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My Memories of Being Supervised

DURING MY ANALYTIC TRAINING I worked with three supervisors, Erich Fromm, Harry Stack Sullivan, and Frieda Fromm-Reichmann, in that order. Each had such a distinct and powerful personality that it would have been impossible to have imitated or identified with each in turn; to have incorporated all three at once would have been indigestible. They emphasized quite different aspects of case material, and each had special interests of his own. They were considered, at least by the students, to prefer to work or to work best with different kinds of patients.

I thought I could learn most by selecting the type of patient that seemed most appropriate to the predilections of the given supervisor and putting myself in the most responsive mood to absorb what he wanted to teach. I then tried to get perspective by comparing the experiences afterwards. The job of integrating what I learned from each into a style of my own was a continuing process that goes on to this day. Each, in his own way, had such an uncanny ability to see into the machinations of both student and patient that I was not tempted to select material in order to please. I was sure such a false effort would have been quickly discerned and exposed.

Erich Fromm's brilliant grasp of psychodynamics was most impressive. He was particularly interested in the use of dreams and fantasies as well as conscious verbal productions and had a powerful way of using them to read the unconscious of the patient. Fromm, who was irritable with mere verbiage and refused to let the patient talk *about* himself, emphasized the importance of getting the patient to talk *from within* himself, *to be* himself, to genuinely experience himself and the analytic situation. He was

impatient with vague generalizations or phony, pretentious, defensive exchanges whether these were between patient and therapist or between therapist-student and supervisor. Fromm was very critical of students who merely went through the motions of therapy while a patient rested, coasted, or depended on magic while refusing to expose his most crucial problems or to work on them. Authenticity and lively engagement mattered a great deal to Fromm. He was wary of the patient who seemed to merely verbalize what the doctor wanted to hear, and of the therapist who said what he thought the supervisor wanted to hear.

Periodic "taking stock" of progress or lack of it was recommended to make sure that growth, although slow, did not come to a halt. If after two and a half years of treatment, there was no clear change and no new concept had evolved as to the work to be done in the near future, one should confront the patient (and oneself) with this dilemma with a goal of rectifying it, terminating, or interrupting treatment. Fromm felt that many doctors and patients, as though in collusion, droned on together, managing to satisfy each other's dependency needs but doing very little that mattered. He believed that students had an affinity for going on and on in unproductive therapeutic situations because of their feelings of omnipotence and lack of humility. Patients often accepted these situations owing to fear of separation and of facing their aloneness. When forced to examine their apathy or rigidity, patients often were impressed by the fact that the therapist took them seriously, expecting and believing that change could occur. Thus, they were encouraged rather than discouraged. If they could still see no way out, a clear description of the therapeutic stalemate gave them a solid, sober concept to mull over and digest after termination. It allowed a constructive end that might lead to later growth.

I found Fromm especially excellent in helping with the treatment of the neurotic, well-defended patient. He stressed how to break down defenses, confront the patient with anxiety-provoking but pertinent ideas, challenge him to face them, and then help to reorient him to new, constructive experience. Therefore, I found myself bringing to him some of the most verbal, productive, and imaginative neurotics, who seemed especially to need this approach.

Fromm advised against talking too much. He felt that most stu-

dents did so, either to reassure themselves as to how much they knew about the patient or to fill up time because silence made them uneasy. He definitely felt that I had a tendency to talk too much, and advised me to watch the clock in order to train myself not to intervene more than once every five minutes.

Supervisory work with Harry Stack Sullivan was in many ways a different kind of experience. Known for his work with very sick patients, especially schizophrenics, he was most humble with these sick people and did not expect any high level of attainment from them. He was satisfied with correcting their major distortions, bringing their dissociated systems into awareness, and enabling them to tolerate this, thus decreasing their suffering and panic.

Having only an office practice, I was not working with such sick schizophrenics; but I brought to Sullivan my borderline patients, many of whom were quite verbally unproductive and seemed, on the surface, to be dull or unimaginative. He had an uncanny, intuitive ability to read into the unconscious of such patients, even when they were unable to produce much material or were too negative and frightened to do so. He had a very effective way of handling schizoid negativism by maintaining a cool facade, seeming somewhat detached and benignly indifferent. His genuine interest in the patient and extreme attentiveness to relevant material were rather obvious despite the cool facade. In part, this attitude may have reflected his own personality; some of it was also the natural outgrowth of his long experience, which made him both wise and weary. One had a feeling that he was never really surprised at anything that happened. He kept the patient interested and working but made it quite clear that the patient was working for his own needs and not to satisfy the therapist. Sullivan felt that it was disastrous for the therapist to have a stake in the patient, as this recalled the over-involved, intrusive, and often hostile parent.

When pointing out a particularly conspicuous omission on a therapist's part or his avoidance of an issue because of his own anxiety, Sullivan would frequently turn to the student in a most disarming fashion and ask, "Tell me, can you afford to lose this patient? If you can't, you had better not go on in supervision with me." He would say, "You have to talk straight at this point or the patient will never believe you." If the student disclaimed any fear of losing the patient, Sullivan could be pretty sure that the student was not being honest with himself.



Great emphasis was placed on the accurate collection of data, both historical and present. Sullivan would accept no clichés, no generalizations, no fancy or ambiguous technical terminology. When one offered a theory about what was happening with a patient, he would frequently ask, "As illustrated by what?" or "Precisely what do you mean by that?" "The man says he has an Oedipus complex; did you get him to spell that out for you?" "What makes you think so?" "What made him arrive at *that* conclusion?" Or, he would say "Yes, many people hate their mothers; exactly how was it with you?" "What did she do?" "How did you react when she did that?" "Tell me how the battle developed between the two of you." He felt that precision was necessary to understand the uniqueness of an individual, and that whatever resentment a patient might have at being questioned would be easily offset by the relief he felt in knowing that somebody cared enough about him to inquire and to listen. Then, a *unique* formulation could be arrived at which precisely fit that patient and no one else. Sullivan felt that the basic security needs of individuals were so similar as to be boring. What made the work interesting was to find out exactly how they were lived out by each person.

He did not recommend cross-examing patients in the same critical way he did students, but he certainly recommended very direct ways of collecting relevant data early in the treatment situation provided that the patient could tolerate that approach. He was acutely aware of manifestations of the patient's anxiety level and, whenever anxiety seemed to be so great as to be disruptive, he would say to the patient, "Let's put a red tag on that. It's an important area to explore. We will get around to it later when it is easier for you to handle." While the patient would thus be let off the hook, putting the red tag on the problem reduced the likelihood that it would be forgotten. There was little danger of throwing a borderline patient into a schizophrenic panic, Sullivan felt, if one were aware of minor manifestations of anxiety. This did not mean that he believed that one should be reassuring or avoid basic issues. It was, rather, a matter of how rapidly and in what order one approached them. He cautioned against overt reassurance as he felt that most sick people were dreadfully suspicious of it and could smell it a mile away as false.

Sullivan also warned against kindness or sympathy as being disrespectful. It was clear from knowing him, however, that he was

quite kind to sick people, though always in an offhand rather than sticky or smothering fashion. He was acutely aware that schizoid persons were fearful of inappropriate or premature intimacy before they were fully ready for it.

He could use his extreme perceptiveness to be very tactful or offhand when the occasion demanded it, but he was also capable of conducting a stress interview with such deadly accuracy as to get to the core of a person's anxiety with record speed. He was noted for his high degree of accuracy in predicting the possible breakdown or failure of members of the Armed Forces sent on dangerous missions. He felt that, after fifteen minutes of a personal interview, he could determine whether a pilot had the stamina to handle a bombing mission by observing how well he handled pressure on areas of deep personal anxiety. Sullivan had a reputation for making predictions far more reliable than those based on other types of testing procedures available to the military services during World War II.

His high degree of accurate insight enabled him to penetrate a student's foibles as well as the problems of their patients. Everyone who had supervision with him came away at some point with a neat characterization that Sullivan had hung over him, one that he was not likely to forget. Mine has certainly haunted me ever since. It was this: "You tend to be disrespectfully intelligent with your patient, who certainly doesn't need to be put down by you. He has had enough of this kind of treatment from other people in his past. Of course, you know much more than he does, but your job is to help him find it out in a way that enables him to keep his self-respect and not have to be either grateful or feel humiliated." To another student who had a tendency to be overtly warm and motherly, he said, "The patient does not need your kindness but your understanding. Many friends and relatives have tried to be kind to the patient before. None of them understood what was important. That's your job." To a third student he said, "You barely missed being a charlatan."

Sullivan was concerned about the tendency among White Institute students, particularly during the mid-forties, to be much too casual and relaxed with patients. He certainly did not favor orthodox pomposity or unnatural neutrality, but he did not believe in foisting on a patient data about oneself that could only make him anxious and served no purpose. Thus, he advocated that political



views, private matters of taste, details of family life, and the like, should be kept out of the way of the patient, who had enough to deal with from within himself without having to contend with extra hurdles. He warned against excessive socializing with patients, having seen a good deal of this in Provincetown. He felt that Clara Thompson could get away with seeing many of her patients and students in that casual summer setting but that most students could not afford to do the same with their own patients. In the first place, few possessed Clara's quiet, unanxious simplicity; besides, no student would be able to handle whatever reactions his patients might have to observing the therapist's private life. Sullivan felt that patients would then be apt to withhold reactions that might make the therapist uneasy, thus making it impossible to work through paratoxic distortions.

My last supervisor was Frieda Fromm-Reichmann. I have much less to say about my work with her, partly because it was of rather short duration and partly because I was by then more competent, more experienced, and less afraid of criticism. Some students were afraid of her, but I found her friendly and reassuring. She discouraged my note-taking, regarding it as an interference, and I found that I was able to present whole histories as well as to process many hours with only a few words as reminders.

I presented to Fromm-Reichmann a very talented but anxious homosexual man. At the time, I was feeling quite ineffectual because I was unable to alter his sexual pattern. The essence of her comment was that what mattered was not what people did with their sexual organs but what they did with each other. This took emphasis off the sexual behavior as such, and made it much easier for me to work on more accessible aspects of his behavior.

She cautioned against the danger of "teaching the patient" too much, saying that this underestimated his own knowledgeability and capacity to learn for himself. If one could dislodge blocks and dissolve anxiety, patients would usually learn readily of their own accord. She had a special appreciation of the creative abilities and artistic capacity of many schizophrenic patients. Her belief in them, although never warm and motherly, was very encouraging to growth.

It must be clear how different were these three supervisory experiences. The process of digestion and integration was much easier then than now because personal contact with each supervisor,

seminar leader, and student was readily available. There were very few students because many men were away in military service during the early days of the Institute—1943-1946. There were no formal training rules or regulations, nor was there any need for them. Everyone seemed to sense what was going on with everyone else. It was clear from my analysis that Clara Thompson knew what all my supervisors thought about my work, and she felt free to use this knowledge as she saw fit. The hours of supervision required were the same as now, but there were fewer courses. The faculty was much smaller, but this was offset by the fact that its members were much more accessible. Training in those years was much more individualized and intimate than possible now, largely because the students and faculty have increased at least five-fold.

The sense of dedication to a liberal analytic cause, and a strong need to prove one's capacity to survive prejudice and isolation, united the students and faculty. There was also a strong sense of dedication to the intensive treatment of individual patients, with fewer distractions and less external pressure than we all suffer from currently. Thus, one tends to look back with nostalgia on the spirit of those early years when we were the New York Branch of the Washington School of Psychiatry.

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