SULLIVAN'S CONCEPT OF PARTICIPANT-OBSERVATION
(A SYMPOSIUM)

This is the first in a series of informal symposia concerned with the theoretical and technical concepts of Harry Stack Sullivan. The following essays were written at the request of the Editors.

Participant Observation

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Sullivan defined the psychiatric interview as a particular kind of interpersonal relationship which differed from other intimate relationships by its purpose, that "something useful" should be accomplished, namely increased skills of living for one of the people, the patient. He defined the role of the other person involved, the therapist, as that of a participant observer who needed to possess particular skills in the evaluation of interpersonal processes.

Sullivan's contributions need to be examined against the background of psychiatric and psychoanalytic thinking at the time when he formulated his most substantial innovations—the late 1920's and early 1930's. Sullivan was one of the early American psychoanalysts who was greatly appreciative of Freud's contribution for having drawn attention to the fact that abnormal mental phenomena were capable of being understood,
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for having focused our interest on the individual person suffering from mental disorder, and for having developed a therapeutic method. However, his own experiences with schizophrenics soon convinced him that Freud's theoretical elaboration did not contribute to the understanding of the background of their difficulties, and that the classical model of psycho-analytic therapy was not suitable for their treatment. According to the classical model, the psychoanalyst was like a blank mirror onto whom the patient transferred his libidinal attachments. Sullivan's concept of the psychiatrist's role as participant observer stands in opposition to this passive image. Though not explicitly stated his formulation involves also a different role for the patient. In the classical model the patient's contribution to therapy were his free associations to which the analyst listened, seemingly passively, but to which he gave meaning through interpretations of the unconscious content. If the patient did not accept the interpretation his resistance became the object of analysis. In Sullivan's concept the patient takes part in clarifying the distorted ways of his habitual patterns of living, preconceptions and fantasies. To the extent that they are inappropriate, be it out-dated, distorted or unrealistic, they interfere with the patient's skill in living.

The therapeutic investigation is primarily concerned with clarification of the context of the established patterns. Patient and therapist begin the investigation with mutually unknown assumptions and proceed to reaching mutually validated conclusions. This clarification is accompanied by favorable change, a lessening of the anxiety and more accurate interpersonal observations and experiences. A precondition for the therapist to function effectively as participant observer is that he is aware of his own actions, reactions and feelings. He needs to be alert to any situation or process that arouses uneasiness in him, or competition with the patient, or the need to use the situation for his own satisfaction or enhancement of his own prestige. Sensitive attention to one's own feelings is a helpful guide to further inquiry and thus to successful resolution of a patient's problems. This stands in contrast to the image of the uninvolved analyst who interprets a patient's associations or behavior on the basis of some secret knowledge.

This formulation of the therapeutic interaction is closely linked to Sullivan's theoretical considerations. Sullivan was first and foremost a clinician and the need for theoretical reformulation arose from his therapeutic experiences with schizophrenics and obsessives. In the classical frame of thinking treatment consisted of uncovering repressed conflicts, invariably of a sexual nature, and of the psychic traumas that had caused them, thereby liberating the libido. Making such unconscious conflicts conscious, by working through the transference and resistance, was supposed to bring about a cure through insight. Sullivan discarded the whole psychoanalytic terminology as misleading neologism based on unprovable assumptions. He felt that such preconceived notions interfered with clarifying the patient's problems and he was unsparing in expressing this.

Sullivan presented his formulations as a definite departure from the classic psychoanalytic theory and always objected strenuously to any attempt to translate his definitions into psychoanalytic terminology since they had been constructed in a different frame of conceptual thinking. His essential innovation does not rest in his agreeing or disagreeing with one or the other aspect of psychoanalytic theory, but in his knowingly employing a conceptual framework derived from developments in modern physics, which had led to broad changes in the approach to scientific problems. In this new orientation, phenomena can no longer be explained as occurring in an isolated organism, a closed entity, and according to the deterministic, one cause/one effect mechanism of old time physics. This deterministic conceptual frame underlies the orthodox psychoanalytic theory. The changes in theoretical orientation which at that time had been formulated as field theory, implied that human behavior could not be studied in terms of isolated events but needed to be approached in terms of processes resulting from the interaction of multiple forces within the pervading field.

Sullivan insisted that "immutable private" intrapsychic experiences were not accessible to observations by someone else. Even a person reporting about his inner life, including dreams and fantasies, transforms them by the process of communication from the absolutely private into something public. Instead he defined processes that take place in the interpersonal field as the legitimate area of study of psychiatric observations.

With this process-oriented approach, Sullivan felt that in the study of human development an individual could not be con-
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received of as existing at any time in isolation. He emphasized that the human condition, by its very definition, was at all times a communal existence, that all development took place in the interaction with others. He also stressed that important for understanding of developmental data is the concept of experience, the inner component of any event and of anything that is undergone and lived and which mediates our contact with the world. The quality and symbolic meaning of experience is not the same as the event in which the organism participates. In reconstructing a life history the difference between the "outer event and inner experience" is often overlooked, and even more, the way the experience becomes integrated into the mental organisation. Sullivan postulated that this integration of experiences occurs in different modes, depending on the state of maturity and also the quality of the interpersonal relatedness, whereby severe anxiety, and also fatigue, may be interfering factors.

In this conceptual model the individual is at all times an active participant in his own development, not a passive organism under the influence of instincts. Though Sullivan used the term, participant observation, specifically to describe the therapist's role, it expresses at the same time a significant aspect of his whole theoretical formulation.

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Participant Observation

The dogma of neutrality

One of the basic tenets of classical psychoanalysis is the dogma of neutrality in the analytic process. Freud's initial model of the psychoanalyst is the emphasis on the instrumental role of the analyst who is depicted as a mirror reflecting the patient's attitudes and emotions. Another analogy for the classical psychoanalyst is that of a catalyst i.e., an agent that is basically not affected by the ongoing reaction. In a similar vein the image of the surgeon is invoked as performing an operation without emotional involvement in the procedure.

The rationale of participant observation

The construct of the participant observer, introduced by Sullivan, places the analyst-analysand contact in a novel light. In this frame of reference the patient is no longer the focal object of study rather than the transactional, relational process linking patient and therapist into an indivisible therapeutic unit. It emphasizes the fact that the analyst as the observer, and the analysand as the observed, are both part of the same therapeutic field. Observing is a phenomenon that invariably modifies and alters what is being observed. In other words, the role of the analyst is such that epistemologically the notion of the mirror analyst or the concept of the analyst's neutrality is not viable. One cannot be outside of the field of one's observation. Neither can the observed object be independent from the observer. Accordingly, participant observation includes significant aspects of the observer's personality in the emergence of therapeutically meaningful data.

Description of participant observation

Participant observation refers to a complex transaction in which patient and analyst are defined in terms of their respective roles and their reciprocal relationship. The patient's verbal, emotional and non-verbal communications are expertly monitored by the analyst who must include his personal impact on
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The field of observation as part of the unfolding data within the therapeutic field. The method of observation centers around the appreciation of the fact that the analyst hears what he hears and observes what he observes by never experiencing himself outside the field of his observation. His participant observation is an expression of an ever-present reminder of his intricate involvement in modifying the patient's mode of revealing himself within the analytic relationship.

Participant observation in contrast to direct participation presents a potential fail-safe barrier against being party to the patient's neurosis or psychosis. All effective forms of psychotherapy require a measure of distance from the patient's area of disturbance.

The role of the participant observer

The role of the participant observer also changes the structure of the therapeutic alliance in two significant directions. On the one hand the model described above relies on an ongoing interchange or transaction between analyst and analysand. Accordingly, it minimizes the authoritarian position of the analyst. On the other hand, participant observation represents a predominantly confrontational rather than an interpretative modus operandi. Essentially, interpretation centers on a preconceived theory of therapy with a strong metaphychological underpinning including specific notions of insight, free association and related analytic mystique. By contrast, confrontation is more concerned with the sharing of experiences and the injection of the analyst's Self in the therapeutic process.

Theoretically there is great merit in the principles outlined here. The main question is to clarify what clinical difference exists when we apply participant observation instead of classical neutrality. It does not mean that we abandon a basically analytic stance i.e., an emphatic way of tuning in to what the patient is able to tell us about his or her own feelings, experiences, impulses, wishes, fears and so forth. Another dimension is added, however, by presenting to the patient feedback of the way in which the analyst hears, experiences and responds to a variety of events. The nature of the feedback is not necessarily telling the patient "the way things are." There is a minimum of comment along the line of "this shows your resistance, your parataxic distortion, your immaturity, hostility, infantility" or what have you. Instead the analyst may comment when and where he has such experiences, that he feels left out by the patient, affected by the patient's anxiety, able or unable to see events through the patient's eyes.

Clinical illustrations

A patient is consistently late for his appointments and it becomes increasingly clear to the analyst that this is not predominantly resistance. The patient is one of four siblings. His sisters and brother have been institutionalized in mental hospitals as suffering from chronic schizophrenia. Their prognosis is very poor and he is the one and only functioning member in his nuclear family. He is married, has children, but leads an inherently lonely existence. It is most difficult for him to make personal request or express his needs and wishes freely.

It was my impression that his lateness was a communication that needed to be understood by both of us. I concluded that he wanted me to give him something that had personal significance to him. Accordingly, I inquired whether he would like me to call him by telephone on the day of his appointment as an attempt to give us more time for the therapeutic session. The offer was eagerly accepted and enabled the patient to come to his sessions somewhat more promptly. My action should not be misinterpreted as a gesture of appeasement or of placating the patient. It is the result of monitoring personal experiences and judiciously sharing appropriate aspects with the patient. In other words, participant observation represents an attitude on the part of the analyst that focuses a great deal of attention on viewing oneself, one's personality and one's mode of observing; as integral aspects of the therapeutic process.

Another cursory illustration pertains to a patient who expresses repeated, strong anger to the analyst. First, transference components are explored. Then attention is focused on the ongoing therapeutic transaction with its potential cause as a contributory factor to the patient's angry sensations. It turns out that the patient experiences me as an authoritarian person with a condescending attitude. I have no difficulty in acknowledging an authoritarian side of my personality. My main question to the patient is how she deals with my authoritarian behavior.
when it manifests itself. We hear that she does not wish to embarrass me and usually pretends that anger is not in the picture when she experiences it. There evidently are historic roots for her selective inattention and her reluctance to deal with the issue head on. Nevertheless, our particular transaction has a pattern of its own that needs to be clarified and dealt with.

Summary

Participant observation is a milestone in transcending the original construct of the mirror analyst and the illusion of therapeutic neutrality. Nevertheless, the model has some drawbacks that also deserve to be mentioned. The principle of participant observation contains an element of tautology since all observation includes the observer in what he observes. Every act of observation brings about a modification in the object of the observation. Furthermore, we must appreciate the fact that participant observation is largely based on the element of consensual validation i.e., a system of checking and verification that can in some instances lead to a folie a deux between analyst and analysand. There are a number of rational and irrational components that emerge in the therapeutic alliance. One particular problem centers around the analyst's ability to cope with parataxic phenomena.

It may be useful to view participant observation as a fundamental breakthrough in defining aspects of the analyst's part in the psychoanalytic process. It does not matter that the model has some limitations as long as it is considered to be a viable stepping stone in transcending many aspects of prevailing analytic mystique.

Great care must be taken not to sloganize the term lest the term deteriorate into a verbalism unrelated to constructive, clinical practice. The participant observer cannot be merely an instrumentality that is in tune with epistemological considerations. The model thus defined must make allowance for individual, specifically human attributes of both the observer and the observed. More reliable methods of checking and verification would be useful together with clinically appropriate redefinitions of the transference-countertransference continuum.

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Participant Observation

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Sullivan used this term not only to describe the activity of a therapist, but also the activity of scientific observers, particularly those researchers in the social sciences of anthropology, social psychology and sociology.

As a therapist the term means that one participates in the patient-therapist communication on the basis of careful observation, not only of the patient, but also of the therapist's own reactions, and of the communications that go on between patient and therapist, verbal and non-verbal.

Participant refers to active responsiveness to and communication with the patient by the therapist. It also refers to observation as an active process on the therapist's part.

Observation means that one's therapeutic interventions are based not on a-priori theory, a procrustean bed into which observations are made to fit, but instead, on here and now observations of the relations of the patients' communications, one to another, of omissions in the patients' stories and memories; and of what is going on in the patient interaction. For example, when the therapist notices whenever he says something, that the patient's reaction is to say "no, that's not it" or the like, he can point this out to the patient. Or he may observe that a patient...
talks continually of feeling and being rejected by others, and also of rejecting others, including the therapist, the therapist may point out the stereotyped view of the patient for himself or others as mainly rejection-machines, rejecting and being rejected. This is participant observation, on one level at least.

Sullivan disavowed the classical psychoanalytic view that the analyst should be a mirror and have the “objectivity” of a surgeon. In contradistinction, he saw the analyst as a participant observer, and that the analyst’s expertise lay in his skills.

He believed that the therapist has a role to play and in his role as participant observer, he needed constantly to be aware of the result he wished his communications to have in the patient. If the communication or intervention failed to have the desired result, he looked into what went wrong with the communication. In other words, the therapist needed to study and perfect his art of communication, how to say what he wanted to convey, and adapt it to the needs and personality of each patient. By this, I do not mean that the art is incapable of generalization. For example, questions beginning with the word “why” are likely to arouse the same defensive emotional reactions parents aroused when they “ask” a child, “Why did you do that?”, “Why do you feel that?”. These are rhetorical questions which communicate disapproval. The patient rarely gets past hearing the disapproval and reacting defensively to it, with no gain in information about himself.

Kenneth Colby criticizes Sullivan’s concept of participant observation as implying a passive role; he favors the term “participant communication”. I think it is clear that this is actually what Sullivan meant. Observation, to him, was an active process, and participant implied communication on the part of the therapist.

Another implication of the concept is that investigation and exploration have an important role in effective therapy. These are also the tools of research. One article stated recently that “research destroys therapy”. Sullivan differed. He thought good research in personality investigation in a therapeutic setting could be good therapy. I agree. I think research in this sense stimulates the patient to observe and to be curious about himself, and helps him attain objectivity about himself and other people. Furthermore, he gains the ability to see himself as others see him.

Related to the concept of participant observation is Sullivan’s “one genus postulate”, i.e., “Everyone is much more simply human than otherwise”. This implies that “everyone is much more simply human than unique, and that no matter what ails the patient, he is mostly a person like the psychiatrist.” (Italics Sullivan’s).

So participant observation implies looking for human identities or parallels, for human similarities rather than differences. It stresses adaptive abilities rather than psychopathology, or personality deficits or weaknesses.

A psychologist who was in the process of researching Sullivan’s concept of participant observation recently asked me how I used the concept, how I applied it. I found this most difficult to describe. It is so much part of the way I work that I cannot separate it out. As I work, I do not think, “Now, I will be a participant observer.” I simply am one. That is, I participate, I respond, I react to my patient and his verbal and non-verbal communications, and at the same time I observe what’s going on, what the patient is saying and what he is not saying, evidences of anxiety, what I am feeling and thinking, and where, if anywhere, the interchanges are going, and wondering how best to formulate to the particular patient what I observe.

Sullivan taught that observer and the observed one constituted a unit, a field. Not only was the observed one influenced by the observer in ways the observer might not be aware of, but the observer was influenced by the observed one as well. Not only in therapeutic dyadic situations is this true, but also in social science research. An uninvolved researcher or observer does not exist.

Sullivan attempted to get this message across to social scientists. He believed that in doing research, they too are participant observers. This meant that they need not only to know themselves through therapy or personality inventory, but they need to report, in their researches, about themselves as well as about the people they were studying.

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Sullivan's Participant Observation

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Sullivan wrote little about his technique as such, focusing instead on the principles and assumptions underlying the words and gestures of the therapist as participant-observer. In 1924 he was already noticing how the "warps" of the psychiatrist affected the psychopathology exhibited by the patient during that session. Henceforth, in all his teaching and writing, he assumed that the psychiatrist is inextricably and inescapably involved with all that is going on in the session. His emphasis, in contrast to most others of his time, was not on eliciting hidden psychopathology, nor upon encouraging a dependent relationship for the uncovering of unconscious fantasies. He explicitly states that clear communication is what he is after. To the extent that a person can clearly articulate and communicate what he is thinking or suffering or whatever—he has a grasp on it. Sullivan stated succinctly, "and no one has grave difficulties in living if he has a very good grasp on what is happening to him."

The notion of participant observation as Sullivan refers to it again and again is as follows: The psychiatrist as a well trained expert, is knowledgeable, about the various fictions or dead weight past figures operating in his present perceptions of other people, so that regardless of how crippled he may be in other human relationships, he nonetheless functions as an effective, skilled participant-observer in enhancing the clarity of the patient's formulation in communication of whatever is ailing him. To do this he must avoid arousing unnecessary anxiety, and must produce some communication before termination of the session that will be beneficial or useful to the patient.

It has always impressed me how much Sullivan emphasizes that in the first interview especially, two strangers are meeting. The patient, regardless of what diagnostic label he has been referred with, is a complete stranger, and hence due all the courtesy, hospitality, and caution due a strange person making one's acquaintance for the first time.

It is not important to distinguish between Sullivan's use of participant observation as an information gathering inquiry and his use of this approach therapeutically. He makes very clear that treatment from the very beginning is a learning experience, and he uses learning in the sense that Dewey does—personality change and growth, not simply intellectual skills. To quote from Sullivan's Psychiatric Interview.

The thing that keeps one from favorable change, from profitable returns from certain of their experiences, is that they do not learn anything from those experiences or, if they learn anything, it is not enough to produce much benefit. Why is he not moving forward? The answer lies in the fact that sometime in the past it became dangerous for him to inquire into certain aspects of what happened to him... Whatever it is, he has been taught by early experience to shy off, to permit no test, to make no adventure in this dangerous field... work towards uncovering those factors which are concerned in the person's present recurrent mistakes, and which lead to his taking ineffective in-appropriate action. There is no necessity to do more. (p. 236)

Sullivan repeatedly stressed the developmental framework in which the psychiatrist practices participant-observation with his patient. In this respect, he found the diagnostic inquiry in rigorous detail to be very important. First of all, it established the obstacles, blocks, and patterns of difficulties in communication that would have to be circumvented at the beginning and dealt with later in treatment; and secondly, it pointed to handicaps, inadequacy, lacks that were a consequence of unfortunately missing out on various developmental opportunities in the life cycle. To whatever extent possible, the psychiatrist would try to help remedy these developmental misfortunes.

In this endeavor, Sullivan watched himself as well as the patient observing what impact the patient had on him, and what effect his words, gestures and tone had on the patient. In this way one could see one's minor or major mistakes and try to avoid repeating them. At the same time in what was happening here and now with the psychiatrist, the psychiatrist would get details of similar events and patterns of behavior with other people, examining the inner world of personifications "out there".

His notion of participant observation goes back to his early work in 1920 and is consistently developed in the discussion he gives of treatment cases he conducted or supervised throughout the later years. It is mostly evident in his treatment of the severe obsessional; what Kernberg today would call obsessional bor-
derline, and of the schizophrenic. While he presented no sys­
tematic description of his technique one can gleam from his
writings his consistent effort to provide a new experience for
the patient that would be more likely to enhance his self-esteem
and not diminish it.

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Harry Stack Sullivan's
Contribution to Clinical Method

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FROM AMONG SULLIVAN'S MOST IMPORTANT contributions, I want
to discuss what seems to me most innovative in his working
methods. First, by way of background:

1) Perhaps his fundamental observation was of transference:
this did not only develop, he claimed; it was present and
ubiquitous from the start. In the language of the English analyt­
ic school, introjects and projects are the building blocks of per­
sonality and social relations; or as I prefer to say, there are al­
ways “other people in the room”.

2) These transferences or parataxes are based on experience.
Society, not anatomy, is destiny.

3) In dealing with transferences there is no single, detached
position from which interventions can be made; the observer is
always a participant, reinforcing some projections, diminishing
others. Therefore technical activity and flexibility are necessities.

Of course many workers have suggested active and flexible
technical measures, perhaps most notably Ferenczi. In our own
time, Kernberg has tried to match the difficulties of some trans­
ferences with heightened interpretative activity. Kohut has re­
sponded with a heightened empathy. Vestiges of Ferenczi's and
particularly Alexander's influence continue in the several rec­
ommendations for increased manipulations in therapy. We can
term these the interpretative, empathic (or existential) and cor­
rective schools of transference work. I will argue that Sullivan
introduced still another approach.

I will describe this under two rubrics, the “social geography”
of the patient and “kicking at the underpinnings of ideas”,
taken from the recently published “A Harry Stack Sullivan Case
Seminar” (Kvarnes and Parloff, 1976). In a book of my own
(Havens, 1976) I collected many of Sullivan's anecdotes from a
variety of sources and drew working principles from them. The
use of the Case Seminar material serves to test and, I think,
confirm the validity of those principles.

The “social geography” of the patient: While clinical analysis
has been centrally interested in eliciting fantasies and existential
method in eliciting feelings, participant observation aims at the
facts: “What I would have seen if I had been there” (Kvarnes
and Parloff, 1976). This is what Sullivan called the patient's “so­
cial geography”.

He believed that one cannot determine what is fantasy until
one knows the facts, and that once the social landscape is filled
in “I know that the recollection of actual feeling will be valid”
(Kvarnes and Parloff, 1976). Furthermore, getting at the facts
requires considerable activity. The Case Seminar book contains
an extended discussion of the New York subway system, knowl­
dge of which Sullivan believed was important if the therapist
was to help the patient reconstruct one episode in his life. In
essence, therapist and patient are to fill in the landscape to­
gether.

In addition, Sullivan recommended use of “the third person
method”: “… it is much easier for patients to tell you what is
important and unimportant, even about you, if they talk about
a third party” (Kvarnes and Parloff, 1976) Attention is drawn
away from the relationship and deflected “out there”. This is
the germ of what I call ‘making marks’.

There is not space here for more than one example. Sullivan
sometimes recommended “setting an example of desperation and
rage” (Kvarnes and Parloff, 1976) for his patients. The
therapist was not to stand by and at most urge on the patient's
feelings. He was to be beside the patient, even leading him, in
the expression of appropriate feeling toward the figures and
events emerging on the social landscape. Each of the great
methods has a specific geography. Analysts sit behind their patients, out of sight; in medical psychology, some objective instrument is put between doctor and patient, whether desk, notepad or stethoscope; in existential work therapist and patient are to be "close". Sullivan sometimes sat beside his patients, the better to hear (and not stare) and also to be "on the side of" the patient as the two developed, faced, and felt about the patient's social experience.

"Kicking at the underpinnings of ideas":

We play with the self-system to a certain extent to literally remove an enemy from our way. (Kvarnes and Parloff, 1976, p. 214).

The patient has certain "dangerous ideas", misconceptions that undermine his relationships with others. These misconceptions are also false expectations or projections, in short the built-in transferences. Most of these cannot be approached directly. The therapist has to "kick at the underpinnings" of these dangerous ideas.

He might kick at an idea simply by a "grunt or groan" (p. 106). The important thing was not letting the idea pass without comment.

If a patient says to me, "Well, you must think I am terrible" and I don't feel this is just hysterical drama, but really means something, I am apt to say, quite passively, "About what?" as if I had not heard anything about such a notion. Quite frequently, just because my reaction has seemed so astonished and annoyed, they tell me, and to that extent I have gotten somewhere in getting the self-system out of my way. That is, I am no longer a suitable target to hang that on, and to that extent I expect that some material will begin to come forward in that area. (Kvarnes and Parloff, 1976, p. 214)

Being "no longer a suitable target to hang that on" means a bit of the self-system has been removed "from our way". The transference is reduced.

Part of this is role-playing. Still more is what I have called counter-role-playing, that is responding in ways that make impeding a certain role or opinion to the therapist more difficult. The goal is not bringing the misconceptions into consciousness and then interpreting them; instead Sullivan wanted to keep kicking at the dangerous ideas until their hold on the patient had loosened. In other words, change was given more importance than awareness. This can be seen as a deconditioning process or, from the viewpoint of object relations theory, as a process of modifying the introjects.

A different way of working: It seems to me there are in Sullivan's clinical intuitions the germs of two principles that can be drawn up into a new and systematic way of working. I have developed this at length elsewhere (Havens, 1976).

The first of these principles can be termed 'working away from the patient' or in Sullivan's language 'the third person method'. The idea is to move the projections away from the therapist-patient relationship to 'out there' where the social landscape is gradually being sketched in. The narrative screen is to receive the transferences rather than the therapist-screen. We can note a close resemblance to play therapy in which the play objects before analyst and child constitute a miniature world for receiving the child's fantasies, feelings, and facts.

The means of doing this I have termed making marks. Statements, or hypotheses, as Sullivan would have preferred, are thrown on the narrative screen, like shapes in a projective test, and the patient encouraged to erase, correct or fill in the picture emerging (or as Sullivan liked to say, 'don't take yes or no for an answer'). This is a profoundly collaborative way of working, for therapist and patient together, and perhaps sitting beside one another, fill in the historical geography of the patient's experience.

I have also suggested a second and, it seems to me, equally critical part of this work. It is an extension of Sullivan's "kicking at the underpinnings of ideas". The misconceptions or transferences settling on the therapist we see as confusions of the therapist with earlier figures in the patient's life. We can let the transferences deepen, as in psychoanalysis. At other times we may want to lighten them, even move them from us. Statements moving the projections I call counter projective statements. Essentially they direct the projections onto the social geography, that is back to the figures from whom they originated.

Counter projective statements have three general characteristics. They talk about the important figures in the patient's life. They 'point': by making reference to the important others, attention is drawn to them, and with that attention goes projection, because projection follows attention. Thirdly, in order to move the projections, the figures must not only be referred and
pointed to, the therapist's feelings must match the patient's, hence Sullivan's "setting an example of desperation and rage". The therapist shares, often leads, in expressing the patient's feelings toward the figures emerging on the social landscape.

In this way the difficult transferences can be affected. We are better able to calibrate and control the amount of transference the patient can bear. Moreover, just as the patient learned the parataxic responses at the hands of the others, so he can unlearn them at the hands of the therapist. We move out the other people in the room.

As I remarked, this is not the only way to manage and master transferences, but it is another tool in the box.

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Some Notes on Participant Observation

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A young doctoral student who was writing his thesis on Participant Observation learned that I had worked with Sullivan and asked me what I believed the term meant. The first thought that came to mind was of the character in the play who discovered that all his life he had been speaking prose. In a sense, to the student of interpersonal relations, the term is a redundancy. I trust I can clarify this.

Only forty years ago, most analysts thought that instincts acted on people, and were the root of mental pathology. Sullivan believed it was people acting on people that induced anxiety, and then elucidated the roles of 'significant others' in the development of the individual from infancy on. He studied his own role as psychiatrist in communicating with others, and his observations led naturally to the concept of the analyst as a 'significant other' who not only observed but participated. To him, personality handicaps were due to the presence of anxiety and the lacks in experience. The results of his work with schizophrenics and obsessional compulsives were impressive, and furnished clinical proof of his theory of anxiety, with the therapist as a 'significant other'. The kind of person he was, how and when and what he said and did, were directly related to favorable outcome in treatment and living.

The preponderant view at that time saw the therapist as a pure observer, or 'blank screen', and the patient as the one who 'free associates'. The therapist would make himself as anonymous as possible, remaining removed, distant and detached, at least in theory, lest he influence these free associations. Sullivan, who perceived the situation as an interpersonal field, would say that this orthodox posture was a particular way of participating in a relationship that would have its own effect on what transpired. Thus, no matter that the therapist saw himself as pure observer, he was always a participant in a relationship, for better or worse. This was the nature of things. In essence Sullivan was stating the Heisenberg principle as it operated in human living: the observer is always influencing what he observes.

Once the role was more realistically defined, he began to study its vicissitudes. The observer therapist was at the very least an unwitting participant. Now the question to be answered was: how could he improve his witting participation and more effectively influence the course of treatment? Sullivan's writings, especially the "Psychiatric Interview", Fromm Reichmann's "Intensive Psychotherapy", the large and growing literature on transference and countertransference, which is all about how patient and therapist affect each other, and the current interest in object relations theory, these and more attest to the growing awareness that not only do therapists observe, but they are affecting and at the same time are affected by their participation in a relationship. I remember Sullivan defining this relationship as follows: "two people, both with problems in living, who agree to work together to study their problems in living, with the
hope that the therapist had fewer problems than the patient!

How different from an earlier attitude that if you liked a patient you were being seduced. Heaven forbid if you had sexual fantasies!

To suggest how the therapist refines his participant observation, and learns to do it better, let me introduce a brief bit of interpersonal theory. All behavior with others is the result of two opposing forces: 1) the self system, or anti-anxiety system which consists of assumptions, behaviors, and processes developed to avoid anxiety. It operates to maintain the status quo, no matter how it complicates living, because it achieved security in the past. 2) A drive toward mental health which seeks new experience for growth. When two people come together in any but the most casual way, their behavior, what they say, do, think about, deal with, even dream about, is motivated by the interaction and interplay of these two forces. They will satisfy or thwart each other, be drawn toward, or move away from each other. Communication may improve in intimacy, or deteriorate. All of these shifts occur as a result of self system operations that serve to steer one away from experiences that would cause anxiety. And of course the self system was developed to achieve security with the people in one’s past. The persons’ current living with others, as well as with the therapist, will in effect reflect these major and minor catastrophies of the developmental eras.

The therapist, exercising skill in participant observation, brings to the therapeutic session self knowledge and knowledge of developmental theory. He is hopefully somewhat familiar with patterns of successful and unsuccessful living. He is aware and participates in the subtle play of anxiety, the sudden appearance of self system patterns, the moving toward and away. Over the long and short span he can formulate, and open for discussion certain patterns of behavior that repeat themselves. The cardinal rule is that if the patient is too secure, nothing happens, but if he is made too anxious he will leave therapy. The aim is to facilitate gradual self system expansion, in which the patient becomes his own observer of his past, views the inevitability of certain developments in his living, and considers the measures necessary for change. The therapist by this time, if he has been aligned with the growth forces of the patient, will have participated as listener, teacher, model, gadfly, friend, villain, encourager, guinea pig, and so forth, as the patient struggles to clarify past from present, and learns to be a participant observer as well.

To conclude, if one views therapy as the study of interpersonal relations, if one engages in this study, one is engaged in participant observation.

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The Analyst’s Participant Observation
As Influenced by The Patient’s Transference

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I never met Sullivan personally, and do not consider myself to be a Sullivanian. But the early years of my analytic training took place in a Washington strongly influenced, if not dominated, by him and his ideas; I was a student in 2-1/2 of the courses he taught (he died midway through the last of these); and I have acknowledged in earlier writings my debt to him. His term, "participant observation", seems to me well and succinctly to capture the spirit of the analyst’s functioning vis à vis the patient.

Concerning the psychotherapist’s role my earliest concept, developed prior to my coming to Washington, and based largely upon medical training coupled with my predominantly obsessive-compulsive psychodynamics, required of me that I maintain myself and my feelings in a kind of stance which had essentially nothing to do with the individual patient. My ego-ideal, as regards my functioning as therapist, required that I endeavor always to be helpful to the patient, that I be unflaggingly interested in him, and that I experience no negative emotions whatsoever toward him—let alone express such feelings to
him openly. I regarded my personal identity as changeless, and my therapist-role as similarly fixed and absolute.

I have described elsewhere that, in the course of subsequent years of personal analysis and clinical experience,

... my sense of identity has become ... my most reliable source of data as to what is transpiring between the patient and myself, and within the patient. I have described ... the 'use' of such fluctuations in one's sense of identity as being a prime source of discovering, in work with a patient, not only counter-transference processes but also transference processes ... (Searles, 1966-67)

The main point of the present remarks is analogous to the one just quoted: as with the analyst's over-all sense of personal identity, so the customary style of participant observation which he has developed over the years, his observation of the ways wherein he finds himself departing from this normative style, in his work with any one patient, provides him with particularly valuable clue to the nature and intensity of this patient's transference-responses and attitudes toward him. Beyond the analyst's privately observing such variations in his customary mode of participant observation, he can find it constructive, with increasing frequency as the analysis progresses, to share these data with the patient.

If one has some superego-based, professionally-ingrained standard for oneself (as did I initially to an almost paralyzing degree), such as evenly-hovering attentiveness or unflagging interest and helpfulness, one will fail to note the patient's transference-derived vicissitudes in one's interest, participativeness, and so on, which are occurring.

In one's attempt to achieve and maintain some personally idealized, superego-imposed participant observer position, one is apt never to notice that the patient may be perceiving or experiencing, on the basis of his transference-distortions, the analyst's position and functioning to be quite different from those the analyst is experiencing these as being. The patient may be reacting to one's subjectively helpful participativeness in terms of one's threatening to devour or destructively pervade him, and to one's observational functioning as emanating from his own projected, harshly condemnatory and omnipotently controlling superego (his own 'Watcher-Machine', as one schizophrenic patient phrased it). In this connection I have found many times, both in my own work as an analyst and in my supervision of the work of analytic candidates, that when the analyst is being unaccustomedly warmly participative with the patient, we have a clue to the analyst's unconsciously avoiding the negative-transference role in which the patient is tending to perceive him (as being, say, a perceivedly remote and unfeeling parent). Similarly, when the analyst finds himself being disproportionately observational and minimally participative in any tangible fashion, he now possesses a clue to the likelihood that he is unconsciously fleeing from the recognition of, say, cannibalistic urges on the part of the patient or himself, or both.

A few weeks ago, in my work with a highly intelligent, intensely ambitious lawyer who had begun in analysis a few months previously, I found myself immersed in deeply troubled feelings concerning my sense of identity as an analyst. I had had a nagging feeling, from the beginning of our work, that I was unable to keep up with the rapid and abundant flow of analytic material from him. He typically reported dreams which were not only numerous but which clearly possessed much significance for the analysis, and he himself was able to perceive their significances more rapidly than I could. I felt that this man, who showed many signs of moving unusually rapidly in the analysis, was only highlighting a chronic and pervasive deficiency of mine as an analyst—a deficiency, so I felt, of underinterpreting. The work with him intensified my long-familiar concern lest I be burned out as an analyst.

It came to me as an immense relief, then, a few weeks ago, to discover that an important cause of my troubled feelings consisted in his transference to me as being his own small-child self, the youngest child among several siblings, a child who had felt chronically unable to keep up not only with his highly-competitive older and larger siblings, but also with his mother, who seemed to him always in motion, always going away somewhere. I now remembered that I had gone through much this same sequence of analytic developments a few years previously with another such man, whose childhood-family dynamics had been similar to those of this current analysand.

A narcissistic man with whom I am currently working used, earlier in the analysis, to give me to feel insufficiently intelligent to qualify for working as an analyst. He is a highly intelligent
person and I used often to feel admiration, bordering upon awe, for his ability to make nice differentiations, in his thoughts, his fantasies, his memories. The subtlety of his thought, and his ability to create beautifully apt metaphors to express his ideas, all seemed quite beyond my reach. I seldom found any opportunity to make any verbal contribution to the analysis, and he spent much time silently immersed in—so the intricate verbalizations which were the product of these silences gave me to assume—thought of a subtlety and richness that I could scarcely begin to appreciate, let alone hope to participate verbally with him concerning it.

Here again, transference-data which emerged subsequently gave me to know, to my great relief, how powerfully motivated he had been to project upon me the feelings of inadequacy which he had felt toward an older brother, a brother who had lived, during the patient's childhood, in a longed-for world which felt utterly beyond the younger boy's despairing reach. I now became more aware of the defensive aspects of the patient's functioning during the sessions in the way which I have described, and was better able to see the narcissistic, bordering on autistic, aspects of his displaying so complex a mental activity—a kind of activity not necessarily so highly superior to my own but designed, more, to shut me out of his world. While I still can well believe that he has a mind superior to my own in important regards, he no longer gives me to feel unqualified to conduct work as an analyst.

In my work with another male patient I began early to feel semi-moribund during most of each of the sessions, and for at least some months attributed this largely to chronic fatigue from an unusually heavy weekly schedule of patients. But as the analysis went on I became appreciably less burdened by such a feeling as, bit by bit, transference-material emerged which made clear that he was reacting to me variously as his chronically depressed mother, and as a long-senile grandmother who had lived largely as a vegetable, nearby, during a considerable portion of his developmental years.

Several months ago I confided to a middle-aged female analysand that she was, and long had been, my favorite patient; I told her this because I knew that this phenomenon, although in various ways pleasant to me, must indicate one of her major problems. My sharing with her this information (information which represents, obviously, an aberration in my customary participant-observer functioning with my patients collectively) had highly constructive results in terms of the emergence of a wealth of newly-remembered transference material. She recalled, with intense feelings of murderous rage and grief, how all her life she had felt it absolutely necessary to be pleasing to other people generally and, above all, to her mother. Her negative mother-transference feelings toward me, largely repressed for years in our work, now emerged with an intensity which I found at times frightening and awesome. With all this, she began manifesting a coherency and a purposefulness in her ego-functioning which had been largely lacking before.

Lastly, and apart from my main theme, I long ago learned that the analysand's part of the work involves something far more and other than learning to be a free-associating, and dream-reporting, machine; the analyst must both require, and primarily by collaborative personal example help, him to internalize the participant-observer activity as an ego function which he can carry away from the analysis as a part, now, of himself.

REFERENCE

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OfTEN CRITICIZED FOR HIS CONVOLUTED language and psychiatric neologisms, Sullivan's participant observation and participant observer have become part of the language, filling a need in meaning and, though polysyllabic, seeming apt and comfortable on the tongue. The terms have penetrated the general vocabulary of psychiatry, psychoanalysis and the social sciences. The core of thought unfolds as an axiom of elegant simplicity, with a wide range of implication and application.

In 1939, in his first lecture on Conceptions of Modern Psychiatry, Harry Stack Sullivan referred to participant observation as, "the root premise of psychiatric methodology" (Sullivan, 1940), for the theory which had emerged at the beginning of his career as research psychiatrist. It arose out of thrashing discontent with how psychiatrists were functioning in regard to schizophrenic patients. His compassion for the weak and those all but outcast from the psychiatric world was joined to his search for meaning in their illness and for a foothold for therapy.

And in behalf of these goals, and expressive of his intellectual genius, he, from the beginning of his career, had an overriding interest in forging a scientific methodology for psychotherapy. He drew on ancillary resources via an interdisciplinary approach; another innovation in methodology. Throughout his life his thinking proceeded on two parallel tracks—the humanistic, and the scientific in service to the humanistic.

In a side comment in "The Oral Complex, presented in 1925 at age 32, Sullivan states that for the reconstruction which is needed for the recovery of the schizophrenic, hopefully the therapist can provide "the direct effect of another mind" to neutralize "emotional material of too primitive a nature for any conceptualization in the disordered mind." (Sullivan, 1925).

Sullivan had an interest in the field of physics, powerful enough for him to have considered it as career, and it remained for him a continuing preoccupation, as did the contemporaneous philosophy of science. He drew on these resources for developing a scientific methodology feasible for psychiatry and psychotherapy. He refers to the operationism of Bridgman in 1946-47, in the posthumously published The Interpersonal Theory of Psychiatry (Sullivan, 1953).

Conservative and Malignant Features," he said, "interpretations and other suggestions thrust upon the patient without close regard to [his] life situation ... in themselves represent a destructive dilettantism, which jeopardize any success which might otherwise result from the psychosis; and thus tend to determine an unfavorable outcome.... The catatonic is frequently the victim of psychological homicide unwittingly perpetrated by attendant, nurse, or the psychiatrist who forgets that his duty is to understand and assist, not to tinker and amuse himself" (Sullivan, 1925).

In "The Common Field of Research and Clinical Psychiatry," he speaks of the choice that lies before the clinical psychiatrist, between scientific rigor of observation, which is "the touchstone of psychiatric research," and "blissful meandering through the day's alleged work, with results of no therapeutic importance to the patient or scientific importance to anyone" (Sullivan, 1927).

It is in this paper that there is the foreshadowing of the recognition of the particular role of the therapist. "May I take the liberty of discussing a pitfall in [the] understanding of the patient.... The personality of the observer must either be exterior to the scientific observations which he secures or be represented explicitly in their context when it enters into them.... Emotional situations sentiments elaborated in regard of the patient, exercise a powerful influence on what is perceived, and on interpretations ... Even more unquestionably, however, does the sentiment of self of the observer play tricks on his reliability.... But how curiously opaque we are to our own observational scotomata.... How more than difficult it is to see evidence of an unpleasant theory.... There is no scientist but should blush at an accusation that he liked or disliked an hypothesis, on the basis of ethics or aesthetics, or—and this is the important ground—on the basis of his own early training...." (Sullivan, 1927)
One of Bridgman's minimum requirements, formulated in *Symposium on Operationism* in 1945, is that, "in order to be of practical value, the operations must . . . be such that they are repeatable and performable on demand" (Bridgman, 1945). This clearly is not feasible as standard procedure in clinical psychiatry. How to meet the spirit if not the body of this requirement? It behooves the therapist in his role as observer to be as scrupulous and broadly observant as possible. Since operations in spontaneous human behavior do not meet Bridgman's minimum requirement, this desired exquisite perception becomes the minimum requirement in psychiatry, and hopefully its equivalent.

From the very beginning Sullivan had stressed the complexity of perceiving the interpersonal situation while within it with accuracy. Indeed, it is a fact of biology and physics, he said, that even "our perceptions of the physical universe are always separated from that physical universe by the act of perceiving." And in the interpersonal situation are added distortions in perceptions arising from the psychiatrist's bias and preconceptions, the role of his belief system, and, profoundly, the distortions arising from his own personal evolution with its parataxic distortions. This is a far cry from Freud's image of the psychoanalyst as the uninvolved impartially reflecting mirror for the productions of his patient. It is recognition of how things are.

And Sullivan had a longstanding concern with communication—first by the patient in reporting his experience of the inner world and events in the outer world; and then by the therapist in his comprehension of the patient and in his reciprocal communication. Sullivan stressed that these are often complicated by the linguistic factor as to whether meanings of words exchanged are the same for the two participants—and that because of the reservoir of previous experience, not only the patient's but the therapist's observation may be obscured. Thus, again, the therapist-as-person, and language-as-communication, or miscommunication, affect the participant observation. Here Sullivan was respectful of one of the tenets of operationism (and its British equivalent, logical positivism), although impossible of attainment in psychotherapy, of a consensual meaning of terms: "A term is defined when the conditions are stated under which I may use the term and when I may infer from the use of the term by my neighbor that the same conditions prevailed" (Bridgman, 1945).

In his controversial paper, "The Illusion of Personal Individuality," presented in 1944, he reveals his familiarity with the world of physics by alluding to "this new world of the quantum," to the need for "operational validation," and to the ensuing need in physics for disposing of "a great deal of abstruse nonsense" in empty statements—which was one stimulus for the development of operationism and logical positivism. And Sullivan associated the problem of accurate, uninflected, authentic communication in the hard science of physics with the equivalent problem of communication in psychotherapy—as an obligation of the therapist, and a desideratum for the patient. He also was scrupulous about drawing inferences—that an inference might have a high probability, but rarely one hundred percent certainty—again an echo of the thinking in the mathematics of physics. This is reminiscent of a statement of Bridgman's, that, "no operation can be specified with absolute precision. . . ." (Bridgman, 1945).

It is one of the functions of the therapist to help the patient in his communication with himself and to the therapist, perhaps by means of encouraging him to report his "marginal thoughts," as more authentic than asking for "free association," which is particularly difficult for many obsessionals; and to note the flicks of anxiety, which might easily be ignored or repressed.

The therapist is participant, first, by the basic fact that his perception of the other person, the patient, is screened through his own past experience—not only in terms of his belief system, but through parataxic distortions—and all of these contribute to his mode of interaction with the patient. If the therapist lacks skill in self-observation, then, says Sullivan, he is more the participant—and not the adequate observer, of either himself or the patient. That is, the ideal in behalf of accurate observation of the patient in order to serve him well in therapy, is to cultivate, to its best, one's own self-observation. Thus, participant observation is a double process. Since in psychotherapy the therapist uses himself as tool in the treatment, it is his obligation to perfect this tool. By this logical progression, Sullivan arrives again at the humanistic aspect of the functioning of participant observation in the enterprise of psychotherapy.
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The means by which the therapist becomes the more authentic observer of the patient involves noting in himself any arousal of his own anxiety, any activation of his own defensive self-system, and the linkage with what in the situation with the patient touched these off. Hereby Sullivan includes in its wider range what is subsumed by Freudian "counter-transference." In "Psychiatry: Introduction to the Study of Interpersonal Relations" (Sullivan, 1949), Sullivan states that, "the act of observation is itself human behavior and involves the observer's experience. That which one cannot experience cannot be observed."

But Sullivan points out that we may tune in, nevertheless, to such experiences of the other person because, people seem, "all much more simply human than otherwise" (Sullivan, 1949). And it is this which offers the opportunity for transcending direct experience.

These statements epitomize Sullivan's conjunction of two of his basic postulates—the one whose presenting surface is of scientific methodology, and the other, whose presenting surface is the kinship of mankind beyond each one's limited direct experience.

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OUR INTENTION IN WRITING THIS ESSAY IS TO EXPLORE THE DIDACTIC VALUE OF SULLIVAN'S CONCEPT OF PARTICIPANT-OBSERVATION.

Sullivan was a pioneer who opened new possibilities for those who were interested in intensive psychotherapy. The concept of participant-observation denoted a break with the traditional view of the psychiatrist being a mere observer of the strange world of the mentally disturbed by stressing the participation of the observer in the operational field. Furthermore, the interpersonal approach makes it clear that the nature of the participation of each member is determined by the nature of interactions and the impact of the participants on each other.

Sullivan went perhaps too far in ascribing to this concept a crucial theoretical significance around which he built his operational, interpersonal theory of psychiatry. The concept of participant observation is neither a theory, nor is it a specific technique. It defines an essential attitude—a skill to be developed and cultivated in order to be proficient as a psychotherapist.

Sullivan wrote in 1949 that: "The expertness of the psychiatrist refers to his skill in participant observation of the unfortunate patterns of his own and the patient's living, in contrast to merely participating in such unfortunate patterns with the patient." (Sullivan; 1949)

One can tell much about the quality and style of a psychotherapist by the amount of care and thought he expends on the more humble and routine details of the patient's life. Sullivan obviously had a mind trained in this direction; otherwise he would not have ascribed such importance to the relation between these two distinct faculties of the mind.

Those who worked with Sullivan in supervision remember his insistence on adhering to the observable data, verbatim reports to the interaction, and the care he gave to every sentence he uttered. There was economy and precision in his communications reminiscent of a chess player, and he was very often able to
foresaw the response of a patient to a given intervention. He didn't tell the presenter what to do. He posed the question: What is psychotherapy? Answers to this question are dispersed in his writings of which the article quoted here is a good example.

Participant-observation, as a concept, may be compared to proverbs or sayings, and as such may be used as a cliche, an empty slogan, or lip service, without much thought given to its significance. A proverb usually is meant to convey in condensed form, poetically expressed wisdom that can be used as a didactic precept—a guideline to be constantly rethought and freshly evaluated. We look at this concept in such a light.

The apposition of these two words makes one constantly review the relationship between observation and participation, so crucial in learning the elements of our work.

Medical training used to be training in small details about a patient in order to arrive at a diagnosis. The machines do this more accurately in this era of technocracy, and one speaks nowadays of biomedical technology, which develops skills other than arriving at a diagnosis on the basis of observation. Yet, it is to be assumed that without observation, no decision can be made about anything, and that the importance of observation is stressed by a variety of professional activities.

The processing of the observational data, and the results of the processing of information have to become available to the mind in order to select when and how to respond. This requires a presence of mind.

Observation is the essence of discovery. That observation is important is a well known fact not only in our field, but in all scientific work and in the performing arts. It is also the basis for accumulating experience. What is special in the therapist's case, is that he has to simultaneously observe the patient from the outside and himself from the inside. Furthermore, he has to have a sufficient degree of empathy so as to be able to select whether and how he will intervene, having the patient's benefit in mind. This requires practice and training in addition to the therapist's studies in psychiatry. It must be admitted that our training does not provide sufficient opportunities to practice these skills except as we know, through training analysis under supervision. Therefore, Sullivan's insistence on the importance of participant-observation was and is very important for the training of psychoanalysts.

In reading Sullivan, we realize that he recognized certain objective laws in psychotherapy and that fulfillment of them is possible through sufficiently developed prowess in participant observation. For Sullivan, psychotherapy was not a self-indulgent form of self-expression.

Over the years, one of us (A.B.S.) has been occupied with the relation between observation and operation. During her 1949-1953 work with schizophrenics at Chestnut Lodge, she conducted a series of interviews with a very disturbed patient in the presence of, and with the participation of a nurse and attendant. She was struck with how differently she saw the patient under conditions where she was more of an observer at one moment, and more of a participant the next. At the time, Szalita devised a formula measuring mental competence by expressing it as the ratio of one's ability to be an observer and an operator at the same time. Szalita "did not specifically relate this to Sullivan's term, but participant-observation may very well have the same meaning." (Szalita; 1971)

The nature of participation and the interpersonal theory implies that the therapist's participation is very much dependent on the patient. To cite superficial examples, one cannot feel joy when seeing a depressed patient. One will not feel sad when sitting with a manic patient. One cannot be in a shallow mood when working with a schizophrenic patient. What complicates matters is that we are usually trapped by the moods and pathology of the patient and the effectiveness of the therapist depends on the rapidity with which he recognizes the entrapment by the patient's pathology, and extricates himself from it.

Participation may be erroneously perceived as dependent on the quantity of response rather than the quality of absorbed listening and the degree to which one is attuned to the observational data. However, there are certain situations in which one is compelled to respond as, for instance, when a patient is in a panic and one responds just to reassure him.

Participation and observation are two variables that may change depending on the specific situation with which one is confronted. It is an attitude of distance that gives one the possibility to be close to the patient or to keep distance from him, in
order to see from a different perspective. Sullivan cautions that the therapist must realize that he is dealing with very powerful dynamic systems and that the adjustment of personal distance either by reduction or augmentation must be done slowly in order to avoid potentially dangerous consequences.

Participant-observation correlates the two faculties and also poses the question as to what degree one can perfect the ability to use the faculties simultaneously and with sufficient degree of effectiveness.

The most important matter is how to develop the observational and participant faculties either simultaneously or in rapid succession, and for that we think that one may go to the theater and works of literature. Of particular relevance may be the Stanislavsky Method. Stanislavsky was preoccupied throughout his life with what he called the steady current of truth and a growing attention to getting close to reality. In this context he taught his actors the significance of what he called the interior monologue, which was a way of saying or interpreting the unwritten text. The actor has to use this monologue to get close to the character and make him real and truthful. There is great similarity in the methods by which actors are trained to store experience and to respond, and the training by which one becomes a psychotherapist.

Participant observation is related to this intensive monologue. When there is a flow of truth; this monologue does not interfere with the proper listening to the patient.

Of course the theater is not the only vehicle to refine one's ability in participant-observation. There are other methods, including family interviews and group experience. What is unfortunate are the erosion and discounting of the humanities, the decline in the study of literature, philosophy, and languages, in our training institutions. The inclusion of these disciplines might contribute to the optimal development of participant-observation.

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From Mirror
To Participant Observation,
To Coparticipant Inquiry
And Experience

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The following excerpts are taken from Chapter II and Chapter III of my study of countertransference (Wolstein; 1959),\(^1\) and I select them for this symposium, with minor changes, to indicate the general direction of my first working statement that reconceives the early 1950s ego-interpersonal perspective on psychoanalysis along the lines of two-way, coparticipant inquiry by a particular psychoanalyst and his patient into their shared, experiential field of therapy. I select these brief excerpts for consideration here, moreover, because they contain some background references to both Freud's mirror-observational and Sullivan's participant-observational views of that inquiry and experience, and, also, because they present some reasons then set forth that still hold for so reconceiving the structure of psychoanalytic inquiry today (Wolstein, 1977)—by which, empirically, to (1) observe and (2) define the clinical manifestations of, for example, countertransference; then, systematically, to (3) transform and (4) explain them; and, finally, from a pluralism and diversity of speculative perspectives, to (5) interpret them.

For the reader who desires to review the continuity of discussion in the original 1959 context, there is a page citation in parentheses at the end of each excerpt.

In the third or contemporary view, psychoanalysis becomes an inquiry into the experiential field of therapy . . . transference analysis includes both the classical genetic emphasis and the functional emphasis of character analysis as compenetrating aspects of a single approach, and transference and countertransference reactions are now considered integrative and unitary phenomena of the total personality in an active field of experience. Such is the general basis of this study of countertransference (pages 18-19) . . . The theory of analytic therapy has developed beyond the analysis of the vicissitudes of childhood libido, which was the first conception of transference, and

\(^1\) Reprinted here with acknowledgment to Grune & Stratton, Inc.
beyond the second conception of transference, which was bifurcated into transference of libidinal impulses and transference of defense [mechanisms], to the current identification of the two as concomitant and integrated aspects of single and unitary phenomena in the patient's total relatedness. And the same holds true, of course, for the concept of countertransference (page 44).

The great obstacle to the construction of an adequate theory of countertransference has been the ingrained tendency in scientific analysis to view the therapist as one self-contained system of ongoing dynamisms and the patient as another ... the patient's transference is interpreted as basically indigenous to his system, the analyst's countertransference is also interpreted as self-contained and referred back to his system, and the ensuing therapeutic activities are construed as somehow taking place between two closed systems (page 46) ... The analyst who accepts this view and checks his countertransference manifestations successfully has also erected implicit but de facto barriers to the therapeutic search. These barriers to open inquiry may then be transformed into an explicit but undesirable goal of the analysis: the patient has to learn to keep his transference manifestations in check. Psychoanalysis would become a caricature of its possibilities ... (page 47).

In the original model ... the analyst was treated as a tabula rasa who was present in the two-person process but could, in some mysterious way, avoid participating in it. In the proposed model of the experiential field, however, the analyst's personality is seen as actively involved in the development of transference ... it would obviously be senseless to undo the work of the last 30 years, revive the older model of inquiry, and now construe the patient as a tabula rasa who is somehow present during the countertransference experience but does not at all participate in it (nor have anything to do with its emergence). If it is clear that the analyst's personality ... [participates] ... in the unfolding of transference, then it is also clear that the patient's personality participates in the unfolding of countertransference. If the analyst's personality is not a blank screen for the patient, then neither is the patient's personality a blank screen for the analyst (page 48).

Any analysis is a failure if it does not arouse serious curiosity and concern about the unconscious structure of the personalities involved in the process ... Only when the analyst's understanding of the patient runs deeper than the conventional cliches can the patient feel encouraged that a genuine attempt is being made to know him as he is and as he feels in his individuality and uniqueness ... (page 56) ... Once the patient begins to accept the authority of intelligence and truth, he may properly be encouraged to use it in the "me-you" situation with his analyst, for, in this circumstance, a fruitful analysis is in the making.

Why, after all, need the analyst be afraid to face his countertransference, since it has already proved its worth in the patient's understanding of his transference (page 57)?

But in search for new dimensions in the meaning of the transference process, an impasse was reached when the understanding of the patient's experience was short-circuited by an interpersonal dualism in the therapeutic situation. It stopped short of those qualities of the transference manifestations that were evoked by and were in response to other equally dynamic qualities in the experiential field, namely, those of the analyst's countertransference. Because of this interpersonal dualism, a very confusing situation arose ... while the dynamic model has brought out new possibilities in the study of the patient's transference experience, the analyst's countertransference [experience] continues to be seen in terms of the static model. The therapeutic situation has been split up, and two noncomplementary models are being used at one and the same time to understand similar processes within a single field of inquiry ... but since the dynamic model has been so instructive in the study of transference, it may prove equally instructive, before the issue is closed, to utilize this model to study countertransference reactions as they occur in a total experiential field (page 59).

The chief obstacle to this development has been the view of the analyst and patient as first being in separate fields of action and then [as] interacting at a distance in the therapeutic situation. [For] the historical background of this problem ... in the first approach, based on id psychology and id therapy, the analyst and patient were both conceived as self-enclosed systems of forces ... in the analysis of defenses or character analysis, based on ego psychology and ego therapy, the transference of
defense was separated from libidinal transference, and ... while the patient was seen as a more dynamic unit, the field of interaction was still viewed in the static model ... But the therapeutic situation was still being construed as a statically interpersonal one, and the next logical step was not taken: to view the total experiential field constructed by analyst and patient as a dynamic one in which transference is related to countertransference and even shaped by it in some important respects (pages 59-60).

... To the extent that the analyst is a participant observer in the experiential field of therapy it is necessary to admit the patient’s powers of participation and observation ... at least in principle, he is as capable of making observations as his analyst in the experiential field in which he participates. Were this not admitted, no psychoanalytic theory could make claims to being an interpersonal one, and the patient would be deprived of an experience of intimate relatedness that is potentially his ... (page 63)

If, in the experiential field of therapy, the analyst is considered the participant observer in the study of transference while the patient remains an observed participant, then the situation is reversed in the study of countertransference. When the patient is well enough along in his transference analysis, he can also become a participant observer while the analyst may then be described as an observed participant (page 63).

The concept of the experiential field of therapy embraces personal and interpersonal processes within it, and both participants are construed as being in total relatedness at various levels ... When it is finally realized that countertransference elements are embedded in them [transference distortions] and condition their emergence, it will also be realized that they may best be studied in relation to each other as compresent and compenetrating in an experiential field (page 68).

... [T]he patient’s transference distortions in this field are not only in response to his own constructing past but also in open movement into the immediate present. Now the analyst [s countertransference] obviously has a participant function in the immediate transference situation ... as germane to the inquiry into the patient’s transference as anything else in the unconscious present.

In theory, this is a generalized view that does not necessarily apply to every concrete therapeutic relationship. In practice, only fear or arbitrary fiat on the part of the analyst will prevent the patient from moving spontaneously into the analysis of the analyst’s personality, at least to the extent that it is immediately present and effective in his experiential field. Analysis, in fine, becomes a highly concentrated attempt to understand human experience as it is lived and suffered in concrete fields of relatedness (page 71).

If manifestations of countertransference are not considered, the patient will stop short of [a] complete analysis of his transference distortions as they unfolded in the experiential field. The analysis may be terminated, but it cannot be considered closed ... certain aspects of the experiential field—what in the analyst’s personality evoked the manifest forms of the transference—are treated as if they were as unconscious [for the patient] as his transference distortions; the analyst’s countertransference manifestations have been placed beyond the ... patient’s attention even though they were significant conditions in the formation of his [transference] experience (page 71).

As the transference symbolizations begin to take shape, they not only reach back into the patient’s past but they also reach out into his present in order to confer a semblance of continuity on his experience. That they also extend into the present is of primary importance, for it is the analyst’s personality in that present that he is currently experiencing and trying to relate to. So the manner in which he relates to his analyst is not only a projection from his past; it is also an assimilative effort to encompass the present (pages 71-72).

If the analyst decided arbitrarily that no reference to his personality were embedded in the transference, he would place himself and his theory in a position that is unrelated to the temporal dimensions of [the] past, present, or future. He would also find himself upholding the untenable position that his experiences are of no relevance to the patient, and, to push this absurdity to its ultimate, that what the patient communicates is irrelevant to how he attempts to cope with his experience[s]. Thus, the arbitrary decision to divorce transference from countertransference would make an absurd mockery of the whole therapeutic enterprise [of psychoanalysis] (page 72).
REFERENCES


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