TO FEEL, WE'VE REACHED THIS STALEMATE BECAUSE YOU DON'T KNOW WHAT YOU'RE DOING!"

Cartoons by Severin

"YOU MUST REALIZE OF COURSE, THAT IMPASSES LIKE THIS RARELY OCCUR ON THE VERY FIRST SESSION!"

"IT'S A DEAL THEN, YOU QUIT CALLING ME A HEADSHRINKER AND I QUIT CALLING YOU A KOOK!"

"... AND TO HELL WITH YOU, TOO!"

From the Archives

Encountering the Impasse

Fall, 1968

Bernard J. Somers, PhD

DR. BERT SOMERS grew up in Brazil and in the eastern part of the U.S. He received his Ph.D. from Columbia in clinical psychology. He is presently Associate Professor of Psychology and Director of the Psychology Clinic at California State College at Los Angeles. His special interests are in family and group therapy, and in the training of therapists. He is 42 years old, is married and has two children. His hobbies and extra-professional activities include poetry, music, camping, cooking and social action for peace and human rights.
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CALIFORNIA STATE COLLEGE AT LOS ANGELES

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An approach to the breaking of the therapeutic impasse must be conceived and implemented within the theoretical framework of each therapist. Within the framework of experiential-encounter therapy, it is not helpful or relevant to discuss impasse in terms of resistance, transference, countertransference and other such concepts. Rather, the therapist working in such a framework is attuned to his subjective experiencing with the patient (impact) and uses this experience to begin or renew the encounter. The following is a description of the breaking of impasse by the therapist's subjective use of his own imagination. In this use of the "directed daydream," the therapist focuses imaginatively upon the experience of his patient's impact upon him and shares his findings in direct encounter with his patient. In order to present this approach, there follows a brief description of the encounter framework, a discussion of the nature of impasse in this framework, and finally, the description of one approach to breaking the impasse.

The Encounter Framework

As all encounter or experiential approaches include the use of the therapist's own subjectivity, there is much diversity in the actual work. However, certain general principles which are common to all can be formulated.

The therapist facilitates encounter by confining the focus of the interchange to the present. Where discussion does involve the past and the future, it is brought back to the immediate present as the therapist tries to discover with the patient its relevance to the moment. The very act of restructuring the temporal focus sensitizes the participants to each other's presence and impact. The here-and-now focus sets the stage for the work of encountering mutual openness and self-disclosure.

The therapist focuses on his own being in the encounter. He pays attention to his own actual lived experience within the impact created in the meeting with this other person. He discloses to the other person what he experiences in the moment and encourages him to open himself to the impact of his own being. The therapist in the use of himself becomes a model and a facilitator as he encourages the mutual sharing of experiences. In such acts of mutual openness, the quality of each person's presence is

placed in sharper focus. Each participant discovers the common experiences he is having with the other as well as the sharp differences. Each partner in self-disclosure discovers his own distortions and is helped to discover the impact such distortions make upon the other.

The experiencing of each other's immediate subjective state involves an active interchange that begs for meaning. In Frankl's language there is a "will for meaning." Each person in the encounter seeks the meaning of his impact upon the other and the impact he is experiencing from the other. Both strive to discover and create meanings that are relevant to their respective styles and position in their encountering. When the participants give consistent attention to their own meeting, these meanings become far more relevant than those suggested by external authority or projections from the past.

In summary, experiential therapy involves the therapist and the patient in a dialogical relationship which comprises impact, here-and-now focus, mutual openness and self-disclosure, and a search for the personally derived meanings of the impact that each is having upon the other. The framework invites the participants to actualize their personal, creative styles. The therapist facilitates full encountering by his own acts of openness, focus and impact.

Experience of Impasse

Most of us experience impasse at one time or another as repetition. When patient and therapist are drawn into the repetitive theme, there is a damming up of the flow of interchange and interaction. At this impasse there is no longer vitality and freshness in the relationship. This does not mean that there is no longer movement but that in the spiralling or circularity there is no *new* movement. For the partners there is always the sameness of asking followed by anger, sadness, bitterness or denial.

The therapist often experiences this impact *as a lack of involvement* and feels that he is being used as an object, as someone who is not real. When there is no involvement, there is no encounter. When I allow myself to be unreal or a screen for the patient's projective repetition, I have encouraged the impasse. Only when I am willing to communicate my experience of stalemate, to fully share the patient's impact upon me, do I become real and a subject for this person.

The impasse can be the result of the patient's withholding and avoiding, but it is the therapist who is also withholding his subjective reactions and avoiding the confrontation. When impasse occurs the question that is typically asked is, Why? It is more fruitful in the experiential framework to ask *what* and *how* questions. *What* am I doing that makes for repetition and sameness? Just *how* am I doing it? Just how am *I* allowing it to happen?

I see stalemate occurring when I am unwilling to share feelings with this person that may be personally threatening to me. When I am practicing "the psychology of the Other"[1] and saying to myself, "Let's keep the spotlight on the patient," I am so focused on questioning him and interpreting his accounts that I fail to put my presence *into* the relationship.

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1 Perls' term

> An older woman became progressively whining and petulant about her life situation. She expected answers from me, sympathy — always it seemed to be more than I was giving or could give. I found her unlikeable and did not tell her. I remained focused on her complaints and disappointments. After much restlessness on my part, and fantasies of transferring her, I decided to *meet* her! I shared the impact, what was *really* happening to me. Her comment was, "Why didn't you tell me sooner?" My reply was, "I was afraid of my anger and that if I told you, you'd feel that I couldn't help you at all." I was able to like her or rather begin to like her, and she could talk about having similar repetitious impacts on others.

When the therapist fails to affirm his sense of impotence in the encounter, new information is truncated by recreating the "predicament that affords no escape" (that has brought the patient to us in the first place). When the therapist shares the facts and his feelings about the impasse, he subjects himself to considerable scrutiny by his patient, and tests his capacity for openness and change, and his strength to remain the model of relatedness he has been asking of his patient.

Breaking the Impasse

When I acknowledge with my patient that an impasse exists, it is quite important that I clearly indicate that it is a *joint* predicament. Too often the patient is burdened with the responsibility and forced to bear the "blame" alone. The therapist must accept the fact that he himself has reached the limit of his own flexibility or creativity. Often, just confronting the patient with the idea of a stalemate begins to put movement back into the relationship.

T: You keep smiling all the time. First I think that you like me, and then I think that I haven't done much to make you feel that way.
Pt: That's the way I am. I always smile a lot.
T: I don't like it; that's why I mentioned it.
Pt: That scares me . . . you smile a lot, you know.
T: I feel like I want to be nice to you, I guess. I didn't know I was smiling so much.
Pt: Most of the time. It makes me feel good when you smile.
T: Now I see that I smile to keep you safe, and me, too!
Pt: Safe? I don't get it. I can't hurt you, can I?
T: I'm afraid you're going to blow up one of these days and I won't be expecting it. I've had some times with you when I wanted to scream at you, "Stop all that damn smiling, will you?"
Pt: I didn't know you thought *that* way about me! You sit there being so nice all the time . . . that gets me scared and kind of, oh! I don't know what, but sort of, kind of, hurt; maybe I'm annoyed with you.
(The interchange leads to more intense feelings and expression for both of us.)

This beginning interchange is one in which we share in a joint examination of our mutual contributions. It leads to more intense feelings for both participants, and helps us accept our parts in the joint predicament.

The focused fantasy or "directed daydream" is an approach described by therapists such as Assagioli, and Hammer. It involves the patient in visualizing certain typical

scenes[2] and allowing the fantasy to unfold. In this use of the directed daydream, the therapist is usually only a facilitating agent. At the conclusion, the therapist may provide interpretation, encouraging the patient to make interpretations. In Assagioli's summary, we find a variety of visualization settings which the therapist can suggest for the beginning of the daydream. This technique, originating in an analytic framework, offers the therapist an opportunity to adapt a primarily experiential, projective method to his own creative use. By introducing himself into the patient's life style and projecting this into his own familiar settings, he is able to make an internal comparison by juxtaposing the two life styles. The focused flight enables him to bring new meaning and awareness into the stalemated relationship and to give both persons new possibilities for acting.

Following some of the suggestions of the above writers, and using my own "imagination," I deliberately focus on fantasies about my patients. I engage in these fantasies when I find that I have exhausted other means of trying to break the impasse. It is now past the point where I have experienced, acknowledged and communicated the feelings and impact of the impasse. The interchanges that have followed have been experienced as more repetition.

> Rick and I have not been growing in our encounters. I find him stolid, constricted, angry at me for not getting him out of his "lowsy, dull state." I am angry and have discussed this, and he is on the verge of leaving. I have begun to accept this. We have talked about the stalemate in great detail. We are caught in a cycle of boredom, resentment, anger and disappointment. In this session, I close my eyes and "see" him in my office. I let him act and move. He gets up and comes over and sits on my lap. As I reach out to hold him, he pushes me away. He seems sad and I am disappointed. I open my eyes, and in reality, tell him of my fantasy. He is embarrassed. I am uncertain and hesitant. I ask him to do what I had him do in the daydream. He is very reluctant and I push him to sit on my lap. When he does, he is very stiff and ashamed. I put my arm around him and he resists greatly. Suddenly I feel his own wanting for closeness and his sadness, and it seems very intense. I cry and he does also. He hugs me desperately.

In this sharing of the fantasy, we seem to *introduce possibility* where hopelessness existed. We do it *together*. The patient in the above example returned to this kind of contact with me on several subsequent occasions at his suggestion; I did likewise.

In varying the focused fantasy, these are some of the "scenes" that allow me to experience the patient and myself in new relationships:

1. Patient in my office alone; as my therapist; in a costume.
2. Patient and I in his home; with specific members.
3. We are in my home; talking to my family.
4. We are walking across a field; patient with an animal.
5. We are climbing a difficult mountain together.
6. We dive into the depths of the ocean.
7. We go into a house together, the patient leading the way.
8. Patient is in therapy with an admired colleague relating his dissatisfaction with me.
9. In addition, using Frankl's suggestion of the deathbed scene is often very productive.

With regard to the deathbed scene:

> I find myself in that fantasy telling a young, detached engineer who is bland, agreeable and very repetitious that I wish that he had shown some interest in me. I am disappointed

2 e.g., meadow, house, mountain, blank wall; cf. Assagioli

> that he never asked me about my interests, my politics, or my feelings. When, in reality, I relate this fantasy to him, he is amazed that I have such a need. He tells me of his expectation of me, namely, that I listen, and will not act or feel about him. When I encourage him to get curious about me, to think about what he doesn't know about me, he is immediately enlivened. He is able to argue with me when he hears a contradictory opinion, and now can talk of his own fears and inadequacies in encounters with males, including me. I am finally *really* interested in this person.

The focused fantasy is another way of discovering the multiple impacts the patient is having upon the therapist. It also can provide awareness of the impact that the patient wishes his therapist to make upon him. In the fantasy, I go beyond what the actual relationship is like, discovering something new in me, and something new about the patient. The use of the focused fantasy is facilitated by experiences in which the therapist has been helped to engage in such imaginative activity himself. Practice leads to more fantasy possibilities, better visualization and concentration. However, long, involved fantasies are not necessary or desirable. The intent of the approach is to develop possibilities for discussion and action *in* the encounter with the patient. Merely one new image of the patient, one new act by him, a new attitude or action on the part of the therapist in the fantasied relationship often creates a new possibility and breaks the impasse. The brief fantasy, then, has considerable heuristic value for the encounter.

Summary

In an encounter framework impasse occurs when one or the other participant comes up against his own anxiety and creates a barrier beyond which he will not pass. The repetition exists to help avoid impact, which, if faced would require one or both parties to experience aspects of self that would be very different and frightening. One of the parties must take the courage to face into the impasse, to encounter in *this* moment this non-action. It is the courage in the passing through that causes change — to know, despite the risk, that two people together could stand in the intensity of the moment. The sharing together of the mutual responsibility for the stalemate and the discovery of the fantasied possibilities allows for new images, new vistas, and new alternatives and feelings in the relationship. ▼

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2. Frankl, V. E., *Man's search for meaning*. An introduction to logotherapy. Boston: Beacon Press, 1962.

3. Hammer, M., The directed daydream technique. *Psychotherapy, 4:* 173-181, 1967.

Fall, 1968

Leonard I. Stein, MD

Dr. Stein was born in Connecticut in 1929, and after frequent moves his family finally settled in Madison, Wisconsin. After receiving an M.S. in Botany and serving in the Army in the Far East he decided to go into medicine. He received his M.D. in 1960 from the University of Wisconsin. After interning at Los Angeles County General Hospital he returned for psychiatric residency to the University Hospital at Madison, Wisconsin. His professional interests lie in psychotherapy, in learning how to make the study of human behavior alive and exciting to students, and in clinical investigation of interpersonal relationships. He likes to play tennis but most of all he enjoys the time he and his wife spend sailing. He looks forward to the time when his three children will be old enough to join them on the boat. He is Assistant Professor in Psychiatry and Director of the Psychiatry Out-Patient Department, University of Kentucky Medical Center, Lexington, Kentucky.

The Threat of Suicide
A Therapeutic Barrier

"Hello."

"Dr. Stein, I am very sorry to be calling you at home at this late hour, but I feel awful and I just have to talk to you."

"You sound upset, Nancy. What's happening?"

"I'm feeling pretty awful — I know I've been in therapy for only a month but things seem to be worse — I really have to see you. I'm afraid if I don't see you now I'll do something to myself — — — I'm afraid if I can't see you tonight and talk this 'thing' out, I'll kill myself."

***

With the words "if I don't see you tonight I'll kill myself" reverberating through my head I feel a vise tightening down on my body. A thousand thoughts and feelings, jumbled together, coming all at once, are racing through my mind.

***

It was a party — I was in the second year of my residency training. The wives were in the living room and my fellow residents and I were standing in the kitchen. I could hear the tinkling of the ice in our glasses, the laughter and the conversation. We were recounting the stories we had heard of how the "master therapists" handled the threat of suicide. "So you're going to end it all. Okay, but if you kill yourself I will cancel your appointments and not see you the rest of the week." And another — "Thinking of jumping off a bridge? My, that's interesting. I've never had a patient suicide that way before. Would you consider doing me a favor? I am very interested in your fantasies about death, bridges and water. Would

you, before jumping, free associate to those words on paper and mail them to me?" In both cases, of course, the patients returned to therapy and are now extremely successful executives who are able to have marvelous orgasms . . . But, for me, at this moment, these solutions don't seem right at all.

***

Hardly a second had passed and I could feel her pain. It was as if I were holding her hand rather than the phone, and my hand gently tightened on the receiver. The thoughts and feelings continued to whirl through my head.

***

I was in the middle of a debate — it was in the third year of my residency. The question: "Does a person have the right to kill himself?" My stand on the question: I have long forgotten. The issues: Physician responsibility vs. individual autonomy. Is there a difference between the man with a terminal illness who with a "clear mind" makes this choice, and a man in the depths of a psychotic depression? Isn't it true that one must be psychotic to kill himself? Isn't it true for a man to be truly whole he must possess the prerogative to end his life? The scene shifted from the debate to my office. George, a 45-year-old man who had experienced great success in business, was sitting across from me. His head was buried in his hands. He could hardly speak or move. When he did talk the words were listless and his phrases seemed separated by eons of time. "I can't go on . . . , I am stuck . . . , I am worthless . . . , there is no way to turn . . . , no way out . . . , I want to die." I don't remember what I said but I do remember that whatever it was, it didn't register. I couldn't get him to engage with me — he continued to talk of his wish to die. I remember the blur of phoning his wife, the hospital, and escorting them to the ward . . . Nancy is not like George; the hospital is not the answer.

***

My hand is moist on the receiver. My thoughts race. Oh, how I wish you didn't mention suicide. Then perhaps we could have gotten together tonight. I am trying hard not to take the easy way out by saying, "Okay, see you in my office in fifteen minutes." But then, maybe, that is what I should do. She is hurting, she needs someone *now;* or maybe *now* is just the time she can learn that she can get through this on her own ... I remember Jane; for her the possibility of suicide was almost a daily struggle.

***

There were many times when Jane left my office that I wasn't sure that I'd ever see her alive again. There were indeed times when I whispered a silent, sad farewell as she left the room. Earlier in her therapy I had made a decision. I decided against a therapy that was primarily nurturing; although that approach would greatly diminish the possibility of suicide, it would rob her of the potential to grow. I decided on a therapy that would provide the environment for growth but also would have greater risks for suicide. I guess it really can't be any other way — growth always involves risks. For a long time Jane was convinced that I continued to see her because I had no choice. "You don't really care about me," she would say, "you don't want me to kill myself because it would look bad for you." A core issue was her feeling that I didn't *choose* to see her but

was *forced* to by her potential for suicide … I remember a great deal of talk about the difficulties of therapy when the patient is forced into therapy against his will. I believe, however, a greater barrier is the patient's feeling that the therapist has no choice, but is forced to see him. This is a barrier that must be broken through in every therapy. This barrier, however, takes on monumental proportions when working with a patient who threatens suicide. Often the threat arises out of feelings of worthlessness; the patient feels you couldn't possibly want to see him, so he attempts to force you by threatening self-destruction. If you allow yourself to be forced into the relationship, your resentment will inevitably build up, the patient will sense it, and it will reinforce his feelings that you really don't care — you are indeed with him because you have to be, not because you want to be … I shall never forget the turning point in Jane's therapy. She was very depressed that day. She talked about her feelings of hopelessness and told me that the only alternative she could face was death. I remember being overcome by a feeling of sadness; I felt her absence and experienced grief. I heard myself saying, "Jane, I am going to miss you very much." I remember her looking up; there were tears in her eyes when she said, "I believe you." It was on that day and at that moment the barrier began to break and Jane began to grow.

***

Only a moment has passed since Nancy's plea to have a therapy hour. I feel I know her well enough to make a tentative decision on the structure of the therapy. "Nancy, if I see you tonight, it would be because I felt forced to. And, dammit, I don't want that to be the basis of our relationship. I see you because I want to and I take for granted you see me because you want to. I don't want that to change. I know you are hurting now and I feel some of that hurt myself. I'll look forward to seeing you tomorrow as planned." The hesitant voice coming back thunders in my ears, "But I'm really worried I may hurt myself."

"I know you are feeling that very strongly. Why don't you see how it goes over the next couple of hours. If you really feel you're going to lose control, call me and I'll arrange to get you in a hospital for a day or two. I'm sure that's all it will take for you to feel in control again."

Her voice returned this time with a slight bite, phrased as a question but voiced as a statement, "You won't see me tonight."

"No, I won't. Call if it gets too rough."

There was a hesitation then the reply, a mixture of hurt and obstinance, "I am not sure."

When I heard the click of her receiver, I slowly lowered the phone.

***

I am having a hell of a night. Sleep won't come. Convincing myself that what I did was best for her in the long run isn't helping. Memories keep sleep away … I am remembering the first time the resident class met with the chairman of the department. He was saying, "You are about to enter the toughest specialty in the practice of medicine." I was fresh out of a very trying internship and frankly didn't believe him, but it wasn't long before I knew what he meant. Now I lie here worrying and doubting … I look forward to tomorrow.

Inviting the Unconventional

Summer 2023

Call for Papers

Deadline for submission: April 15, 2023

Direct questions and submissions to the editor, Carla Bauer, LCSW
crbauer01@bellsouth.net

See Submission Guidelines on the AAP website: **www.aapweb.com** or in any issue of *Voices*

We are living in uncharted times. As psychotherapists, we are tasked with both joining and shepherding our clients in making meaning of the chaos. The upheaval of old systems and questioning of the status quo afford us an opportunity to be curious about new and old clinical tools to unpack the subterranean internal world and inform healing and growth – including the unconventional. Some of these therapeutic interventions or philosophies may be seen as either alternative or unconventional, yet this full palette of approaches creates potent opportunities to treat the whole person.

For this issue of *Voices,* we accompany the co-themed 2023 Institute & Conference in exploration of the ways that psychotherapy is adapting, experimenting, or evolving to embrace the new, the unconventional, and the chaos of our times with its challenges to prior cultural conventions and modes of psychotherapy. How do we both remain true to our clinical values and orientations and adapt to remain relevant in changing times?

Consider: How has your practice been challenged by the changing times – your understanding of clients and of social or cultural conventions, your approach to your clients' processes of meaning-making and growth, or your previous techniques and models of therapy? What new therapy techniques have you tried to help clients process the upheaval of old systems and status quo and embrace the new and/or unconventional? What worked; what did not? What was hard to embrace; what felt seamless? What first felt too unconventional but perhaps, once tried, became a new practice standard? How has the status quo of your own practice changed?

Consider: How has your awareness of multiple layers of diversity and identity held by both clinician and client evolved? How have previous psychotherapy theories (e.g., psychodynamic, object relations, and self-psychology) been re-examined and rewritten through diverse lenses (i.e., BIPOC, women, members of the LGBTQ+ community)? What ethical considerations have you encountered when practicing in new therapeutic styles or responding to challenges to the status quo?

How has your personal development or "person of the therapist" been impacted by innovation and stagnation in the clinical process? How else have challenges to the status quo in your life and person beyond practice impacted what you bring to your work? ▼

Voices welcomes submissions in the form of personal essay, research- and case-based inquiry, poetry, art, cartoons and photography.

Submissions are to be in a Word document, 12-point font, double-spaced, in APA Style, with a 4,000-word maximum. Author's name should not be in the manuscript as all are subject to blind peer review.

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Each issue has a central theme as described in the call for papers. Manuscripts that fit this theme are given priority. Final decision about acceptance must wait until all articles for a particular issue have been reviewed. Articles that do not fit into any particular theme are reviewed and held for inclusion in future issues on a space available basis.

Articles. See a recent issue of *Voices* for general style. Manuscripts should be double-spaced in 12 point type and no longer than 4,000 words (about 16 to 18 pages). Do not include the author's name in the manuscript, as all submissions receive masked review by two or more members of the Editorial Review Board. Keep references to a minimum and follow the style of the *Publication Manual of the American Psychological Association, 5th ed.*

Submit via email, attaching the manuscript as a Word document file. Send it to Carla Bauer *(crbauer01@bellsouth.net).* Put "Voices" in the email's subject line, and in the message include the author's name, title and degree, postal address, daytime phone number, manuscript title, and word count. Please indicate for which issue of *Voices* the manuscript is intended.

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