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Harry Stack Sullivan:

*From Interpersonal Psychiatry to Interpersonal Psychoanalysis**

WE ALL HAVE OUR MYTHS of the primal ancestor. Traditional psychoanalysis has Freud: we have H. S. Sullivan. In both cases, a great deal of fancy hermeneutical footwork is necessary to maintain tradition and continuity: to show that—what the founder meant, should have meant, would have meant had he lived—is what we are claiming today. I never met Harry Stack Sullivan; he died in 1949, several years before I entered the William Alanson White Institute. However, I did work intensively and enthusiastically with many of the people who knew him well and were great proponents of his work. So, I suppose that qualifies me as an early disciple, if not a true Apostle. Someone once said—rather sourly—that one gets the disciples one deserves.[1] I don't know whether Sullivan would endorse my particular brand of interpersonalism; but I do believe that what I have to say is an extrapolation of Sullivan's position.

As I pointed out in *The Web and the Spider* (1984), Sullivan made no claim, as did Freud, to being the Lonely Hero, on a quest.[2] Sullivan (to quote myself):

> did not claim to work in heroic isolation. He was, in a very significant sense, a conduit for many other people's ideas. One might claim, with a high degree of paradigmatic consistency, that if Freud was the singular architect of a great psychological edifice, then Sullivan was the processor, or collator, of the immense informational explosion of the thirties and forties (Levenson, 1984, p. 175).

I would like, first, to delineate Sullivan's position, then illustrate how his essentially open-ended postulates—which he scrupulously defined as Interpersonal *Psychiatry*—can be, and were, extended into a contemporary interpersonal *Psychoanalysis*. I really do not believe this was Sullivan's doing *per se* but rather, was the result of the merging of his American pragmatic psychiatry with European psychoanalysis through the contributions of his colleagues, especially Thompson, Horney and Fromm.[3] This is not to say that he was uninterested or uninformed about psychoanalysis (he had, after all, urged Clara Thompson to study with Ferenczi in Budapest). But, as I shall elaborate, his vision of therapy differed sharply from the psychoanalytic which is based on the centrality of the concept of transference and counter-transference. For all of a certain lip-service to the idea of transference, I would claim that Sullivan's insistence on the centrality of anxiety constrained his use of the therapist/patient relationship to a significant degree.

Sullivan's concepts may be divided loosely into three categories:

(1) Anxiety (in the very specific way Sullivan used the concept), including its major instrumentality *the self-system*, and the consequences of anxiety; namely, *selective inattention, dissociation and parataxic distortion.*

(2) The nature of the patient/therapist relationship; namely the function of *participant-observation* and *consensual validation* (Havens, 1976).

(3) The concept of man, which underlay Sullivan's system. First, the dictum that we are all more simply human than otherwise; that is, more alike than different. Secondly, Sullivan's rejection of the concept of unique individuality; at least, as an appropriate subject for psychoanalytic inquiry. And thirdly, his vision of psychoanalytic cure, which was not coterminous with social cure. Psychoanalytic cure occurred when the patient's self-image was enriched and without major "parataxes," without distortion. "The patient as known to himself is much the same person as the patient behaving with others" (Sullivan, 1953b). Social cure was an-

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[1] See Phyllis Grosskurth for an account of Freud's travails with his disciples (Grosskurth, 1991).

[2] There is, of course, ample evidence to suggest that Freud, too, had his antecedents (Sulloway, 1979; Yerushalmi, 1991; Rice, 1991).

[3] See Bromberg for a particularly lucid presentation of these issues in training at The White Institute (Bromberg, 1991).

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other issue. It involved will, agency, the desire to translate what had been learned in therapy to the world of outside relationships:

> The problem of the psychiatrist is more or less to spread a larger context before the patient insofar as that succeeds, the patient realizes that, anxiety or not, the present way of life is unsatisfactory and is unprofitable in the sense that it is not changing things for the better; whereupon, in spite of anxiety, other things being equal, the self-system can be modified (Sullivan, 1953a, p. 302).

Sullivan's concept of anxiety is the linchpin of his entire system of psychology. "Insofar as you grasp the concept of anxiety as I shall be struggling to lay it out before you, I believe you will be able to follow, with reasonable success, the rest of this system of psychiatry" (Sullivan, 1953a, p. 8). First, it is not what we ordinarily think of as anxiety, but rather an experience of such catastrophic dimensions, so utterly disorganizing, that the patient will do almost anything to avoid it; no "satisfaction" is worth the risk to what he called "security needs." Secondly, anxiety is interpersonal and contagious. Anxiety occurs in the infant and child because it is being provoked in the necessary Other; and, it is the empathically communicated anxiety of the Other which floods the dependent child. The subject develops an instrumentality for detecting, avoiding and "inattending" those occasions which might precipitate anxiety. This is, of course, Sullivan's famous *self-system*—not synonymous with the self, as self psychologists conceive it; but rather an early warning system. Anxiety, then, is not caused by repression of forbidden impulse; but by fear of the Other (or, more accurately, fear of the other's fear). Intrapsychic fantasy is more the reflection of interpersonal events than the cause. This vision of interpersonal anxiety is so radically different that, as is often the case with paradigmatic change, it is totally misunderstood or bowdlerized into another version of the "same old thing."

So, anxiety is avoided through the operations of the self-system which identifies and avoids those interpersonal crises which would elicit anxiety, and, in addition, establishes an amnesia, or scotoma, for these occasions—Sullivan's "selective inattention." The patient simply averts his/her eyes. In more cataclysmic situations, a total dissociation may take place, without that marginal awareness of 'knowing that there is something one is not supposed to know'

which is present in selective inattention. This is an extremely important distinction between inattention and dissociation. In the former, the person may avert his/her eyes, but the self-system knows and operates strategically to avoid anxiety. In dissociation, the unawareness is total. The person profoundly does not engage the issue.

Interpersonal praxis, then, works to catch those moments of nodal inattention, to inquire into what is unspoken, and then to speak the unspeakable. To not ask—to not think to ask—is the index of the therapist's anxiety and consequently counter-transference. It is true that one may have powerful and discomforting emotions towards patients—anger, boredom, sexual feelings. But, these feelings are accessible, often justified and ultimately workable and useful in therapy. The real sins of counter-transference are sins of omission. Damaging counter-transferences are those which operate out of awareness. I would emphasize that the purpose of the detailed inquiry is not simply thorough history taking, but probing and provoking the self-system, attempting to find out where out-of-awareness takes place, where anxiety lurks; and, by virtue of what the therapist asks or does not ask, defining the parameters of the therapist's participation.

This concept of interpersonal anxiety remains largely intact and absolutely central to understanding contemporary interpersonal psychoanalysis. It is Sullivan's formulation of the relationship of patient and therapist that has undergone the most change. "Consensual validation" and "participant-observation" both clearly imply a mutuality; not one person (the therapist) observing and correcting the second person (the patient). As Racker put it, "The first distortion of truth in 'the myth of the analytic situation' is that analysis is an interaction between a sick person and a healthy one" (Racker, 1968, p. 132). Yet, for all that, Sullivan clearly left himself out of the equation. It was the patient's reality which was at question and the analyst's role was to help him/her distinguish between what was veridical and what was distortion, "parataxic distortion." The analyst monitored very closely his/her own anxiety level to avoid bouts of selective inattention which would compromise his/her clarity of vision and purpose and provoke excessive anxiety in the patient. But, who the therapist is, was not at issue; the patient *qua* patient is defined by the assumption that he or she is distorting the therapist. Sullivan had no doubt, whatever,

that the patient suffered from "parataxic distortion," and consequently misread and misinterpreted the therapist.

The contemporary preoccupation with the nature of reality (naive reality, social constructivism, pluralism) is not apparent in Sullivan. It seems clear that the praxis of therapy is to bring the patient into line with a consensually validated view of the world. When the patient sees himself as seen by others, the therapy is over. The function of the therapist, then, is to participate with the patient sufficiently to act as a guide through the thickets of distorted experience. One gets the decided impression that Sullivan discouraged patients from getting too interested in him or too curious about who he really was. His famous dictum about erotic transference was unequivocal.[4]

There is, in *Clinical Studies in Psychiatry* an excellent example of Sullivan's way of working, albeit as supervisor (Sullivan, 1956, p. 371–372):

> The first case is then that of a schizoid—a young married woman who is extremely tense, apprehensive, and inarticulate. Her main difficulty, as she describes it, is that she is an inefficient housekeeper who "lazes" most of the day away. She looks on herself as a failure. Treatment in the case has bogged down, after several months and the question is, what techniques can be used to get things moving again?

As it develops, she is the product of an extremely traumatic childhood, deserted by her mother, and eventually abandoned to her maternal grandparents by her father. She was very gifted intellectually, and, despite her disadvantages, went on to a doctorate in economics. She married a fellow-student in the same field and subsequently sank into a morass of domesticity, giving up her career and submitting to a husband who criticized her mercilessly, and boasted openly to her about his sexual conquest of other women. She had two children during the course of this deteriorating marriage and now her husband was threatening divorce.

It must certainly strike us, in our times, as odd that it never occurred to the therapist that this woman was taking an awful

[4] To a woman patient who expressed erotic interest in Sullivan, he informed her that when he developed interest in someone, he wanted it to be *with a real person!* (White, 1977). "If you go to have your watch fixed, you don't have to fall in love with the watchmaker. People come to me to have difficulties in living untangled—that is what I do" (Kvarnes, 1976, p. 216).

beating in the marriage; or, if it did occur to him/her, it was undoubtedly considered an epiphenomon of her masochism. Sullivan focused immediately on the pragmatics of her life's circumstances, working on the premise that to understand someone, one must begin by assuming that he/she makes sense. Why didn't she hire a part-time maid? They could afford it. Then he inquires politely into how, with a doctorate in economics, she wound up being a housewife. He does not attempt to bring her into touch directly with her resentment against her husband. He expects that there will be resistance to accepting that, because of the inherent anxiety provoked in her by challenging her husband. If she upsets him, she upsets herself and her security is dangerously compromised. She is aware of how fragile he is and is terrified that he will, if pressed, take flight.

So, Sullivan goes into what he calls "the middle distance" (Sullivan, 1956, p. 375), circling in very cautiously, allowing her to arrive at her own conclusions. He shows, very strikingly, a respect for the patient's privacy and anxiety which was, I believe, an unexpected clinical hallmark of this often cantankerous and abrasive man. His intent is to get her to see what she has been avoiding seeing, because of the disruptive anxiety inherent in seeing. This is done carefully, circumspectly, allowing her to encounter her anxiety in small increments. It is also of note that he does not trash the husband or mythologize him as The Bad Parent. Sullivan is sensitive to the husband's anxiety as well as the wife's. It is hoped that consensual validation promotes her sharing Sullivan's view of life which is presumably more open and benign than hers. His participation consists largely of an exquisite sensitivity to her anxiety and to her self-protectiveness. There is absolutely no sense that Sullivan is bringing himself—in any personalized way—to bear in the treatment.

What, if anything is wrong with this? It is entirely consistent with what he said about what he did in therapy. It is not what some of us would do now. The clinical case presented seems far too simple: to wit, Sullivan gets her to see what she has been avoiding in her life, She is then relieved of her symptoms, through his validation of her abused life, and is freed to approach her husband differently, possibly to his relief. The clinical experience I believe most of us have in our therapies is that after this clarification of distortion and mystification in her life, instead of

getting better the patient resists the insight, and transfers the mechanism of defense to the therapist. We become part of the disease we had set out to cure. It was Freud's great insight that this resistance and transference, rather than being simply a frustrating obstruction to change, is the *sine qua non* of psychoanalysis. Indeed, Freud said, "Any line of investigation, no matter what its direction, which recognizes these two facts [resistance and transference] and takes them as the starting point of its work may call itself psychoanalysis, though it arrives at results other than my own" (Freud, 1919). If the patient responds successfully to a benign authoritative interpretation (albeit masked as inquiry), it is psychotherapy. Psychoanalysis begins where interpretation fails. It is defined, both by its recognition of the essentially antagonistic relationship between the patient's defenses and the helper, and its insistence that the adversarial relationship be made manifest and interpreted in the relationship.

We would expect the patient to relate to Sullivan with the same degree of masochistic submission she showed her husband, after an initial "honeymoon" period when there would be wonderful improvement. We would expect that Sullivan would soon begin—despite his scrupulous intent—to feel irritation and contempt for her. "Of course," chortles the Freudian analyst, "You've just proven my point! The interpersonal is subordinate to her intrapsychic conflicts. Therefore, the most solicitous, respectful analyst will come up against the self-perpetuating nature of her masochistic defenses." But, remember that resistance and transference can operate against the Other as well as internally. Perhaps the patient resists Sullivan and incorporates him into her system because she does not believe that he is any different from her husband. Perhaps his help, however carefully framed, is seen by her as obvious and patronizing. Her self-system does not so easily trust Sullivan's intent. Sullivan's commitment to the idea of Self as the sum of interpersonal interactions and his dismissal of an intra-psychic component to personality would make it difficult to conceive of a patient actively resisting awareness, once the anxiety was reduced to a manageable level. But, if she "transfers" to the therapist, if what happens between them becomes a transform of what they are talking about in her life; then, one might expect that she would be exquisitely attuned to the therapist's needs, especially in the realm of self-esteem and potency. The self-system is a master

strategist and an opponent of the therapy, by no means limited to the more primitive device of inattention, of looking away. Her self-system actively probes the nature of the therapist, feeling for his anxiety spots, his defenses.

Paradoxically, Sullivan's treatment of the therapist/patient relationship may have been, in some ways, closer to the Freudian view than to present interpersonal psychoanalysis (or, at least, my version of interpersonalism); inasmuch as he attempted to show the patient the distortions inherent in his/her perceptions by a carefully monitored neutrality. Like the Freudians, he apparently felt that transference was resistance and interfered with the therapy. As did the Freudians, he interpreted away from transference, to what he conceived to be the key issues in the patient's life; i.e., the patient is told that the focus on the analyst—particularly, the distortion implicit in that focus—is an avoidance of the patient's true issues. "The solution of the transference, resolution of the transference, which is so important in certain psychotherapeutic problems, has, I think, in my case, *usually preceded the appearance of the transference*" (Kvarnes & Parloff, 1976, p. 216, my italics).

In the meager corpus of Sullivan's clinical cases, it would appear that he attempted to minimize the impact of his particular personality. He pays meticulous attention to "counter-transference," but it is only to get it out of the way of the patient. There is no sense that the unique personality of the therapist really matters. Indeed, much of what he tells supervisees to tell patients seem mordant, focused, extremely clever observations about the patient; or about areas the therapist is inattending. The general motif seems to be that therapy depends on the therapist's attunement to the patient's anxiety and you—the supervisee—are not attuned enough. Why this particular patient should be having trouble with this particular therapist does not enter the arena of inquiry. At the risk of offending Sullivanians, I must say that I find the clinical examples disappointing, and in many ways, clever grandstanding at the expense of the therapist (see Kvarnes 1976, Pearce 1950, Sullivan, 1956).

Both "consensual validation" and "participant-observation" are really oxymorons. The moment one participates, one has lost any absolute claim to clarity. It is axiomatic that no self-referential statement can ever be proven to be right or wrong. All the participant can know—and that with difficulty—is his/her own experi-

ence of the interaction. The claim that one can participate and still be a judge of the other person's assessment of reality is questionable. It seems to be that Sullivan's position was paradoxical. Either one claimed to be able to make judgements from a superordinate position; or, one gave up the attempt and simply studied the interaction of two persons engaged over an issue, without either position claiming hegemony. With the cases above (Sullivan, 1956), one might reasonably claim that Sullivan did exactly the former; i.e., made an assessment of her life from a position of greater clarity than she possessed. But one might equally reasonably claim that once Sullivan gave her his assessment, he had entered into an interaction with her which was inevitably beyond his total awareness or grasp; and, which depended, not just on what she brought to it, but his own personality and defenses. The cardinal issue might well be, not the truth of Sullivan's observations about her, but their interactional meanings. What is the metacommunication: i.e., the communication about the communication? Is it that Sullivan is telling her something she has "inattended" about her life—that she is disastrously submissive? Or, is it that he is establishing himself as a "Good Daddy," a male authority who thinks that women should use their brains? This is a paradox very familiar to feminist writers in this field who are sharply attuned to the implication of paternalistic authority, no matter how benign or therapeutic the conscious self-regard of the therapist.

It is extraordinary how arrogating and out of awareness is the assumption, mutual really, that the patient is a "patient"; knows nothing about what is bothering him or her, and, for a successful recovery, needs to be a good patient and "open up" to the therapist; who will then figure out what the problem is.

Sampson presents several cases of patients who appeared to be quite knowledgeable about their own dynamics and even improved considerably after making their own formulations (Sampson, 1991). But psychoanalysis requires a psychodynamic explanation, which Sampson provides. Occum's razor is not in the psychoanalytic armamentarium. Yet, if one examines the case reports, the patients suddenly sounded insightful simply when Sampson asked for their assessments! He reports on a woman who has had three previous analyses; six years, nine years and three years respectively. In the course of the therapy, she asks him if he is

angry and he says, "No." She experiences this as an absolutely novel event—an analyst who simply answered a straightforward question, instead of the usual sanctimonious and superior, "Why do you ask?"

From this perspective, Sullivan would need to work through his own participation, his own experience with women, with women with this kind of problem, his reasons for treating her (he was the supervisor, not therapist), even his reasons for being a therapist.[5] As Gill put it:

> A major disappointment for me on reading Sullivan is his relative failure as a therapist to attempt to make the unspoken aspects of the interpersonal interaction explicit as a central aim of the therapeutic process. Perhaps to do so would have required a kind of participation which he could not permit himself. It could be that the very factor which enabled him to perceive that man is quintessentially a social animal was the same that restricted the types of interactions which he could interact with others comfortably (Gill, 1982).

At this point, we have entered the tarpits of constructivism. What is reality? Who can claim to know it? Why is my reality any better than yours? I believe that Sullivan felt clearly there was an external reality, separate from patient and therapist and possible of consensual validation. It was the function of the therapist to help the patient give up his/her distortions and enter the real world. This world was, itself, a matter of consensual validation; inasmuch as Sullivan seemed to believe that there was a community of people living without major distortions in their world. For Sullivan getting well, being normal, was seeing the world the way it was—which was the way normal people saw it. It was this conservatism, this acceptance of the status quo which offended Erich Fromm and caused him to accuse Sullivan of selling out to Mammon. Sullivan apparently felt that being normal—being able to have intimate relationships, avoiding terrible loneliness—was a greater imperative than eschewing seduction by a marketing culture. About that, Sullivan apparently couldn't have cared less.[6]

[5] One need only read Perry's biography of Sullivan to be aware of some of the personal blind-spots and limitations he would bring to working with this particular woman (Perry, 1982).

[6] Again, one must read Perry's biography for the story of his short-lived psycho-

I suspect that he worked on the premise that to understand someone, one must specify and respect his/her view of the world; not necessarily agree with it. It is perhaps his greatest legacy that he led us to see even schizophrenic patients as essentially logical, operating sensibly out of their world-view. Certainly he was a social constructivist inasmuch as he believed reality was socially constructed. Perhaps this would leave him closely allied with the self-psychologists who protect and respect the patient's "psychic reality"; which, as I've said before, seems to me respect for the patient's right to his/her own viewpoint even if it is wrong! I am not struck by the propensity of self-psychologists to assign equal credibility to their view of the world and the patient's (Levenson, 1985).

This is an issue on which I am very unclear and have, no doubt, waffled mightily, earning the disapproval of committed constructivists who at first welcomed me and then decided that I was a "naive realist" (Hoffmann, 1990). It seems to me that there *is* a reality "out there" which can be mutually validated. Real things happen to patients and can be subject to amnesia or partial screen representations. Discovering these events is important.[7] And yet, how I see what the patient tells me, what I do not think to ask about, what values I implicitly communicate are also important, essentially because the patient dare not, in the course of the therapy, talk about those things which will make me anxious. Challenging someone's view of the world produces an existential vertigo and anxiety. This is as true for the therapist as it is for the patient. To assume that the therapist, because he or she is the therapist, has less potential for anxiety than the patient may be a serious misjudgement. Therapists do tend to be more comfortable about being therapists than patients are about being patients; but, that may be because the therapist is armored and protected by the relative anonymity of the role, and by the careful circumspection of the psychoanalytic frame. Why I am a therapist, why I treat this

analysis with Clara Thompson, who was, I suspect, terrified of him. When she objected mildly to his profligate spending of money he did not have for Persian rugs and furniture, he denounced her as "too bourgeois" to work with him—and stamped out (Perry, 1982)!

[7] This does not justify assuming that one's favorite event underlies the screen memory. One need only recall all the presumptive "primal scenes" evoked by enthusiastic analysts; or, maybe now, implicate molestations.

particular patient must be explored. I was very struck, listening to the early Sullivanians, particularly Fromm-Reichmann, to how little attention was paid to what might actually motivate a therapist to work with such extremely difficult and unrewarding schizophrenic patients. There was, in many cases, a powerful odor of sanctity which I cannot believe was ultimately helpful to the patient.

Who I am is central to the process, far in excess of the usual applications of "counter-transference" or blind-spots. My total personality is at issue. I suspect that the reason most patients are so resistant to change is that they fear that they will be used for the purposes of the therapist, who in spite of protestations of neutrality, may very well operate with his/her own agenda. That is why the initial detailed inquiry, or free associative approach activates resistance as anxiety is mobilized. Why should the patient trust the therapist? Because we think we are reliable? The patient is a patient because his/her life has been characterized by a loss of authenticity, by being used by other people for their own ends. The mutual exploration of the interpersonal relationship of patient and therapist works because it develops—over time—a sense of trust and respect for the integrity of the other (this cuts both ways). As the sense of safety increases, then the patient can remember to remember his/her own past and make it explicit in the therapy. The core of the therapeutic praxis may be just this development of a relationship of very considerable subtlety and complexity. The inquiry, the developing narrative, the elaboration of fantasy and dreams, are, I suspect, the context of the relationship: certainly vital to the curative process, but not the curative process itself.

I want to use another example of Sullivan's to reinforce the difference between Sullivan's emphasis on the management of the patient's anxiety, and a more contemporary view of interpersonalism as encompassing the unique personalities and experiences of both participants. This is one of the few dreams that Sullivan presented in detail. His approach to dream analysis is well known and unequivocally stated. Dreams which awoke the patient with an uncanny feeling of dread, he treated as incipient schizophrenic episodes and simply sidestepped. Other dreams, he felt were essentially parataxic communications whose referents could be better grasped by going directly to the source—the day residue (Sul-

livan, 1953a, p. 343). Why he so adamantly refused to use the rich symbolic content of dreams is not clear, but the following example might be relevant.

Sullivan (he tells us) had at one time a "really marvelous assistant," one with a great talent for working with schizophrenic patients (Sullivan, 1953a, p. 336). This young man "rapidly became not only my left hand, but, I suppose most of my upper left extremity." (Why the *left* hand, one might ask? Usually indispensable helpers become one's *right* hand!) This young man had become of interest to a "bitterly paranoid woman." He wanted to talk to Sullivan about his problems with her, which Sullivan felt was a sign of good judgement. "She seemed to be suffering from his very casual heterosexual life away from her, and I thought that such worries would grow if they were legitimized, and so on" (Whatever 'legitimized' meant. Besides, why shouldn't she be upset by "his very casual" sexual infidelities?). "Also," says Sullivan, "I didn't want him upset. He was far too valuable."

His assistant comes to Sullivan with a dream in which he is walking on a very small lush island set in an artificial lake, behind a dam, engaged in conversation with Sullivan. The lake is named Loch Raven, which may, or may not, be significant (it does lend itself to thoughts of "Nevermore"). Then he observes that the area of water between the island and the shore, over which they had stepped easily was rapidly widening. He awakes in terror, "finding himself leaping out of bed into a pool of moonlight." This is, for Sullivan, the prototypical proto-schizophrenic dream.

Sullivan then does a rather perverse thing: he refuses to interpret the dream for the reader, although he implies that he knows what the dream means but that, for the dreamer to know, would be catastrophic. He did exactly the same thing with his presentation of his own dream, the dream of the spider.[8] Yet, why is it so self-evident that the dream should be side-stepped? Suppose Sullivan had said to his assistant, "It sounds like maybe you feel you're getting rather isolated by our being so involved with each other." This does not raise the apparently interdicted, but obviously present issue of homosexual feelings the assistant may be feeling for Sullivan. Don't forget, he was working on a ward of

[8] For an extended gloss on that dream, see Levenson, 1984.

exclusively young male schizophrenics with a great deal of homosexual undercurrents.[9]

Moreover, by putting it "*our* being so involved with each other," the assistant is relieved of an implication of blame, or that the feelings are totally one-sided. By speaking the unspeakable, might not that have put the assistant's terror somewhat at rest? Might he not then have proceeded to distance himself from the isolating relationship with Sullivan and his implied sacrifice ("besides he was too valuable") to Sullivan's purposes as administrator of the ward? Shouldn't Sullivan—presumably picking up the drift of the dream, even why the dream was told to him—have quietly moved to allow the assistant more private life and more freedom to choose a heterosexual partner, even though he, Sullivan, thought she was "paranoid" and "unsuitable?" In a more general discussion of dreams, he says that, "Insofar as he (the patient) remembers it and communicates it, *he is seeking validation with someone else!*" (Sullivan, 1953a, p. 343 my italics).

Please note that this does not require that he discuss his own sexual proclivities, nor the not entirely selfless motivation which invests him in this young man's talents. But, at this stage of the inquiry, who Sullivan is, why he is interested in this man, what his own sexuality is, how he feels about women—particularly aggressive sexual women, how he feels about domesticity, how interested he is in the success of his experimental ward, who or what he would sacrifice for its success; all these issues and virtually anything else relevant about his personality become germane. Why not engage these issues? I cannot see why what appears to be a deliberate inattention to them is less anxiety-provoking than a direct and comfortable inquiry. It has been my clinical experience that patients do not panic or decompensate because they are forced to face an unpleasant and even horrifying issue. It is simply amazing what you can say to patients, as long as you are telling them the truth. Mystifying patients, not confronting them, is what drives them crazy because they know what they are not supposed to know they know; and they are "inattending" that knowledge

[9] There was a good deal of speculation about the homosexual tensions on Sullivan's ward at Sheppard and Enoch Pratt hospital, particularly the apparent homosexual orientation of staff members (Chatelaine, 1981, pp. 445–58).

because bringing it into awareness would mobilize their anxiety and, far more dangerous, possibly mobilize the anxiety, rage and retaliation of their therapists who might well not wish their own vulnerabilities exposed. All this—it goes without saying—presumably operates outside the awareness of the well-intentioned and ethical therapist.

I suspect that, as Bateson put it, "The point of the probe is always in the heart of the explorer" (Bateson, 1979). Every metapsychology contains the seeds of an incipient counter-transference. There is no avoiding it and it must be taken into account by the epigones of a particular position. I would claim that Sullivan's vision of interpersonal psychiatry was bent and directed by his own security needs, as must be so for everyone, if we are, in truth, all more simply human than otherwise. His fastidious attention to the most marginal manifestations of anxiety and his premise that the patient would get better in a milieu of safety and respect for his/her limits, made it simultaneously possible for him to inattend and minimize the use of more intimate and personal interactions. The dictum is: if the patient can not bear it, then one must not confront it. What if the analyst cannot bear it?

One great virtue of Sullivan's theory, as I said at the beginning of this paper, is that it is not an all-inclusive and sacrosanct system. Consequently, one need not exercise the agonized casuistry we usually employ in our field to avoid being anathematized by our colleagues and institutes. A simple extension of his basic concepts—his attention to the basic pragmatics of human interaction—but carrying them farther than Sullivan might have found comfortable, leads us to a version of counter-transference now fitting well within a broadly defined rubric of psychoanalysis. The same attention to anxiety remains, but now the amelioration of anxiety does not depend so much on a careful avoidance of "too much" inquiry; as it does on clarification of the interpersonal relationship of patient and therapist—in all its manifestations.

I would emphasize that how far one goes in openly manifesting interpersonal egalitarianism and honesty is a difficult issue, and carries with it the same counter-transference traps I spoke of earlier. But, I would insist that an absolute minimum requirement is that the therapist be acutely alert to his/her own presence, with an acceptance of the inevitability that one's own needs, preferences, presumptions and limitations will come into play. This is not a

failure of therapy; it is the very essence of therapy. A perfect analyst—and some of our colleagues strive mightily to achieve that epiphany—would drive the patient crazy.

Sullivan established the paradigm for a truly interpersonal psychoanalysis; an accomplishment of great contemporary relevance for our field. He built his interpersonalism around monitoring interpersonal anxiety rather than unique and idiosyncratic interpersonal interactions. I believe this came as much out of his need to protect his privacy as it did out of a need to protect the patient. It is a simple next step to formatting the interpersonal process to include a much more extensive, and intimate, interpersonal interaction. The psychoanalytic concept of resistance and transference comes into play, not exclusively as a projection of the patient's fantasies, but as a virtual reenactment of the material under discussion in the relational field of the patient and therapist. Thus, the therapist scrupulously monitors his/her participation—not to get out of the way of the patient's fantasies—but as a transformation of the therapy process.

What is curative about all this? What is the "mutative" experience in psychoanalysis? I think we do not really know. There is certainly the patient tapping into his/her own *poesis*, the capacity for creative imagination (Levenson, 1988). There is—dare we say it—a corrective emotional experience with the therapist. But, most important of all may be the patient learning what the Vedanta says: that the meaning of an event is its consequences. And, consequences are quintessentially interpersonal and intersubjective. Ultimately, the meaning of my experience depends on its impact on you. If my benevolence has evil consequences, regardless of my intent, my act is evil. Ultimately, the legacy of Sullivan's theory may well be that it places, not just the patient, but the analyst, too, squarely in the interpersonal realm of inquiry.

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Fromm's Humanism and Rorty's Relativistic Historicism

THERE IS A DIFFERENCE BETWEEN recognition that the ultimate justification of our commitment to scientific method and scientific knowledge, as well as to moral and aesthetic values does not rest on anything but that commitment itself, and the inference that one commitment is as good as another. Commitments to courses of action, beliefs and evaluations, have consequences which require renewal of commitments or their alteration. Consequences matter. Richard Rorty would agree. But then, if consequences matter, why does Rorty deny scientific method and scientific knowledge a preferred epistemological position in relation to, say, literature? Literature is a valued product of the human imagination, useful for its intended purposes, but hardly as reliable a guide to intelligent action as the scientific pursuit of knowledge. One is led to think of Peirce's insistence that no intuition—literary or otherwise—is self-justifying.

It will be argued in this paper not only that Rorty is an historicist—a classification he accepts, but also that his position is one of relativism—something he prefers to deny. Further, I intend to rebut what I regard as the deleterious consequences of Rorty's relativism for ethics—the implication that there can be no cross-cultural criteria of moral values. In line with this objective, I have chosen to counter Rorty's ideas with those of Erich Fromm (1941, 1947, 1955, 1962, 1964, 1968, 1963), a thinker who stands out as one sharing many of Rorty's premises but who yet does not draw Rorty's relativistic conclusions. Indeed Fromm argues on the basis of pragmatic assumptions akin to those of Rorty that a scientific knowledge of human nature is possible. It is important to recognize at the outset however that such knowledge does not in itself also deliver knowledge of cross-cultural moral standards: whatever genuine moral standards there are in a given instance re-

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