Education as Transformation in American Psychiatry:

From Voices of Control To Voices of Connection

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Dedication

To
my mother, Olivia,
and to
Carol, Karen, and Teddy,
who have taught me how to listen

Acknowledgements

This dissertation has had its own straight path, which has unfolded in ways similar to "the straight path" cut through the Fijian underbrush, as described in that culture's spiritual tradition. It has been neither straight nor a path in the Western sense of those words. My task in this long journey has been to learn to listen and to create a safe place so that the voices of these healers, psychiatrists and non-psychiatrists alike, could be heard. As this thesis has taken up so much of my life for the last several years it is extremely difficult to acknowledge everyone who has influenced and supported this effort. Like the Ju/'hoansi and Fijians who have graced this work, I have felt inspired and helped by the community of my ancestors, family, friends, clients, and colleagues both inside of and outside of Harvard, as well as my advisors.

This work was one to which I was deeply committed, and it required of me to spend many solitary hours alone with the healers' voices. As I listened, I resonated with my own developmental transitionings. My mother, who died suddenly of leukemia when I was ten years old, has been a driving force behind this work. She had wished to go to medical school in order to become a physician, like her father and her grandfather. Having lost her so suddenly, when she was so young and had had a life so full of promise within a loving circle of family, friends, and colleagues, I have found myself often wondering if perhaps I was not carrying out an unrealized dream of hers to learn and to write about healing.

I would like to thank first of all, my husband, Richard Picariello, who has believed in me and with unending patience has waited for me to complete this dissertation, which I had already begun before we met; also my stepsons, Jim and David Picariello, who have understood when I was unavailable and yet have always been generously ready to discuss things with me or help me "chill out" when I could come up for air; Peggy Liversidge, my friend and fellow traveler on the path to understand about meaning, balance, wholeness, and connectedness in relation to healing, beauty, and life, and who since 1986, when our paths first crossed, has always been there to help me get to the place where I could articulate what needed to be said and to accept that which was better to leave unspoken, while gently encouraging me and giving me the space when I was wrestling with my vision to allow it to unfold. I also wish to thank Elizabeth Valentine, my true friend and colleague whose support, wisdom, and humor have helped me countless times to pick myself up and find my path again when I was ready to abandon it; Amy Klainer, whose wisdom, vision, and humor continued to reinspire me about the importance of completing this work; Martha Stark, M.D., who after my vision about the Möbius strip serendipitously discovered and gave me the book by Schiller and continues to guide, inspire, and give me courage; Laura Chasin, for her never-ending patience, support, understanding, and guidance all the way through this thesis; Claire LaVine, for her true healing presence; my teachers, the Ven. Dhyani Ywahoo, Moshe Feldenkrais, D.Sc., Dr. Yeshe Dondhen, and Karmu, who have helped me to integrate my mind, body, and spirit and through what each has taught me, have challenged me to write an integrative dissertation.

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I'd like to say a little about how this dissertation unfolded before thanking others, including my Harvard committee. After my mother died, I had an opportunity, in the summer between my freshman and sophomore years at college, to work as a laboratory assistant in a cancer research laboratory at the Department of Pathology of Johns Hopkins University in search of a cure for leukemia. As I worked there, I became both fascinated by the complex world of medicine and medical research and distressed at

the callousness of the way that animals were treated in the dog lab. At that time, I spoke with my uncle, Sarge Cheever, a Harvard-educated physician, about my interest in applying to medical school and was disappointed at the time when he discouraged me from pursuing this career path. Nonetheless, I took his advice and, following other interests, pursued a career in history and language. However, I could not forget about my interest in healing and eventually transitioned out of a career in teaching and onto my path as a psychotherapist, massage therapist, and, finally, also as a somatic educator certified in the FELDENKRAIS METHOD® of movement education. It was only in the process of training as a psychologist and while researching and completing this thesis that I was able to understand and to thank him for the way that he was looking out for me with my best interests at heart.

In the late 1970s, when I began the work that would become this thesis, I had no idea of how to proceed. All I knew was that I was passionately interested in healers and healing. I began by interviewing thirty charismatic priests and other kinds of healers in the Catholic Church with a medical colleague from Japan, Toshishiko Hasegawa, M.D., and soon became intrigued by the way that common themes of meaning-making, balance, wholeness, and connectedness, as well as appealing to a greater healing power, kept reappearing. I sought to expand my search to understand the nature of healing inside allopathic medical circles as well as outside. At that time, I had entered Harvard as a doctoral student under the guidance of George Goethals and had begun to study the mother-daughter relationship. Then, in 1980, I was admitted to the Harvard Graduate School of Education's Counseling and Consulting Psychology Program and introduced to Dick Katz, a professor teaching a very popular healing seminar and someone who shared a profound interest in, and experience among, healers, healing systems, and community cross-culturally. Dick agreed to become my doctoral advisor and has accompanied me on this part of my path ever since. His wise guidance in letting me find my way, going up and down and around in search of a sample, including encountering cul-de-sacs (!), has enabled me to have the courage to follow my heart, no matter how discouraged I have sometimes become. When Dick left Harvard in 1984, Dean Whitla, who had taught me about psychological testing and then kindly took over as the head of my committee, continued to allow me to follow my path with unending patience, understanding, and faith. Kiyo Morimoto, who first taught me how to listen in his counseling seminar, and Meg Turner, who understood my insatiable need to know and never doubted that I could complete this thesis, also joined me on my path as my committee. I am deeply grateful for the way that all of them have nurtured me, believed in me, and allowed me to write the thesis that needed to be written in the time that was required in order to do so in the correct manner.

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and clients at Feldenkrais and Body Mind Associates and at Market Street Health for understanding when my thesis took my attention away from other work.

Likewise, I thank others who have helped me to stay on my path—some by their belief in me and some by the very fact that they have doubted that I ever would be able to complete what I had set out to do. Finally, I would like to thank all the healers from Fiji, the Kalahari, and the United States who kindly took part in this study. May others be inspired and learn from your voices as I have. I thank you all from the bottom of my heart.

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Abstract

Olivia Lowell Cheever

Education as Transformation in Western Psychiatry: From Voices of Control to Voices of Connection

This study examines the idea that a traditional paradigm of healer education, "education as transformation" (Katz, 1981), might have transcultural aspects useful in addressing some of the problems in the paradigm of allopathic psychiatric education in the United States. Education as transformation is a spiritually based approach involving altered states of consciousness, service, and the character development of the healer. In considering psychiatrists, special emphasis was placed on the quality of the doctor-patient relationship, including empathy and issues of the appropriate use of power. The findings yielded some unexpected results, causing the writer to re-examine the theoretical definition of empathy on which the Mehrabian and Epstein (1972) empathy instrument was based. They were: (1) that various qualities extrapolated from the principles of education as transformation, including references to altered states of consciousness, were found in psychiatrists of both genders and (2) that Katz and Kilner's (1987) concept of the embedded self, which is close to Gilligan and colleagues' (1982, 1988, 1990, 1992) concept of the connected self in female development, also seems to be present in psychiatrists of both genders. The findings suggest ways of improving Western allopathic psychiatric education, specifically by increasing the "voice of connection" as opposed to the "voice of control" among psychiatrists.

The writer interviewed a sample of community psychiatrists to determine what they felt was important or counterproductive in their education as healers, and then compared and contrasted these qualities and experiences with those of healers educated according to education as transformation. The study was primarily qualitative. To add some balance, an empathy measure, the Questionnaire Measure of Emotional Empathy (Mehrabian & Epstein, 1972), was also administered to those interviewed, as a theoretically objective test measuring a quality often identified with successful outcome in psychotherapy (Corcoran, 1981; Grunebaum, 1983; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Luborsky, Crits-Christoph, Mintz, & Auerbach, l988; Rogers, 1975; Truax & Carkhuff, 1971) and one that might be viewed as a possible Western equivalent of aspects of education as transformation. The study was further informed by observations of researchers such as Kleinman (1988b), Brown & Gilligan (1990), calling for a less ethnocentric research perspective.

Many consider the core of Western culture, its spiritual foundation, to be missing, perhaps dead. The straight path can lead us to rediscover the freshness of our own spiritual traditions from within the dry materialism of our world.... In that, I am convinced, lies the straight path to our survival.

Richard Katz, The Straight Path: A Story of Healing and Transformation in Fiji
(1993, p. 325)

Chapter One:
Statement of the Problem

How does a group of community psychiatrists in the United States view the concepts of helping, healing, and healer education? And how do these views compare and contrast with those of healers in two traditional societies—the Ju/'hoansi in Africa and the Fijians in the South Pacific—who have been educated according to a very different model or paradigm, one that has been characterized as "education as transformation" (Katz, 1981, 1982a, 1982b, 1982c, 1982d, 1983/84; 1986, 1993; Katz & Kilner, 1987; Katz & Nunez-Molina, 1986; Katz & St. Denis, 1991; Katz & Seth, 1986)? This study will examine the idea that this different paradigm of healer education might in some way have transcultural aspects and that the insights gained might be useful in addressing some of the problems of the Western paradigm of medical, and specifically psychiatric, education in the United States. It is the intention of the writer in this thesis, as we compare and contrast these two very different models or paradigms—education as transformation and Western allopathic psychiatric education—to provide an opportunity for healers from all three of these cultures—Ju/'hoan, Fijian, and the United States—to be heard in relation to each other as they discuss their education and their concepts of healing.

It should be noted that in this study, the experiences of each psychiatrist are viewed primarily in a qualitative manner, so that their words offer a unique perspective, an individual way of making meaning out of the experience of being a psychiatrist within the context of the Western allopathic medical paradigm. To add some balance to this qualitative perspective, however, the writer also decided to administer an empathy measure, the Questionnaire Measure of Emotional Empathy (Mehrabian & Epstein, 1972), to those interviewed, in an attempt to connect the information gathered in the interviews with a theoretically objective test measuring a quality that has most often been identified with successful outcome in psychotherapy, an important component of the psychiatrist's role (Basch, 1983; Campbell, 1982; Corcoran, 1981; Grunebaum, 1983; Gurman & Razin, 1977; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Luborsky et al., 1980; Luborsky, Singer, & Luborsky, 1975; Meltzoff & Kornreich, 1970; Mintz, 1972; Pierce, 1974; Rogers, 1975; Smith & Glass, 1977; Sullivan, 1953; Truax & Carkhuff, 1967). The results of the more "objective" measure of empathy will be examined in a later chapter, first, methodologically, in the light of the themes that emerge as the psychiatrists talk about their education and, secondly, in relation to the principles of education as transformation. It is the writer's opinion that empathy in the West shares much in common with education as transformation. Thus, in addition to comparing healers of both cultures and the way they are educated, this study will attempt to clarify from a transcultural perspective what is meant by empathy and its role in healing.

Before continuing, let us briefly look at the organization of this paper. After offering in this chapter an overview of the problems and issues that we will be discussing, we will examine in detail in Chapter Two the two models of healer education by looking at the characteristics of medical students and psychiatric residents as well as of Ju/'hoan and Fijian healers. We will address the question of who chooses to become a healer and how the temptation to abuse the healing power might arise for healers in all three of these cultures. And, as the writer maintains that empathy is a Western way of translating some of the principles of education as transformation and in preparation for examining the findings of our Mehrabian and Epstein (1972) instrument, we will explore the concept of empathy in detail in Chapter Three. Then, in Chapter Four, we will lay out some considerations as to why the writer chose the methodology of thematic analysis to convey most appropriately what psychiatrists say about their formal and informal education before delineating the actual method in Chapter Five. In Chapters Six and Seven we will listen to and analyze the themes of a subsample of eight psychiatrists as they discuss their education, before discussing our conclusions and the implications of our findings in Chapter Eight.

Paradigms, in a general sense, are models or examples that provide an overarching framework to describe some aspect of human experience or to explain phenomena within a specified realm. Thus, we speak of education as transformation and allopathic medicine as paradigms that, in different ways, explain the nature of healing and healer education. This is a large realm, however, large enough to encompass other paradigms within it, and we note here that, in the course of this thesis, we will be juxtaposing several other such sub-paradigms, including those of mind-body integration vs. mind-body dichotomization and of synergy versus scarcity.

It may be that some will question the advantage of examining the education of community healers in the West from a transcultural perspective. In response, the writer suggests that in offering such a juxtaposition, we may notice aspects of our own culture's way of educating healers that we might not otherwise observe. It is also possible that we may learn how to address some of the areas in which our culture's model of healing and healer education has been found lacking. Katz, among others, has suggested that these areas include the unequal distribution of healing as a resource (Berliner & Salmon, 1980; Cheever, 1984; Hastings, Fadiman, & Gordon, 1980; Katz, 1983/84; Katz & Seth, 1986, 1993), the fact that prevention is not stressed as much as treatment, and the failure to address the different world views of patients from other cultures (Cheever, 1984; Katz & Craig, 1987; Katz & Nunez-Molina, 1986; Katz & St. Denis, 1991; Padilla, 1980; Sue, 1981), to name but three.

In Rethinking Psychiatry: From Cultural Category to Personal Experience (1988b), Kleinman, a psychiatrist, points out the dangers of being blind to cultural relativism and diversity, specifically where the practice of healing and healer education is concerned. He argues for utilizing an anthropological and sociological perspective in examining the nature of Western psychiatry:

> Is not cross-cultural research essential to establish the universality of mental illness and the international validity of psychiatric categories? Are not comparative studies an antidote to professional ethnocentrism? Can psychiatry be a science if it is limited to middle-class whites in North America, the United Kingdom, and Western Europe? Yet, in spite of these powerful reasons for international research, psychiatry has made only the slightest of contributions in international medicine, and most psychiatric journals and textbooks evidence little if any interest in the psychiatric aspects of international health.... Against this disquieting background, I will highlight a quite different point of view, a vision of psychiatry in the perspectives of other non-Western cultures—so huge a portion of humanity, yet so silent a presence in psychiatry. (Kleinman, 1988b, p. xii)

This idea has also been addressed by Gilligan, as a result of her and her colleagues' findings from research concerning the development of women and girls (Brown, 1988; Brown & Gilligan, 1990, 1992; Gilligan, 1982; Gilligan, Rogers, & Tolman, 1991; Gilligan, Ward, Taylor, & Bardige, 1988). These researchers have cautioned against the "dangers in imposing one set of ethnocentric categories on another population," additionally stating that psychologists conducting research must "take on the concerns of anthropologists, historians, and literary critics with the complexity of interpretation and the construction of alternative world views" (Gilligan et al., 1988, pp. xiv-xv).

In addition to the issues noted above, one of the central problems in Western medicine that we will be exploring throughout this thesis is the nature and quality of the doctor-patient (and, more specifically, the therapist-patient) relationship, including the potential for abuse within that relationship. Fundamental to this problem is the tension between the necessity to maintain a caring relationship, on the one hand, and the necessity to master a large body of scientific knowledge, on the other. Gilligan and Pollak, in "The Vulnerable and Invulnerable Physician" (1988), have pointed to the vulnerabilities that physicians face as they confront these two opposing necessities:

> The practice of medicine ideally combines scientific knowledge and technical skill with intimate personal care. Medicine differs from other high-status professions in joining the exercise of power with intimate care, just as it differs from other caregiving occupations in its exalted social status.... For the physician, this conjunction creates two distinct vulnerabilities—the danger that intimacy will cloud objectivity and overcome professional restraint, and the danger that perfection of knowledge and skill will distance the doctor from human relationships. (Gilligan & Pollak, 1988, p. 245)

Their research with medical students has suggested that the second vulnerability—that of distance—is the greater danger: "In American medicine, ideals of heroic achievement increasingly have overshadowed the value of nurturance and close personal affiliation. Technological advances have repeatedly been gained at the expense of the doctor-patient relationship" (Gilligan & Pollak, 1988, p. 246). They posit that the "split in medicine" between these ideals results in "antagonism [and] generates an illusion that is particularly dangerous for the physician—the image that safety lies in success, and invulnerability can be gained through separation" (p. 246).

Gilligan and Pollak's findings in both projective and interview data gathered from medical students suggest that behind this split lie "two ways of perceiving and understanding relationships," and they further note that these ways "in this sample...are differentially associated with gender":

> From the perspective evident more frequently, although not exclusively, in the responses of the men, relationships appeared potentially dangerous. From the perspective taken more frequently, although not exclusively, by the women in the sample, relationships appeared safe. These two perspectives toward relationships have significance both for psychological theories of human development and for medical practice and education. (Gilligan & Pollak, 1988, p. 251)

They further note that "although the dangers of intimacy are well marked in ethical codes and professional texts, the dangers of isolation remain comparatively uncharted in medical practice and education" (p. 245). Moreover, these "may be of particular consequence for women" (p. 261) since, as they observed from both their interviews and projective data, women medical students "struggled explicitly to hold professional achievement and human connection together" (p. 266). When taken in conjunction with evidence of "the far greater incidence of suicide among women physicians than among other women in the population" (p. 261), such responses serve to alert us to the danger of not openly acknowledging these struggles within the educational environment.

Relative both to the larger question of this "split in medicine" (p. 246) as well as to the issue of gender as it relates to "the value of nurturance and close personal affiliation" (p. 246), it is interesting to take note of a recent biography of a physician living during the early part of this century who is held up as an example of "the one man in medicine that one would most want to emulate" (McIntosh, letter dated Oct. 25, 1927, cited in Paul, 1991, p. 107). Francis W. Peabody, a graduate of Harvard College and of Harvard Medical School in 1903, was highly influential to medical students of his day through his teaching, both in word and by example, concerning the importance of relational factors in the healing process. His original lecture, "The Care of the Patient," made such a strong impression when it was first delivered at Harvard Medical School in 1925 that it was published in the Journal of the American Medical Association in 1927, thus reaching a far wider audience. Subsequently, this lecture and article were frequently used in the teaching of medical students, and, indeed, it was reprinted as recently as 1984 as a "Landmark Article" in the same journal (Paul, 1991, p. 120).

What is primary to the practice of medicine, in Peabody's opinion, is the doctor-patient relationship: "the practice of medicine in its broadest sense includes the whole relationship of the physician with his patient" (Peabody, 1923, cited in Paul, 1991, p. 156). He began his 1925 lecture by saying that

> the most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine—or, to put it more bluntly, they are too "scientific" and do not know how to take care of patients. (Peabody, 1923, cited in Paul, 1991, p. 155)

Thus Peabody, like Gilligan and Pollak over sixty years later, pointed to an unfortunate opposition of science and care, or, as Peabody expressed it, of "the art of medicine and the science of medicine" (Peabody, 1923, cited in Paul, 1991, p. 156). But rather than contradict, or to be "antagonistic" to one another, Peabody continued, the art and science of medicine should be "supplementary," sharing a relationship similar to that of "the science of aeronautics and the art of flying" (p. 157). Thus, we might suggest that the science and the art of medicine are deeply intertwined, fully dependent on one another for the true healing potential of medicine to be realized.

While Peabody recognized the importance of "an understanding of the sciences which contribute to the structure of modern medicine," he nonetheless felt that "it is obvious that sound professional training should include a much broader equipment" (Peabody, 1923, cited in Paul, 1991, p. 157). His understanding of this situation led to an interest in whether this larger perspective might be addressed from the standpoint of the medical curriculum of his day, including a broadening of medicine's province beyond a focus on any one people or nation. Thus he queried:

> Can the practitioner's art be grafted on the main trunk of the fundamental sciences in such a way that there shall arise a symmetrical growth, like an expanding tree, the leaves of which may be for the "healing of the nations"? (Peabody, 1923, cited in Paul, 1991, p. 157)

It would seem, then, that this tension in medicine between the necessity to maintain, on the one hand, a caring relationship—Peabody's "art" of medicine—and the necessity to master a large body of scientific knowledge, on the other, has a long history in Western medicine. It is the writer's hope that, through taking a transcultural perspective, we may shed new light on this, and other, problems.

The specific cultural model or paradigm of healing and healer education that we will juxtapose with our Western model is, as previously noted, one that has been termed "education as transformation." In a 1981 article that appeared in the Harvard Educational Review, Katz, drawing on his background both as a psychologist and as an anthropologist, concluded that the manner in which two traditional societies educate their healers is similar enough to be described by a single model of healer education, which he termed education as transformation. The Ju/'hoansi are a tribe in southern Africa that remains close to the hunter-gatherer mode of existence as they are still connected to their nomadic ways. (The Ju/'hoan people have been known as the !Kung, !Kung San, Bushmen, Zhutwasi, or Zhun/twasi, but they call themselves Ju/'hoansi, which means "people," "we," or "us"; the writer has chosen in this paper to utilize the new orthography used by these people themselves.) The Fijians are a fishing- and agriculturally based culture in the South Pacific. Katz's model, initially proposed to describe the way in which healers of these two very different societies are educated and subsequently offer their healing services to their communities, has been further delineated in other work, including an examination of how it describes healer education in ten hunter-gatherer societies (Hahn, 1982; Katz, 1981, 1982a, 1982b, 1982c; 1982d; Katz & Lamb, 1983).

Within this world view, healing is seen as "a process of transition toward meaning, balance, wholeness, and connectedness, both within individuals and between individuals and their environments" (Katz, 1982b, p. 3). Among the Ju/'hoansi, healing occurs as the community's healers struggle to access n/um or "boiling energy," as the healing power is known (Katz, 1981, 1982a), during a communal dance ritual. In Fiji, where healing is effected through the ritual exchange occurring between healer and the one seeking healing which releases mana (as the healing power is known), the emphasis is placed on the development of the healer's character; indeed the "ideal" healer is viewed as embodying the values and qualities of the "ideal" Fijian (Katz & Kilner, 1987). Thus, among the Ju/'hoansi it is a question of *access* to the healing power or boiling energy (Katz, 1981, 1982a, 1982b, 1982c), while among the Fijians it is a question of *the proper use* of the healing power or mana (Katz, 1981, 1993; Katz & Kilner, 1987). Yet both of these traditional societies' practices and beliefs, however different from one another, are nonetheless characteristic of the larger education as transformation model of healer education, in that both emphasize the principles of "transition toward meaning, balance, wholeness, and connectedness" (Katz, 1981).

What, then, do these two societies, different from one another yet having some common ground in the way that they educate their healers, have in common with an even more different culture, that of the United States? And how can their cultural experience inform our own? Katz has suggested that this particular paradigm of healer education, based on the experience of other cultures, might have relevance in considering how to improve the education of community psychiatrists in the United States. Specifically, he has suggested that healers in Western post-industrial societies, though operating from a very different world view and educated in an entirely different way, might nonetheless look to the principles of this traditional paradigm in order to address some of the ways in which Western psychiatric—and, more generally, medical—education has been found lacking by both insiders and outsiders to the field.

To this end, Katz (1981) has suggested that it might be helpful to investigate specifically the education of community psychiatrists in the United States. The subgroup of community psychiatrists, as opposed to psychiatrists in private practice or to doctors in general, he maintains, is most comparable to the healers in the two traditional societies where he did his field work, thus offering the most suitable group within the dominant Western medical education system for comparison in such a transcultural study. As to the choice between psychiatrists (or doctors of the mind and emotions) and medical doctors (or doctors of the body) for such a study, Katz's initial interest in the way in which altered states of consciousness (without drugs) are used by the Ju/'hoansi to effect healing at the level of both mind and body led to his focus on the former as the more primary Western counterpart to these traditional healers. He then further refined this category to a focus on community psychiatrists, who, despite large and obvious differences between traditional and modern Western societies, can be considered community healers insofar as they work in settings that are, at least in principle, community-based (i.e., community mental health centers), just as the healers in these traditional societies carry on their healing work within community settings (Cheever, 1984; Katz, 1981). While there are other types of community-based healers within Western society, practicing the various folk-based traditions of different ethnic groups, as well as other types of community mental health professionals within the Western medical system, such as psychologists, social workers, and psychiatric nurses, it can be argued that the community psychiatric educational model is representative of the dominant form of mental health education in the United States (Cheever, 1984).

Several researchers have examined the relevance of education as transformation in a variety of Western contexts. Aspects of education as transformation have been found to characterize the educational life histories of Western nurses (Cheever, 1984) practicing an alternative, holistic model of nursing education, "Therapeutic Touch" (Krieger, 1975a, 1975b, 1979, 1981; Quinn, 1981). It has also been found to describe the education of healers practicing the Espiritismo ("Spiritism") form of healing in Puerto Rico, which the researcher termed "education as desarollo (development)" (Nunez-Molina, 1988). Aspects of the model have also been found to characterize a counselor education program in the United States (Simonis, 1986) and an elementary school classroom (Gonzalez Ortega, 1992), the experience of Chicano students in an undergraduate university program (Meza, 1988), and the experience of women who, having undergone amniocentesis, were in the process of deciding whether or not to have an abortion (Menary, 1988). In addition, the writer has, in an earlier paper (Cheever, 1984), considered from a transcultural perspective the nature of community psychiatric education in the United States as a form of healer, or helper, education, comparing it to the education as transformation model. However, no study has yet been undertaken to examine Katz's suggestion that certain aspects of education as transformation might be transculturally relevant in order to improve the education of community psychiatrists in the United States (Katz, 1981).

Thus, following the line of thinking suggested by Katz and further informed by the observations of researchers such as Kleinman and Gilligan, the writer decided to interview a sample of community psychiatrists to determine what qualities they felt were important in their healing work and what they considered either important or counterproductive in their formal and informal education as healers, and then to compare and contrast these qualities and experiences with those of healers educated according to the principles of education as transformation. Utilizing an open-ended, semistructured interview process, the questions posed to this sample of community psychiatrists were designed to give respondents an opportunity to explore different facets of their education as psychiatrists, and specifically as community psychiatrists. The writer thus hoped to elucidate in a manner appropriate to Western healers how a particular group of them conceives of healing and views their own education as healers.

It should be noted that the constructed sample of community psychiatrists is in no way a representative one. Those who participated in the sample volunteered and due to this self-selection may not be considered in the same light as a sample that is randomly chosen. Thus, there will be no attempt to generalize the findings in this study to all community psychiatrists in the United States, as the aim is simply to conduct an exploratory study in order to further develop the model proposed by Katz (1981).

We now return to our original question: Why is education as transformation relevant to a study of Western medical education? We have previously referred to some of the problems that beset our medical system. The extent of these problems is such that the medical system can fairly be described as being under stress; indeed, some consider it to be in crisis (Blendon et al., 1993; Illich, 1982; Konner, 1993). For instance, Konner, an anthropologist and M.D.-Ph.D. who participated with Katz in the Harvard Kalahari Research Group among the Ju/'hoansi, states that "in the United States today medicine and society appear to be on a collision course" (1993, p. ix). Although the allopathic medical paradigm continues to have a great deal of cultural authority and is still seen as playing a dominant role in the post-industrial society of the United States (Starr, 1982), it would appear that, increasingly, the ideas, systems, and institutions that are intended to support our health—not to mention our healing system and its form of healer education—have proliferated into a vastly complex system, containing many subsystems. Perhaps as a result, the overall system has instead become less and less able to promote health—i.e., our wholeness as human beings (Gilligan & Pollak, 1988; Illich, 1982; Jonas, 1981; Kleinman, 1988a, 1988b; Konner, 1993; Mishler, 1984; Paul, 1991; Reiser, 1978). In addition to the increasing depersonalization that has resulted from technological advances, the system has come under growing scrutiny due to spiraling medical costs and is further burdened by the increase in malpractice suits in the last ten years and by the growing problem of the uninsured (Illich, 1982; Jonas, 1981; Konner, 1993; Reiser, 1978).

Yet another challenge is the proliferation in recent years of alternative helpers and health professions (D. M. Eisenberg et al., 1993; Ferguson, 1980; Katz & Rolde, 1981; Kleinman, Eisenberg, & Good, 1978; Murray & Rubel, 1992). Eisenberg et al. (1993), in a study concerning help-seeking behavior of 1,539 respondents, found that 34% reported having utilized at least one "unconventional therapy" in the previous year. However, perhaps the most interesting finding of this study was the fact that 72% reported that they had not shared this fact with their primary care physician. These findings leave one wondering about the implications of this lack of communication between patients, allopathic physicians, and alternative practitioners.

This situation is even more serious when one considers that healers and healing systems, in addition to offering an invaluable service in relatively peaceful and prosperous times, often play an especially important role in helping societies to adapt for their own survival during difficult periods of transition (Katz, 1982b). Thus, when a society's healing system is itself in crisis, it is difficult for it to play this stabilizing and sustaining role. Western culture might be described as being in such a time of transition and cultural crisis and, at the same time, as we have noted, there are many indications that the dominant medical paradigm is itself also in a time of transition or crisis. As a result of these various pressures, the allopathic system, although still the dominant healing system, is more and more having to adopt a defensive stance (Konner, 1993; Murray & Rubel, 1992), in keeping with the nature of the process of a paradigm undergoing change (Kuhn, 1970; Tart, 1975), and the larger culture is less able to look to it as a sustaining influence. Yet we should bear in mind that the Chinese character for "crisis" is the same as the one for "opportunity" and instead of letting such a stressful situation overwhelm us, look for new possibilities that may result in a better, more equitable healing system.

Under these circumstances, there is perhaps value in looking to a different model or paradigm of healing and healer education for insight, especially if this alternative model shows evidence of an ability to maintain itself in times of cultural crisis and transition, as Katz has suggested is the case with the education as transformation model. Over the past several centuries, the lands and the lives of the Ju/'hoansi and the Fijians have been increasingly exposed to and influenced by other cultures, including the West, a process that continues today at an accelerating pace. Despite this, however, both societies have succeeded in maintaining their systems of healer education, and these systems have continued to produce healers who have helped their communities and cultures survive during this extended period of transition and cultural crisis.

Kuhn (1970), a researcher in the history of science, and Tart (1975), a psychologist whose research specializes in the psychophysiology of consciousness, have addressed the questions of how paradigms (specifically within the context of Western scientific thought) exert their influence and how they change over time. Defining scientific paradigms as "universally recognized scientific achievements that for a time provide model problems and solutions to a community of practitioners" (Kuhn, 1970, p. viii), they note that although a given paradigm may eventually be superseded by newer, more comprehensive, and/or more useful theories that members of a given community of practitioners agree are more useful, it has a tendency, in its period of ascendancy, to become a super-theory or "formulation about the nature of reality with such a wide scope that it seems to account for most or all of the major known phenomena in its field" (Tart, 1975, p. 7). Thus, as Tart points out, the danger in a "successful" paradigm is that it undergoes a "psychological change" and becomes an "implicit framework" for most scientists who are working with it to explain what they observe (p. 17). When this happens, scientists no longer subject the paradigm to further testing, and it "acquires tremendous controlling power over its adherents" in a tautological way, such that they may become blind to other options (p. 17). Perhaps looking at the ways in which the education as transformation paradigm is both similar to and different from our own will allow us to open our eyes to the grip of our own Western paradigm(s) and be open to other options.

As noted at the beginning of this chapter, the juxtaposed paradigms of education as transformation and allopathic medicine can be thought of as encompassing other pairs of paradigms within them, and we will now turn our attention to one of these, the paradigm of mind-body integration vs. mind-body dichotomization. Gilligan and Pollak (1988), as we have noted, have spoken of a "split in medicine" between care and technology, further characterized by a juxtaposition of intimacy and connection with isolation and distance. Other researchers, however, have pointed to the more fundamental split in Western medicine represented by the dichotomization of mind and body (Dossey, 1982; Hastings et al., 1980; Locke & Colligan, 1986; Ornstein & Sobel, 1987). Perhaps it is in this dichotomization that we find the key to the multiplicity of problems that confront the Western allopathic model, and perhaps in its opposite we will find some solutions.

There is perhaps no better example with which to observe the implications of a dichotomized view of mind and body than that of illness. All medical or healing systems, of course, address the problem of illness, an experience that is part of being human. While the most obvious aspect of illness is the suffering that takes place on the physical level, suffering also has an emotional and spiritual component, for humans are meaning-makers who seek to make sense of and to give the dimension of meaning to their experiences, and suffering thus involves meaning-making, an aspect of mind. One psychologist, writing from a constructive developmental perspective, has pointed out the primacy of meaning-making from infancy onwards and the fact that it is a multifaceted or even holistic activity involving both physical and psychological elements:

> Meaning is, in its origins, a physical activity (grasping, seeing), a social activity (it requires another), a survival activity (in doing it, we live). Meaning understood in this way is the primary human motion, irreducible. It cannot be divorced from the body, from social experience, or from the very survival of the organism. (Kegan, 1982, pp. 18-19)

Thus, we note that "consciousness" (a term which includes "mind") plays a part in healing, in that it is through consciousness or mind that a patient seeks to make meaning of his or her illness experience. Yet medical caregiving in the West has been faulted for not addressing the problem of suffering in a way that integrates these emotional and spiritual aspects of the illness experience—i.e., the meaning-making aspects—with the more obvious physical aspects. Cassell, a physician-researcher writing in the New England Journal of Medicine about the nature of suffering as it relates to the practice of medicine, has addressed the problems that result from making a "distinction between physical and nonphysical sources of suffering" (Cassell, 1982, p. 640). He observes that although friends and family of the dying, for instance, do not make such a distinction, doctors do, and he concludes that "medicine and its critics [must] overcome the dichotomy between mind and body and the associated dichotomies between subjective and objective and between person and object" (p. 640) in order to address the nature of suffering in a more complete way, in its emotional/spiritual sense as well as in its physical sense. Of this less tangible form of suffering he notes: "People suffer from what they have lost of themselves in relation to the world of objects, events, and relationships" (p. 642).

The problem of suffering raises the question of how to compassionately care—or of how to establish and maintain connection as well as to heal disconnection—which once again leads us to consider the quality of the doctor-patient relationship and its importance in healing. In this regard, it has been suggested by some who have looked for possible approaches to the problems that occur in the psychotherapeutic relationship specifically that the quality of empathy—a much-researched but elusive concept—might be an antidote to these problems in that it has been closely associated with positive outcome in psychotherapy (Luborsky & Crits-Cristoph, 1990; Luborsky, Crits-Cristoph, Mintz, & Auerbach, 1988; Weiss & Sampson, 1986). Cassell's observations are directed to doctors of physical illness while the suggestion concerning empathy comes from the realm of illness of the mind and psyche, yet it is obvious, if we break through the dichotomization that separates mind and body, that this suggestion is equally applicable to the realm of physical illness.

The mind-body dichotomy in the Western scientific and medical paradigm is symptomatic of an underlying difficulty in grappling with the concept of mind and consciousness—not to mention spirit. Indeed, according to some, mind and spirit have been left out of Western science since the time of Descartes, who in the seventeenth century, in return for being allowed by the Roman Catholic Church to continue to engage in scientific pursuits, agreed to leave "the soul, the mind, the emotions, and consciousness to the realm of the church" (Pert, cited in Moyers, 1993, pp. 179-180).

This bias notwithstanding, some scientists, have continued to believe that consciousness or mind must be linked with body. Among the most notable of these is William James, both a philosopher (espousing "pragmatism") and a founder of psychology in the United States at the end of the nineteenth century when it was newly emerging as a science from its precursors, physics and philosophy. Yet we hear exasperation in James's words in a letter to a close friend as he tried to clarify the relationship between "reason" and "nature"—or between the realm of mind and consciousness and the realm of physical substance and physical laws, including but not limited to the body:

> I feel that we are nature through and through, that we are wholly conditioned, that not a wiggle of our will happens save as the result of physical laws, and yet notwithstanding we are en rapport with reason. How to conceive of it who knows?...It is not that we are all nature but some point which is reason, but that all is nature and all is reason too. We shall see, damn it, we shall see. (Letter from W. James to T. Ward, March 1869, cited in R. B. Perry, 1935, pp. 472-473)

To James, psychology was "the science of mental life, both of its phenomena and their conditions" (James, 1890/1950, vol. 1, p. 1). The phenomena were "such things as we call feelings, desires, cognitions, reasonings, decisions, and the like" (vol. 1, p. 1); the conditions, he felt intuitively, must incorporate physiology. He expressed it thus: "It is to mind quite inconceivable that consciousness should have nothing to do with a business it so faithfully attends" (vol. 1, p. 136), referring to the many bodily processes. Yet, despite his keen interest, James never succeeded in identifying the biological substrate of "consciousness" or "mindstuff."

Nonetheless, James has left us clues that point to his holding an integrative view of the mind-body relationship, especially in his view of the emotions. Together with a Danish colleague, Lange, he conceived of the James-Lange theory of emotion, which held that one first perceives the bodily expression of an emotion, such as crying or trembling, and then experiences the emotion. Thus, James argued in his Principles of Psychology that the emotions are wrongly regarded "as absolutely individual things" that can be separated out from their somatic (bodily) expression (1890/1950, vol. 2, p. 449). Indeed, he went so far as to say that "emotion dissociated from all bodily feeling is inconceivable" (vol. 2, p. 452).

Since James's time, the split between mind and body has, we might suggest, become even further institutionalized within Western scientific thought, which includes allopathic medicine, and to counter this dichotomization, "holistic medicine" has developed in the West as an alternative (Hasting et al., 1980). Holistic medicine is part of the "holistic health" movement, the many alternative approaches to healing that proliferated in the 1970s and have the common goal to treat "the whole person" (Cassel, 1982; Hastings et al., 1980). Thus, dysfunction is viewed in relation to the whole person, and treatment frequently involves mobilizing the patient to take greater responsibility for his or her own healing, stressing prevention as well as treatment. In ordinary, everyday perception to healing (Katz, 1982a, 1982b, 1982c, 1982d; 1993; Krieger, 1981; Kripner & Villoldo, 1976; LeShan, 1974, 1982; Villoldo & Krippner, 1986) and others, including some from an allopathic perspective, have documented the importance of the patient's belief or faith in the doctor and the treatment in determining successful outcome through their research into the "placebo effect" (Benson, 1984; Borysenko, 1987; Frank, 1974; Locke & Colligan, 1986; Ornstein & Sobel, 1987; Shapiro 1971). Thus, in this view, mind is interconnected with body in the healing process.

As noted at the beginning of this chapter, the juxtaposed paradigms of education as transformation and allopathic medicine can be thought of as encompassing other pairs of paradigms within them, and we will now turn our attention to one of these, the paradigm of mind-body integration vs. mind-body dichotomization. Gilligan and Pollak (1988), as we have noted, have spoken of a "split in medicine" between care and technology, further characterized by a juxtaposition of intimacy and connection with isolation and distance. Other researchers, however, have pointed to the more fundamental split in Western medicine represented by the dichotomization of mind and body (Dossey, 1982, 1989, 1991; Hastings et al., 1980; Locke & Colligan, 1986; Ornstein & Sobel, 1987). Perhaps it is in this dichotomization that we find the key to the multiplicity of problems that confront the Western allopathic model, and perhaps in its opposite we will find some solutions.

The holistic health movement includes a diverse array of practices, both medical and nonmedical: "humanistic medicine, transpersonal psychology, parapsychology, folk medicine, herbalism, nutritional therapies, homeopathy, yoga, massage, meditation, and the martial arts," according to Berliner and Salmon (1980, p. 1), researchers in medical policy who studied the holistic health movement in the United States and Western Europe during the 1970s. In addition to Berliner and Salmon, another researcher, Hanna (1979/80), maintains that the holistic health movement also comprises the area of somatic education, giving the example of the FELDENKRAIS® Method; other types of somatic education are the Alexander Technique, Aston Patterning® (Aston, 1991; Aston, Molnar, & Krier, 1992), Body-Mind Centering™, and the TRAGER® Approach. We will look more closely at the nature of somatic education when we consider the alternatives to the dichotomous mindset.

Of the nonmedical practices listed above, meditation in particular has been studied and applied in clinical settings to promote stress reduction (Benson, 1975; Kabat-Zinn, 1990; Moyers, 1993; Wilber, Engler, & Brown, 1986). Some body-mind-integrated approaches are based on other cultures' healing systems, as in Chinese acupuncture (Austin, 1972; Kapchuk, 1983), Tibetan Buddhist medicine (Clifford, 1984), "espiritismo" (Delgado, 1979; Harwood, 1977; Nunez-Molina, 1988) and "curanderismo" (Sharon, 1978) among Latinos, and Native American healing (Neihardt, 1932/1972; Fire/Lame Deer & Erdoes, 1972; Ywahoo, 1989), to name but a few.

It should be noted that some newer approaches within the allopathic model, such as "behavioral medicine" (Brown & Fromm, 1987), do attempt to integrate mind and body, or to include societal and environmental factors along with mind and body, as in the "biopsychosocial" perspective (Engel, 1977; Green, 1985). New medical specialties bridging the gap between the holistic and allopathic perspectives are also emerging, such as "psychoneuroimmunology," which looks at the connections between the brain and the immune system (Borysenko, 1987; Dossey, 1982, 1991; Locke & Hornig-Rohan, 1983).

Despite these adjustments within the allopathic system, however, a majority of medical services are still delivered by specialists whose perspective does not include an integration of body and mind.

Moreover, the predominant orientation in neurology, which is increasingly emphasized in the neuropsychopharmacological approach in current psychiatry curricula (Michels & Marzuk, 1993), is similar to that of the behaviorists, who have limited the definition of mind to such an extent that they "have virtually denied existence for mind other than as sets of behavioral dispositions" (Skinner, 1974, cited in Laughlin, McManus, & d'Aquili, 1992, p. 10).

According to Ferguson, the editor of Brain/Mind Bulletin, holistic medicine has its philosophical roots in the concept of "holism," a term that was introduced in 1926 by Jan Christian Smuts, a Boer general, philosopher, and twice prime minister of South Africa, to describe a "powerful organizing principle inherent in nature" (Ferguson, 1980, p. 49). With this theory he sought to explain the rapidly emerging, paradigm-shifting scientific discoveries of his day, such as quantum mechanics and the Heisenberg uncertainty principle, asserting that "if we did not look at wholes, if we failed to see nature's drive toward ever higher organization, we would not be able to make sense out of our accelerating scientific discoveries" (Smuts, 1920, cited in Ferguson, 1980, p. 49). Ferguson points out that Smuts also observed that "there is a whole-making principle in mind itself.... Just as living matter evolves to higher and higher levels, so does mind, [which is] inherent in matter. Smuts was describing a universe becoming ever more conscious" (Smuts, 1920, cited in Ferguson, 1980, p. 49). Another writer, Gordon, a physician who has examined the paradigm of holistic medicine, states, "To Smuts holism was an antidote to the analytic reductionism of the prevailing sciences. It was a way of comprehending whole organisms and systems as entities greater than and different from the sum of their parts" (Smuts, 1926, cited in Hastings et al., 1980, p. 3). In other words, it is a synergistic model (Benedict, 1970), a concept to which we will return later in more detail.

The holistic perspective has, to an extent, found a place in mainstream Western scientific thought in the form of systems theory, a cross-disciplinary perspective that has evolved since the 1930s. Bertalanffy (1950, 1968), an originator of what has become known as general system theory (GST), believed that this way of thinking constituted, when it was first proposed, a new departure amounting to what Kuhn (1970) would later call a "paradigm shift." Defining GST as the "scientific exploration of 'wholes' and 'wholeness' which, not so long ago, were considered to be metaphysical notions transcending the boundaries of science" (Bertalanffy, 1968, p. xx), he notes that it arose simultaneously within and affected many disciplines, offering "a new scientific paradigm (in contrast to the analytic, mechanistic, one-way causal paradigm of classical science)" (p. xxi). According to Bertalanffy, "Modern technology and society have become so complex that traditional ways and means are not sufficient any more but approaches of a holistic or systems, and generalist or inter-disciplinary nature became necessary" (p. xx).

Thus, what a systems perspective offers us is a way to deal not only with the many "elements" within a given system "but [also] their interrelations...say, the interplay of enzymes in a cell, of many mental processes conscious and unconscious, the structure and dynamics of social systems and the like" (1968, p. xix). Dealing with the interrelationship between variables also offers a new way to deal with problems. In applying a system approach to our study, such a perspective allows us not only to view each psychiatrist as an individual but also as an individual in relation to various elements: a given healing system, a healing power, a healing body of knowledge (including but not limited to the healing technology), patients, colleagues, the self, family, and community.

Macy, in her dissertation, "Interdependence: Mutual Causality in Early Buddhist Teachings and General Systems Theory" (1978), and in Despair and Empowerment in the Nuclear Age (1982), points out how GST (Bertalanffy, 1968) introduced "a more holistic, complex and dynamic conception of reality" (Kreisberg, 1986, p. 62). Macy underlines the fact that for living systems to evolve intelligence they must not close themselves off to the environment through creating barriers, but rather open themselves up to ever wider "currents of matter-energy and information" (Macy, 1982, p. 31). Following in the footsteps of Bertalanffy, she points out that one of the properties of a system is that it is defined by its organization:

> Von Bertalanffy found that the behavior of phenomena could best be understood in terms of wholes, not parts, and that wholes, be they animal or vegetable, cell, organ, or organism could best be described as "systems." A system is less a thing than a pattern. It is a pattern of events, its existence and character deriving less from the nature of its components than from their organization. (Macy, 1978, p. 61)

Moreover, a system is synergistic:

> As such it consists of the dynamic flow of interactions that cannot themselves be weighed or measured. It is "non-summative" and irreducible; that is, the character of a system as a

> pattern of organization is altered with the addition, subtraction or modification of any component. Hence it is more than the sum of its parts. This "more" is not something extra, like a vitality principle or elan vital, but a new level of operation which the interdependence of its parts permits. It is lost from view when a system's composite units are investigated independently of each other. (Macy, 1978, p. 61)

Could empathy be another such phenomenon that might benefit from such a systems perspective insofar as it might also be "lost from view" if its composite units were investigated independently? We will discuss this further in Chapter Three.

Biologists Maturana and Varela have brought this systems concept to bear on biological systems. In The Tree of Knowledge (1987), an investigation of neurology from a biological systems perspective, two ways of understanding reality are described. In the first, reality is viewed as a collection of independent parts, and the whole is equal to the sum of the parts. Therefore, the emphasis is on understanding the components. Such a perspective involves cause-and-effect, with the basic assumption being that finding the cause leads to the solution. The alternative view is holistic, in that living organisms are conceived of as integrated wholes in which structure, or form, and function interact dialectically—i.e., through the circularity of mutual feedback occurring as the system continues to organize itself—and through such organization, the whole is greater than the sum of the parts. It may be that Maturana and Varela's research is pointing the way towards an understanding of the nature of the biological substrate that will help to clarify the relationship between mind and matter that eluded William James a century ago, with important implications for understanding what occurs in human learning, particularly as it manifests in the psychotherapeutic relationship.

One somatic educator, writing from a holistic perspective, describes his approach to learning as "organic" (Feldenkrais, 1981, 1985). Leri, another somatic educator building on the thinking of Feldenkrais, explains, however, that in the process of Western acculturation, dichotomization of mind and body takes place as "the nearly infinite possibilities of the child's nervous system are pruned and shaped to fit its culture" (Leri, 1993, p. 51). Although he points out that "in their development, most children follow an ordered process particular to our species...[that] take[s] place without instruction" (p. 51), aspects of this process get interrupted in a dichotomizing culture such as ours:

> During this process the original organismic wholeness of the child turns into an assemblage of parts. The hand, a part, serves the whole, the body, by feeding it with fork or chopsticks. Language breaks the body into separate parts: the hand, the wrist, the arm, etc., which create a fragmented 'body of thought' apart from our unified organismic body. To make language a part of our biology, we need to be able to read, gain access to, and use the organismic body's "alphabet," "grammar," and "vocabulary." (Leri, 1993, p. 51)

Taking Leri's words to heart and returning to Cassell's warning concerning the implications of Western allopathic medicine's separation of mind and body in relation to suffering may enable us to see one of the most important ways in which we can learn from education as transformation. For this is a model of healer education where no such dichotomization takes place. Indeed, in this model not only is the realm of mind included, it is expanded to include the spirit. Katz reports that the Ju/'hoansi say that "being at a [healing] dance makes our hearts happy" (1981, p. 34). Moreover, he explains that

> For the [Ju/'hoansi], healing is more than curing, more than the application of medicine. Healing seeks to establish health and growth on physical, psychological, social, and spiritual levels; it involves work with the individual, the group, and the surrounding environment and cosmos. Healing pervades [Ju/'hoan] culture as a fundamental integrating and enhancing force. (Katz, 1981, p. 34)

In education as transformation, healing involves a particular kind of meaning making, one that stresses "balance, wholeness, and connectedness" (Katz, 1982b, p. 3). Although we must be careful not to impose an etic view—one from outside the culture—that inappropriately applies Western categories to another culture (Katz, 1982) and thus we must observe that the Ju/'hoansi do not have the same understanding of "mind" and "body" that we do (Menary, 1982), nonetheless these are cultures that view everything as interconnected, and healing involves maintaining this sense of connection and "stress[es] the education of the heart" (Katz, 1981, p. 74).

Looking to other cultures as well, we might note that Native American cultures also stress this idea of balance and connectedness when they speak of living in "right relation" to the land and to all beings, and that they see that "breaking any...relationships [is] a cause for the rising of disease of mind

and/or body" (D. Ywahoo, personal interview, 1987). Ywahoo, a Tsalagi (Cherokee) medicine woman, states that

> a key aspect of the Cherokee healing tradition is about people's relationships and how to call oneself into balance, and...the relationship with yourself and your immediate family members, and then your clan, too, which relates to an archetype, as mythic muse, that guides one and inspires one to creative action; [there is] also your relationship with the land and whether one is really keeping [one's] word. Like someone says "I will do this," and if they don't ever come through on doing [this], it creates a depletion in the life force, according to [the] Cherokee view, because they're breaking a vow and a commitment. So these are basic thought forms underlying the healing tradition and as causes of disease. [As a Cherokee], you see breaking any of these relationships, as a cause for the rising of disease of mind and/or body. (D. Ywahoo, personal interview, 1987)

Other cultures point very directly to the connection between healing and compassion. A Tibetan Buddhist doctor/lama, for instance, stated in a personal interview with the writer, "He [the doctor/lama] tries to help give happiness, just as he [himself] wants happiness. He tries to give happiness to others as much as he can, emulating Boddhisattva [saintlike] characteristics" (Y. Dhonden, personal interview, 1984). As Katz notes, "while stressing the way of the heart, education as transformation and these other educational paths [Lakota Sioux, the Bhakti path of Hinduism, the Christian devotional life, Mahayana Buddhism, and the life of the curandero] also include the way of the 'head' and the 'hand.' [Thus,] the classical Western distinction between thought, feelings, and beliefs is not important in [these] approaches" (Katz, 1981, p. 74).

For the purposes of discussion in this thesis, the writer maintains that education as transformation is a holistic paradigm, in that it is a model where all aspects of culture—including that which corresponds to the Western categories of body, mind, and spirit—are interconnected, and this is in contrast to the Western allopathic paradigm, which dichotomizes body and mind and tends to discount spirit altogether. The writer also maintains that the Western holistic medical perspective is closer to education as transformation than is the Western allopathic model. By the same token, we might note that Maturana and Varela's first way of understanding reality, based on cause-and-effect, is akin to the Western allopathic model, whereas their alternative view might be said to correspond in some ways to the education as transformation model.

In the preceding discussion, we have pointed to the importance of both the patient's and the physician's or healer's beliefs about their respective roles in the healing process. We have noted, in our references to compassionate care and to empathy, that the physician's or healer's beliefs are important in determining the degree to which he or she actually facilitates healing, an issue to which we will return in Chapter Four when we discuss empathy. Here, however, we turn to the underside of the question of the physician's or healer's beliefs, asking not what facilitates healing but what causes abuse of the knowledge and power that are intended for healing. Most importantly, we refer to the problem of sexual misconduct, which has proven to be an issue for some psychiatrists, among other professionals (Peterson, 1992; Rutter, 1989).

One recent study reported that 5%-13% of psychiatrists, other doctors, mental health professionals, and clerics have engaged in sexual misconduct with patients (Schoener, 1989, cited in Peterson, 1992). In another survey, circulated to members of the American Psychiatric Association, 6% of respondents admitted to having had sexual relations with patients (Gartrell, Herman, Olarte, Feldstein, & Localio, 1986). As we remind ourselves of Gilligan and Pollak's observation that "the dangers of intimacy are well marked in ethical codes and professional texts" (1988, p. 245), results of such studies cause one to ponder why it is that a small, but not insignificant, percentage of psychiatrists and other health professionals at some point in their careers become sexually involved with one or more of their patients, despite the fact that, in becoming physicians, they have taken the Hippocratic oath, "Thou shalt not inflict harm." A sexual relationship with a patient is not only unethical according to the profession's ethical code, it is counterproductive or even harmful to the patient. In attempting to answer this question, we should remind ourselves of the other part of Gilligan and Pollak's warning—namely that "the dangers of isolation remain comparatively uncharted in medical practice and education" (p. 245)—for isolation provides the context within which what is ideally a means of expressing mutual intimacy becomes an example rather of one individual in a more powerful position exerting power over another.

What, then, is the nature of this isolation and why has it not been looked at more closely? In addition to the problem of sexual misconduct, what other dangers does isolation hold for doctors and

therapists, and is it more dangerous to women than to men in medicine, as Gilligan and Pollak's data has suggested (1988)? While we will look more closely at these questions in Chapter Two, here we will touch on the question of how isolation is tied in with issues of status and power, both in general and specifically in the doctor-patient or the therapist-client relationship.

Peterson (1992), a social worker, has recently pointed out that "for centuries the conduct of society's most trusted servants was deemed above reproach" and professionals such as physicians, attorneys, clerics, and teachers "were assumed to be paragons of wisdom, morality, and excellence" (p. 1). Thus, one aspect of the isolation to which Gilligan and Pollak have referred might be the fact that doctors and mental health professionals are among those who, because of their power, are accorded a high status in Western society. As a result, their actions have been less likely to be scrutinized, or their power has made it possible to avoid or mitigate punishment for wrongdoing—although this is changing as "a better-informed and increasingly skeptical and litigious public" no longer has "such blind faith" (p. 1) and is becoming aware of what perhaps has always been there, the potential for the abuse of power by trusted professionals who hold a fiduciary relationship with those who employ them.

At the same time, this high status often correlates with difficulty in expressing vulnerability, either with the public or with peers. Unlike the traditional healers of the Kalahari and Fiji, who may openly share their pain and struggle with the community and not be penalized, physician-therapists in practice and/or in training often report that they do not feel they can easily acknowledge their vulnerabilities, for revealing one's weakness to another may leave one at risk. Thus, the learning environment in medical education, unlike in education as transformation, is not conducive to self-reflection or to examining one's mistakes—an inevitable part of learning—in the context of the community of one's peers.

The vulnerability of the patient has been well documented in sexual misconduct cases involving psychotherapists, including psychiatrists (Schoener, Milgrom, Gonsiorek, Luepker, & Conroe, 1986). Yet little attention has been given until recently to the vulnerability of the therapist that leads to this misconduct by psychiatrists (Benjamin, 1988; Messner, Groves, & Schwartz, 1989), other psychotherapists (Apfel & Simon, 1985; Bates & Brodsky, 1989; Guy, 1987; Kottler & Blau, 1989; Pope & Bouhoutsos, 1986; Sussman, 1992), and others in the helping professions (Rutter, 1989). In addition to possible characterological weaknesses on the part of perpetrating psychiatrists (Gabbard, 1989, 1991; Sussman, 1992), it may be that this unacknowledged vulnerability is exacerbated by the way in which psychiatrists are educated. Sussman, a psychologist who has studied the unconscious motivations of those who practice psychotherapy, has pointed out that those who choose psychotherapy as a profession too often do so because they themselves suffer from unresolved emotional issues in their own development, of which they are all too often ignorant (Bermak, 1977, Deutsch, 1985, Holt & Luborsky, 1958, Looney, Harding, & Barnhart, 1980, and Willi, 1983, cited in Sussman, 1992). He cautions, however, that psychotherapists "can no longer afford not to explore [their] own motivations to heal" (1992, p. 259). Indeed, these motivations, and the vulnerability they may lead to, should be looked at closely, at least in part because they may contribute to an abuse of the therapist's power, whether intentionally or not. Sussman's warning, in pointing out that these motivations and their implications <u>have</u> been ignored, points again to the isolation and the sense of distance amounting to disconnection that are the results of trying to maintain one's invulnerability (Gilligan & Pollak, 1988).

Peterson addresses the issue of sexual misconduct from the perspective of boundary violations, which she sees as involving "a <u>process</u> of disconnection that occurs within the context of the relationship" (1992, p. 3). Moreover, she believes that "in the client's eyes, the core of the connection with a trusted servant has a spiritual dimension" and that "boundary violations occur in part because our society is increasingly minimizing this [spiritual] dimension" (p. 3). Katz echoes her words in a different way as he concludes after his stay among the Fijians that:

> Many consider the core of Western culture, its spiritual foundation, to be missing, perhaps dead. The straight path can lead us to rediscover the freshness of our own spiritual traditions from within the dry materialism of our world.... In that, I am convinced, lies the straight path to our survival. (Katz, 1993, p. 325).

Continuing with our transcultural lens, then, we will also try to understand the question raised earlier in this chapter as to why some healers, whose training is intended to develop capacities that will allow them to help the individuals and communities they serve, might instead find themselves abusing that power. This is not to imply that any of the psychiatrists in the present sample are such abusers of power. Nonetheless, through their voices' revealing their relationships to the healing power, the self,

their patients, and their communities, as well as their strengths and vulnerabilities, perhaps we may further elucidate some of the issues facing psychiatrists today that might render some vulnerable to the temptation to abuse their power. In so doing, we will consider a recurring image found in the healing stories of many cultures—that of the "wounded healer" (Achterberg, 1988). To consider this theme is to ask whether indeed the price that one must pay to be a healer is to have been wounded and, ideally, to have learned how to heal oneself.

We also find throughout different cultures recurring themes of the "teacher as healer," one who, while living according to the principles of a "renewing tradition" and passing these on to others, becomes even more of use as a teacher to his or her community, empowering both self and community in a synergistic manner (Katz & St. Denis, 1991). Thus, a "teacher as healer" teaches from awareness of his or her own, as well as the community's, wholeness and interconnectedness.

Do our psychiatrists also teach from an awareness and acknowledgement of their own vulnerability, as well as their strengths? We will listen to the voices of our sample of psychiatrists in Chapters Six and Seven as they share—or choose not to share—these vulnerabilities and strengths with us, and what they feel that they have learned in so doing. We will return in Chapter Eight to the question of what, if anything, we might learn from traditional healers about empathy and the vulnerability of healers, and we will also consider whether the psychiatrists in our sample have anything to teach us about empathy and the problem of vulnerability versus invulnerability, a discussion that also involves related issues of power.

In contrast to the "teacher as healer," we juxtapose "the healer as expert," where a healer teaches by imparting the truth as the expert and utilizes a "power over" model in order to demonstrate that he or she knows more than the student. This mode of teaching corresponds to what one researcher (Light, 1980) has termed "training for control" or "omnipotence," as we will see in greater detail in Chapter Two. Light, a sociologist, found in his study of the socialization of psychiatric residents that psychiatric education specifically, and medical education in general, foster a tendency toward "omnipotence" and "training for control," which in turn results in "immunity to criticism" (p. 295). Thus, we might say that this encourages medical students and residents to cultivate invulnerability. In addition, overemphasis during medical and psychiatric training on the acquisition of a large body of intellectual knowledge and technical expertise, coupled with a lack of emphasis on the intricacies of therapeutic interaction with patients, can make medical professionals "oblivious to the needs of patients as patients define them" (p. 295). Indeed, Light asserted, these problems are "the unanticipated consequences of [medical] training programs" (p. 295).

These issues—of "training for control," the sense of "omnipotence" on the part of the psychotherapist within the psychotherapeutic relationship, and the emphasis on technical expertise—as well as the increased status of the psychotherapist in relation to his or her patient, which Light also raises, are all issues of power. Is there anything, then, in Western power models that sheds light on the question of why power and abuse are so often linked in Western culture?

When researchers examine, in general terms, the concept of power in Western societies, the model of "power over" appears to dominate in the literature (Kreisberg, 1986; McClelland, 1975; Miller, 1986). Thus, the most common concept of power entails the domination of one person or group over another more submissive person or group—thus of necessity implying a nonegalitarian relationship (Miller, 1986). In examining what power entails in the United States, Miller, a psychiatrist, has identified two main components—power for oneself and power over others—and she notes that the power of the other is "generally seen as dangerous. You [have] to control them or they [will] control you" (1986, p. 116). Thus, this view of power entails "the ability to advance oneself and, simultaneously, to control, limit, and if possible, destroy the power of others" (p. 116). However, more collaborative models of power, i.e., "power with," have also been identified as existing in Western culture although being much less common (Kreisberg, 1986; Miller, 1986). We will return to this idea shortly.

Other than the most obvious manifestation of power as physical force, power is also linked with knowledge. Knowledge in general, including healing knowledge, is quantified and regarded acquisitively, such that the knower "possesses" the knowledge (Freire, 1970, 1973; Polanyi, 1958). In this view, knowledge is power, and the knower has potential power over another person who does not possess this knowledge. Thus the less knowledgeable person is vulnerable to and may even be oppressed by the one who knows more (Freire, 1970). Perhaps tied in with this orientation toward knowledge and power is the fact that the healing knowledge in the United States is not freely available to all community members, but instead is viewed as a scarce and limited resource, where the supply of healing ability or

the healing resource is limited and thus becomes scarcer through use. What is given to one is not available to another (Katz, 1983/84).

This view of knowledge and power has particular implications for the psychotherapeutic relationship, for the patient is particularly vulnerable, especially when the knowledge shared includes areas that the patient has previously kept secret—perhaps even from the self—and when there is no corresponding sharing of secrets on the part of the psychiatrist. Often such secrets involve feelings of shame and disgust, and the most painful and shameful memories may have been kept secret even from the self, through repression, as with those who have a history of trauma (Herman, 1981, 1992). Thus psychotherapy patients keep secret those things about which they are most ashamed until they trust the relationship enough to feel that it provides, according to Havens (1989), a psychiatrist/analyst, "a safe place" to share.

At the same time, it is known that psychiatrists empathically resonate with the experiences and secrets that their patients relate, creating their own experience of meaning-making—through the processes of countertransference and interpretation (Basch, 1983; Bollas, 1987; Book, 1988; Buie, 1981; Casement, 1991; Havens, 1978, 1986, 1987, 1989, 1993; Margulies, 1984, 1989; Ogden, 1982; Schafer, 1983; Sussman, 1992; Winnicott, 1947/1958). Ideally, the therapist enters into a positive empathic understanding of the patient's circumstances and clearly comprehends what such understanding evokes in him- or herself, even if these feelings <u>seem</u> negative—what psychoanalysis terms "countertransference"—as the therapist draws parallels from his or her own experience. Psychoanalysis maintains that the patient re-enacts through "transference" with the therapist his or her own past modes of relating to others, and in turn, the therapist re-evokes his or her own feelings through countertransference. In theory, through analyzing this countertransference, the therapist comes to understand his or her own vulnerability vis-à-vis the patient, the better to serve the patient.

Not all therapists, however, deal adequately with their countertransference issues in either supervision or in their own therapy (Sussman, 1992), and, as a result, some might respond with a desire for mastery over the client, which is achieved when one knows another's secrets without reciprocal self-disclosure (Bakan, 1965). Bakan has pointed out the power that "mystery" or "secrecy" have in interpersonal relationships, in general as well as in psychotherapy, and has found that a desire for mystery or secrecy is often juxtaposed with a desire for "mastery" (Bakan, 1965). Thus, "In the social spheres one of the major defenses that the individual has...is the keeping of secrets—the secret of his [or her] state of affairs, or the secrets of his [or her] intentions" (p. 186). Continuing, Bakan points out that "knowledge of the secrets of others gives one the advantage and that discretion, in the sense of revealing only what one wishes to reveal, is valuable both in protecting ourselves from others and in manipulating others" (p. 186). He regards mystery as "the protection against the mastery impulse of others," but since "in our total society we would be both masters and yet unmastered, we walk the complicated path of pursuing both the objectives of mystery and mastery" (p. 186).

Returning to the concept of "power with," Kreisberg (1986) maintains, in an extensive literature review, that a clear distinction was made between "power over" and "power with" as far back as 1918, in a work by Follett about industrial organization and administrative management. Follett described "power with" as "'jointly developed power' where people fulfill their desires and develop their capacities through acting together" and through sharing resources for mutual benefit. (Follett, 1942, cited in Kreisberg, 1986, p. 48). Thus, "power with" entails "capacity," or the power to do (Follett, 1942, cited in Kreisberg, 1986, p. 48). She further maintained that mutual empowerment results for both self and other in a "power with" model, while she viewed "power over" as a destructive form of power: "Genuine power is not coercive control but co-active control. Coercive power is the curse of the universe; co-active power, the enrichment and advancement of every human soul" (Follett, 1924, p. xii, cited in Kreisberg, 1986, p. 49).

"Integration" lies at the heart of Follett's concept of power:

> It is through integration occurring within groups that it is possible for individuals with different and conflicting desires to fulfill these desires. Integration is, simply, the process by which all interests in a given situation get what they want and neither side has to sacrifice anything. Through integration people discover their capacities to fulfill their desires together. (Follett, 1942, p. 32, cited in Kreisberg, 1986, p. 49)

Kreisberg notes that there are "two key concepts" in her description of the process of integration: "reciprocal influence" and "emergence" (Follett, cited in Kreisberg, 1986, p. 50). Thus, "rather than offering a cause and effect or 'linear' description of the functioning and development of power she offers

a 'circular' description" (Follett, 1942, cited in Kreisberg, 1986, p. 50), described in terms of a game of tennis:

> A good example of circular response is a game of tennis. A serves. The way that B returns the ball depends partly on the way it was served to him. A's next play will depend on his own original serve plus the return of B, and so on, and so on. (Follett, 1942, p. 44, cited in Kreisberg, 1986, p. 50)

Likewise, she explained "reciprocal influence":

> The key to our problem lies in what we mean by reciprocally influencing. Do we mean all the ways in which A influences B, and all the ways in which B influences A? Reciprocal influencing means more than this. It means that A influences B, and that B, made different by A's influence, influences A, which means that A's own activity enters into the stimulus which is causing his activity. (Follett, 1942, p. 194, cited in Kreisberg, 1986, p. 50)

We will see further in Chapters Three and Four how empathy may also be characterized by reciprocal influence.

"Emergence" occurs simultaneously in the integrative process as "people seeking to fulfill their desires enter into reciprocally influencing relationships" (Follett, 1942, cited in Kreisberg, 1986, p. 50):

> "Emergence" is the aspect of integration in which individuals and groups create new solutions, new values, new capacities, more power [in such a way that] each calls out something from the other, releases something, frees something, opens the way for the expression of latent capacities and possibilities. (Follett, 1942, p. 197, cited in Kreisberg, 1986, p. 51)

Miller discusses the nature of this model of "power with" in the context of female psychological development, which is influenced by the unequal power relationship that exists between men and women. She believes that women, in particular, frequently learn to fear their own power more than that of others, having "been led to feel that they can integrate and use all their attributes if they use them for others, but not for themselves,...[and, thus,] they have developed the sense that their lives should be guided by the constant need to attune themselves to the wishes, desires, and needs of others" (Miller, 1986, pp. 61-62). This is made more difficult by the fact that "women's direct use of their own powers in their own interests frequently brings a severely negative reaction from [men]" (p. 120). Due to the nature of their psychological development, therefore, "women feel compelled to find a way to translate their own motivations into a means of serving others" (p. 64). As a result, women arrive at a different "integration" than men in relation to power (p. 64), which, in the context of a "power over" model where unequal balance of power is the norm, has often entailed a disempowered stance in relation to men.

Thus, according to Miller, women in the West are not "full-fledged representatives of the culture" (1986, p. 73). In other words, when judged from the culture's dominant "power over" stance, women are found wanting; they don't quite measure up. Yet if viewed instead through the lens of the "power with" model, the positive side of women's stance can be seen. In a culture dominated by the "power over" model, women, in fact, have embodied and kept alive the concept of living in connection with others, the "power with" model. In its most positive form, women "experience pleasure in mutually enhancing interactions and the gratification that they have enlarged the lives of others" (p. 133), a stance that results in mutual empowerment. In this way, women remind us that in all humans, male or female, "individual development proceeds only by means of connection" (p. 83). Miller builds on the thinking of Robbins (1950, cited in Miller, 1986, p. 27) that, by embodying this "power with" stance, women are carriers of certain essential values for our culture. Nonetheless they maintain that, although these values have generally been considered to be feminine attributes, they are, in fact, human rather than solely feminine qualities. Thus, "human" encompasses both stances equally, coexisting in a balanced way, as the Ju/'hoansi also show us through education as transformation.

Indeed, according to one archaeologist (Gimbutas, 1982), recent findings show that early cultures were both goddess-worshipping and matrilineal and that they appear to have been more highly developed and more widespread and to have lasted longer than previously thought—through the time of the Minoan civilization of Crete. Yet Gimbutas maintains (contrary to mainstream archeological thinking) that while women and the goddess were predominant for centuries, there was also no indication that women adopted the familiar "power over" stance. Instead, the imagery in these cultures, according to Eisler and Gimbutas,

> reflects the markedly different attitudes prevailing in the Neolithic about the relationship between women and men—attitudes in which linking rather than ranking appears to have been predominant. As Gimbutas writes, here "the world of myth was not polarized into female and male as it was among the Indo-Europeans and many other nomadic and pastoral peoples of the steppes. Both principles were manifest side by side. The male divinity in the shape of a young man or male animal appears to affirm and strengthen the forces of the creative and active female. Neither is subordinate to the other; by complementing one another, their power is doubled. (Gimbutas, 1982, cited in Eisler, 1987, p. 27)

Having noted, however, Miller's feminist view that women are not full-fledged members of the culture, and thus often do not feel empowered, we might say that they suffer from a lack of inclusion. One researcher in social relations has argued that inclusion is "one of the three needs considered 'primary' in interpersonal relations" (Schutz, 1956, cited in Morimoto, 1957, p. 1). According to Morimoto, "The need for inclusion has been conceptualized on the feeling level as a need to feel self-worth, be unique, important, recognized, accepted, and belonging, while on an action level there is the need to behave in such ways as to provoke responses that will elicit behavior that will fulfill these expectations" (1957, p. 2). We will see that empathy is involved in inclusion, because when we feel included, we feel understood and empathized with. Yet studies have shown that women medical students feel "excluded, isolated" (Nadelson & Notman, 1983, p. 15) and "not regarded as serious" (p. 15). Given these findings, and coupled with the data of Gilligan and Pollak regarding women medical students' and women doctors' relational bias and the higher-than-expected suicide rate among them, we may wonder whether there is any connection between suicide and a nonrelational—or unempathic—learning environment emphasizing "power over." We may also wonder how people of different race or ethnicity who are relationally oriented might respond to the allopathic learning environment. Thus, in general we may ask whether relationally oriented people practicing a "power with" orientation might find it difficult to adjust to a predominantly "power over" orientation in medical school.

This overview of the alternative view of power in the West leads us back to the Fijians and the Ju/'hoansi, for when we look at the stance of these cultures toward power and its abuse, we find that is similar to Follett's "power with" model, with a notion of healing that emphasizes the importance of "integration" of all aspects of community (Follett, 1942, p. 32, cited in Kreisberg, 1986, p. 49). Thus, "healing pervades culture as a fundamental integrating and enhancing force" (Katz, 1981, p. 34). An important aspect of this view of power can be seen in the way in which they conceive of the relationship of the healer to the healing knowledge.

Among the Ju/'hoansi, those who have learned to heal are believed to "possess" the healing power or n/um and thus are called n/um kausi or "masters or owners of n/um" (Katz, 1982b, p. 41). While we note that the English language lacks an exact translation of what the Ju/'hoansi conceive of as "mastering" or "owning" n/um, it can be stated that possession of the healing resource in this cultural context connotes caretaking that resource for communal use rather than accumulation for personal use (Katz, 1981, 1983/84). For as healers dispense n/um to the community during the healing dance, the healing resource is viewed as actually being expanded in the process of being used for healing. There is enough for all members of the community, including the healer. What is available to one is available to all. This, then, is a synergistic model (Katz, 1981, 1983/84), in which the whole is greater than the sum of its parts. The fabric of the whole community appears to be enhanced by the healing of individual members, and there is an abundance of the resource available the more it is used. This perhaps offers an alternative to the scarcity perspective that presently dominates the Western allopathic medical paradigm by serving as an example of a different way of viewing the allocation of the healing resource, a synergistic one in which that resource expands the more it is used (Katz, 1983/84). We will explore this idea further in Chapter Eight, considering whether it is possible to apply the concept of synergy to the allocation of healing as a resource in the West, and if so, in what ways. In addition, both of these traditional societies emphasize the importance of the healer's character and self-knowledge as much as, or more than, the actual acquisition of the healing knowledge and technology. The healer is also held continually accountable as an ordinary member of the community, so that the fact of being a healer does not confer status that puts that person above the other members of the community.

Along with this emphasis on character is the acknowledgement of the temptation to abuse power, including the awareness that the more proficient the healer becomes in utilizing the healing power, the more he or she is tempted to misuse it. As a result, the education of healers in these cultures actively inculcates this awareness, including an understanding that these abuses may be minor. "For example," Katz says, "clients may come with greater expectations for a cure, tempting healers to exaggerate their

powers; or they may come feeling more dependent, tempting healers to manipulate them" (Katz, 1993, p. 52). More blatant abuses are having sexual relations with the person seeking help, taking money for healing work, or using the healing power for witchcraft that is harmful to someone else. Such abuse of the healing power is believed to result in the loss of that power (Katz, 1993).

In Fiji specifically, healers, both male and female, must continually struggle to stay on the "straight path" and to embody certain ideal attributes or qualities for all Fijians. Yet Fijians do not understand either "straight" or "path" in the linear way that Westerners do—as in a "straight" line between two points. But although the process as a whole may be nonlinear, or not "straight" in the Western sense, the healer's attitude within that process must be straight—that is to say, adhering as much as possible to the seven principles of the straight path. As Katz explains,

> A common metaphor for the straight path is a path cut by hand with a cane knife through heavy forest underbrush. In creating the path the healer at times reaches a dead end or finds a shortcut, following both torturously difficult passages and relatively easy ones, so that his or her movement fluctuates in rhythm and speed, sometimes circling back on itself. The Western understanding of development, including clear directions, linear progress, and success defined by levels of attainment, does not apply. "Straightness" refers not to a straight line but to a correct or "straight" attitude or motivation. Though the path itself is not straight, the way one travels it should be. (Katz, 1993, p. 64)

One of the most important aspects of the straight path is that the Fijian healer functions, in Katz's term, as a "moral explorer" to whom the whole community looks for guidance in the face of uncertainty and threats to survival. In this capacity, the healer "[seeks] to define anew what, until the advent of 'progress,' had been relatively set by tradition" (Katz & Kilner, 1987, p. 223).

As education as transformation accepts as a given that the temptation to abuse the power is part of the healer's development, it may point us in the direction of addressing this in Western medicine, which has been slow to accept that the problem of abusing power indeed exists, and has too often failed to address it within the context of professional education and training programs (Konner, 1993; Patenaude, 1994). In a recent study of fourteen mental health professionals, including physicians, psychologists, social workers, marriage and family counselors, and clergy, respondents were asked, among other questions, "How many people, in your professional life, have reported sexual abuse by the helping professional to you?" and "How many people in your personal life have reported sexual abuse by the helping professional to you?" (Patenaude, 1994, p. 22). Patenaude reported a mean of eighteen people per respondent for professional cases and a mean of six people for personal cases, and thus supported the literature that points to "the wide-spread, epidemic proportions of the problem of sexual abuse by the helping professional" (p. 64). Perhaps more telling, however, were the findings that "64% of the sample of this study either were sexually exploited themselves, or had a family member who was sexually abused by a helping professional" (p. 64), that there "is considerable lack of clarity among helping professionals regarding the issue of sexual exploitation of the client...[and that] professionals are...unclear about how to proceed with a client who has been molested or exploited by a colleague" (p. 65). Patenaude cites Stone who, in his book, Law, Psychiatry, and Morality (1984), "addressed the lack of existing cultural structures for this legal, moral, and ethical problem...[and concluded that] as yet these frameworks do not exist in our society" (p. 66). Finally, Patenaude found that "there is a great deal of fear involved in reporting one's colleagues" (p. 66) as well as "legal complications of reporting" (p. 67).

To return to our cross-cultural comparison: the model of power in the West is different from that of the Ju/'hoansi and the Fijians. As a result, Western healers may conceive of a different relationship toward the healing power, the self, the other, and the community than do the healers educated according to education as transformation. This fact also, of course, manifests in the corresponding educational models.

Is this transcultural study involving a traditional, or indigenous, healing system relevant, precisely because of the broadly human experience behind the principles of and the issues raised by both the Western biomedical, allopathic model and education as transformation? For, although this human experience arises within very different cultural contexts, the fact that both educational paradigms are designed to promote the health, or wholeness, of human beings means that they cannot be considered irrelevant to each other. Indeed, since in a broad sense the experience of the present-day Ju/'hoansi and Fijians whom Katz was researching is far closer than that of Western psychiatrists to the hunting-gathering mode that characterized, for millennia, the cultural life of most of humanity and during which some say the foundations for our survival were laid down (Lee & DeVore, 1968, 1976), this experience

must instead be considered highly relevant. Education as transformation, as a paradigm of healer education that arose out of this foundational period of human existence, thus has relevance for us today in the West as we confront our problems concerning healing and healer education, and within this larger frame, community psychiatric education.

Katz and Kilner remind us that the "concept of self-embedded-in-community [of the Ju/'hoansi and the Fijians] contrasts with the dominant Western value of individualism, with its individualistic concept of self, separate and separating from others and community (Bourguignon, 1979; LeVine, 1982)" (Katz & Kilner, 1987, p. 229). In a similar way, some indigenous or traditional peoples in the United States conceive of their own way of making meaning as "primal mind," contrasted with Western dualism (Highwater, 1981). The concept of primal mind embodies such principles as "inclusivity" and "an exquisite homogeneity and a wholeness which puts each tribal member in direct contact with his or her culture and with its carefully prescribed and perpetuated forms" (Highwater, 1981, p. 55). Within the model exemplified by these various cultures, there is no dichotomization of mind and heart, or separation from nature, or disrespect between individuals that the Western allopathic model has been criticized for (Konner, 1993). All is imbued with spirit. Everything is interconnected and alive—what Highwater calls "real":

> The Indian does not make the separation into personal as contrasted with impersonal in the western sense at all...and everything that is perceived by the senses, thought of, felt, and dreamed of, truly exists for him...as *inseparable* aspects of the real. (Highwater, 1981, p. 56)

Perhaps these concepts of the embedded self and of primal mind speak to more deeply human qualities than those of the isolated, "individuated," "fragmented" self with its "pluralization of life-worlds" (Berger, Berger, & Kellner, 1974) that exists in Western culture. Ginsburg (in press) reminds us that, in the West, it is difficult to pin down exactly what we mean by a "self" and that we are wrong to equate "self" with "personality" or "identity." He has maintained in an earlier article that Rogers conceived of a self as somatically based (Ginsburg, 1984, in press), an idea that Ginsburg also supports. Katz and Kilner (1987) juxtapose the concept of self-embedded-in-community found among the Ju/'hoansi and Fijians with that of the fragmented self described above. Moreover, they note that "the embedded concept of self is much closer to the value and functioning of the connected self described by Gilligan (1982) and others in their work on female development" (Katz & Kilner, 1987, p. 229). While some have viewed the self in relation from a feminist perspective, it is the opinion of the writer that that which is often thought of as specifically feminine is, rather, what it has meant, during most of our existence spent as hunters-gatherers, to be <u>human</u> (Miller, 1986; Robbins, 1950, cited in Miller, 1986, p. 27).

In preparation for listening to the voices of our psychiatrists, we will begin Chapter Two with a more detailed overview of the two paradigms of healer education in order to better understand the principles on which each model is based as well as to assess the degree to which each model is similar to or different from the other. We will first introduce healers educated according to education as transformation and examine how they follow or do not follow the seven principles of this model. It is important to note that Katz's research yields generalized pictures of Ju/'hoansi and Fijian healers, and that in both cultures, not everyone conforms with the education as transformation model, nor manages to stay on the straight path. Then, we will look at the characteristics of allopathic psychiatrists in general (who in turn are part of the larger grouping of medical doctors), and we will consider community psychiatrists as a special subgroup within psychiatry. This exploration will help us to consider whether community psychiatrists are characterized by traits that are similar to those of private-practice psychiatrists, or whether they exhibit their own unique patterns.

Central to the critique of the Western allopathic, university-based medical paradigm is the literature that identifies a distancing "voice of medicine" (Gilligan & Pollak, 1988; Illich, 1982; Jonas, 1981; Kleinman, 1988b; Mishler, 1984; Paul, 1991; Reiser, 1978) as the stance of the Western therapist/doctor vis-à-vis his or her patients. We will consider what connection there might be between such a distanced position and the possible misuse of power, although also recognizing that such distancing may, depending on the circumstances, be the best use of power for both physician and patient.

Throughout our exploration, we will bear in mind the concern raised in the literature as to the possible importance of fostering connection and empathy in doctors-in-training, including but not limited to those who will go on to become psychiatrists. In line with this thinking, we will thus look at the concept of empathy in Chapter Three—how it has been viewed in the literature since the time of Freud in psychiatry, the branch of medicine that studies the mind (Havens, 1987), as well as in other fields that

educate psychotherapists. According to one psychoanalytic researcher, Freud himself considered empathy to be a "process [that] remained a neglected and unsolved theoretical problem" (Margulies, 1989, p. 4), and, as we will see, researchers and theorists still do not agree about either how to define empathy or how to measure it (N. Eisenberg & Strayer, 1987; Lichtenberg, Bornstein, & Silver, 1984a, 1984b). We will pay particular attention to a literature describing empathy as a relational process (Myers, 1992), involving interaction between self and other, although placing different emphases on the importance of "the self, the other, and the space between the two" (Mitchell, 1988, p. 33). For example, Belenky and colleagues, writing from the perspective of women's experience with higher education, have noted that an empathic knower is a "connected knower" (Belenky, Clinchy, Goldberg, & Tarule, 1986). Our perspective will thus focus on the interactive nature of self in relation to other, beginning in development with the mother-infant relationship. This discussion will in turn furnish a context within which to consider, in Chapter Seven, the appropriateness and effectiveness of our instrument, the Questionnaire Measure of Emotional Empathy (Mehrabian & Epstein, 1972), in measuring this quality among our community psychiatrists.

In Chapter Four we will lay out our reasons for choosing our methodology, a qualitative approach known as thematic analysis, as an appropriate way of listening for the variety of voices among our subsample of eight community psychiatrists, and for allowing vulnerability a place in research (Katz & Nunez-Molina, 1986; Reinharz, 1979). In addition, while attempting to do justice to the richness of experience that these community psychiatrists' words convey, as well as to open up our thinking in relation to the Western medical paradigm, we will consider the relativity of knowledge and truth in a broad sense to pinpoint the kind of "knowledge" and "truth" we are researching.

After laying the groundwork for our cross-cultural and cross-disciplinary approach based on the notion of "vulnerability in field work" (Katz & Nunez-Molina, 1986), the methodology will be delineated in Chapter Five. In Chapter Six, we will listen to our psychiatrists as they speak of their education and their concepts of healing, including a consideration of whether the distancing voice of medicine is the only voice in medicine. In our analysis in Chapter Seven of our subsample of eight community psychiatrists, we will take into account gender and ethnic differences as well as any unusual characteristics. We will attempt to elucidate any distinctive themes or patterns that emerge in the educational stories of those who opt to go into community psychiatry rather than into private-practice psychiatry. Perhaps their unique perspectives might also point toward new directions. We will thus analyze the themes that have emerged, utilizing our transcultural lens to assess the degree to which the principles of education as transformation are reflected in the themes in these psychiatrists' stories as well as how these themes correspond—or fail to correspond—with their empathy scores.

Finally, in Chapter Eight, we will consider whether the characteristics of community psychiatrists in our sample are in any way similar to those of education as transformation healers, and we will discuss the implications of our findings for the future education of psychiatrists and other health professionals. Among other things, we will consider what we might learn from both traditional healers and our community psychiatrists concerning the questions of vulnerability and empathy and of how to use both in a positive way.

The views we are trying to assume might perhaps be captured in two images, that of an eagle's soaring high over the landscape and that of a mouse's scurrying among grass and leaves below. Throughout these chapters we will seek to know the world of both the eagle and the mouse—simultaneously the very wide perspective and the very close up—that together will allow us to understand our experienced world more fully.

Chapter Two:
The Two Models:
Education as Transformation
and Western Allopathic Psychiatric Education

Education as Transformation

Although Katz's fieldwork among the Ju/'hoansi took place during only three months in the late 1960s, he joined in an ongoing collaborative effort of several researchers known as the Harvard Kalahari Research Group (Lee, 1979; Lee & DeVore, 1968, 1976). Thus, he continued to work with this research group over several years both prior to, and after conducting his fieldwork there. Katz had initially become interested in studying the healing system of the Ju/'hoansi because of the way in which they used enhanced or altered states of consciousness without hallucinogenics for the benefit of all members of the community during the course of their healing dance (Katz, 1982b). Influenced by William James's study of altered states during conversion experiences (1902/1961), Katz recognized that among the Ju/'hoansi, "a particularly powerful form of healing occurs when the process of transition [toward meaning, balance, wholeness, and connectedness] is accomplished through an altered state" (Bourguinon, 1973, 1979, Durkheim, 1915, Levi-Strauss, 1963, LeVine, 1973, and Van Gennep, 1960, cited in Katz, 1982b, p. 3). He thus "saw the possibility that the study of healing and consciousness might provide important insights into human nature and potential" (p. 3). Speaking of "individuals and communities which seek healing...in the midst of crises, confusion, or a search for fulfillment" (p. 3), Katz observes:

> In their vulnerability and openness to change, they reveal fundamental aspects of behavior, such as fears and hopes. As they participate in a healing process that is accomplished through an altered state, these fears and hopes are acknowledged as the context for the healing transition, their resolution or fulfillment as the aim of that transition. In this way the study of healing and consciousness deals with the intensification and enhancement of human potential. (Katz, 1982b, p. 3)

According to Katz, "states of consciousness are patterns of human experience which include ways of acting, thinking, perceiving, and feeling. An altered state of consciousness is radically different from the usual everyday patterns" (Bateson, 1972, Tart, 1969, 1975, cited in Katz, 1982b, p. 3). Nearly a century earlier, James had expressed it thus in The Varieties of Religious Experience (1902/1961) as he struggled to understand "how to regard" such "potential forms of consciousness" (p. 298):

> One conclusion was forced upon my mind at that time, and my impression of its truth has ever since remained unshaken. It is that our normal waking consciousness, rational consciousness as we call it, is but one special type of consciousness, whilst all about it, parted from it by the filmiest of screens, there lie potential forms of consciousness entirely different. We may go through life without suspecting their existence, but apply the requisite stimulus, and at a touch they are there in their completeness.... No account of the universe in its totality can be final which leaves these other forms of consciousness quite disregarded. (James, 1902/1961, p. 298)

James's deep concern with the nature of consciousness, including his interest in altered states, did not become the focus of mainstream psychology in the first half of the twentieth century. Nonetheless, Katz and many other thinkers since James's time have continued to grapple with the question of consciousness and to distinguish between altered or enhanced states of consciousness and ordinary, everyday consciousness (Bateson, 1972; Grof, 1976, 1983; Katz, 1982b; Lee, Ornstein, Galin, Deikman, &

Tart, 1976, Pelletier, 1978; Wilber et al., 1986), both in general terms and as they relate specifically to the issues of sickness, suffering, and healing.

As we continue with our exploration of the education as transformation model of healer education, with our focus on its implications for Western allopathic medicine in general and psychiatry in particular, we will therefore periodically return to the question of consciousness, for it perhaps underlies all of our other questions regarding the nature of healing and the best way to educate healers. Thus, as we consider the educational stories of the community psychiatrists in our sample in contrast to those of Ju/'hoan healers participating in their communal dance, and Fijian healers walking the "straight path," one of the fundamental questions that we will be exploring is the nature of the consciousness that is involved both in the act of healing and in the creation of a meaningful fabric from the vulnerabilities and challenges that confront these healers.

Education as Transformation: General Principles

We turn now to a fuller description of the education as transformation model of healer education, examining it first in general terms and then in its particular manifestations in the two cultures most central to the model, the Ju/'hoansi and the Fijians.

Katz returned to the Kalahari for four months in 1989, after the publication of Boiling Energy: Community Healing among the Kalahari !Kung (1982b), where he told their story to a Western audience as he had been instructed by them to do. He lived among the Fijians for a considerably longer period, from 1977 to 1979, and returned once again in 1985 before publishing The Straight Path (1993), about which he had received a similar instruction. He was gradually accepted as a trusted member of both communities, one who was invited to join in the communities' rituals and was taught much about the spiritual basis of their healing practices. From this cultural immersion, he developed the education as transformation model of healer education to describe how these cultures conceive of the act of healing, how a healer develops his or her abilities or powers, and the qualities of character that are expected of a healer.

Katz acknowledges that, with the influx of Western cultural values, education as transformation is a model in the process of undergoing change in a variety of ways. In both cultures, some healers have moved into urban areas and have begun to charge for their services, while others have begun to adapt the forms of their traditional healing ceremonies in order to perform them for money for outsiders (1982b). Nevertheless, despite the encroachment of other cultures, education as transformation has survived close to its original form among those still living in more remote regions.

Katz has summed up this model in seven general principles:

1) Becoming a healer involves "an initial transformation of consciousness [or Altered State of Consciousness—A.S.C.], a new experience of reality in which the boundaries of self become more permeable to an intensified contact with a transpersonal spiritual realm" (Katz, 1981, p. 71).
2) As healers become educated, they remain ordinary members of the community, continuing to carry out their everyday responsibilities in addition to performing healing (Katz, 1981, p. 71).
3) Healers provide service to the community in the course of providing healing and thus serve as their community's "emissaries" in that "the healers' commitment is to serve as vehicles that channel healing to the community rather than accumulate power for personal use" (Katz, 1981, p. 72).
4) Healers undergo an "inner development" in the course of their education that is not "rewarded by changes in external status" (Katz, 1981, p. 72). This is a transformational model of development, especially among the Fijians, where "movement along the straight path is characterized by moving through transitions.... This movement is neither unidirectional nor the basis for permanent developmental gains" (Katz, 1993, p. 338).
5) Healer education emphasizes the strengthening and development of "character" rather than the technology of healing (Katz, 1981, p. 72). "Character" involves qualities such as "honesty," "judgment," "kindness," and "purity" (Hahn, 1982, p. 5).
6) "Qualities of heart—courage, commitment, belief, and intuitive understanding—that open the healers to the healing potential and keep them in the healing work" are more important than mind or knowledge. (Katz, 1981, p. 72).

7) Finally, healers become "moral explorers" or "tester[s] and definer[s] of reality" for their community (Hahn, 1982, p. 6, citing Katz & Kilner, 1987): By "act[ing] with respect for the essential values of the culture" (Hahn, 1982, p. 6), healers come to define and embody the morality of that culture. Katz and Kilner point out that in Fiji particularly, "the elders...[are] moral explorers, seeking to define anew what, until the advent of 'progress,' had been relatively set by tradition" (Katz & Kilner, 1987, p. 223).

Education as Transformation Among the Ju/'hoansi: The Boiling N/um

Turning now to this model's manifestation among the Ju/'hoansi, we will see that central to this culture's healing practices is the transformation of consciousness that occurs in the course of the entire community's periodic participation in a ritual healing dance. In his book on the Ju/'hoansi (1982b), Katz has described how, through participating in this dance, as well as through the direct laying on of hands, all community members witness and participate in their healers' struggle with the spirits of the dead, and, in so doing, receive healing. "Sickness" is viewed as "a manifestation of imbalance that may flare up from time to time, expressing itself as a specific 'illness' with specific symptoms" (Katz, 1982b). "Healing," while encompassing the notion of "curing," in which the symptoms of an illness are alleviated, is viewed in larger terms as "a process of transition toward meaning, balance, wholeness, and connectedness, both within individuals and between individuals and their environments" (Katz, 1982b, p. 3). Specifically, sickness is seen as involving the struggle of the living with the spirits of the dead, who wish to steal away the souls of the living (p. 43). This struggle, taking place in the context of the communal healing dance, is "at the heart of the healer's art and power" (p. 43). And, many do not succeed in mastering the boiling n/um, or have lapses in the traditional ways that the n/um is accessed.

Shostak, another anthropologist who conducted field work for the Kalahari research project, arriving in 1969 and spending twenty months there, has written about the experience of Ju/'hoan women in Nisa: The Life and Words of a !Kung Woman (1981). Speaking there of the ancient origins of the healing dance, she describes it as "the central ritual event in traditional !Kung [Ju/'hoan] life" (1981, p. 10):

> [It is] grounded in a very old tradition—so old that its origins are beyond speculation, even among the very oldest living !Kung. Its long history is confirmed by scenes depicted in rock paintings, by dance circles etched in rock, by archaeological findings, and by the occurrence of dances similar in form, content, and musical style in San groups that speak languages other than !Kung and live several hundred miles away. (Shostak, 1981, pp. 10-11)

Konner, another anthropologist and member of the Kalahari project who, after spending two years among the Ju/'hoansi, went on to be educated as an allopathic doctor, characterizes the dance in the following way:

> I witnessed an ancient and supposedly "primitive" form of medicine: healers entering trances in the course of a complex ritual dance, set to an eerie music between the firelight and the desert night sky. They laid their hands on the ill and the well alike, showing with all the energy in their hearts, minds, and bodies that they cared deeply about the outcome. (Konner, 1993, p. xv)

The healing dance begins with the singing and clapping of the women, and all community members subsequently gather and participate in this ritual which occurs throughout the night. Seasoned healers dance in order to reach an altered state of consciousness, a trance state known as kia, which in turn allows them to activate their "boiling energy" or n/um, which normally resides in a quiescent state in the base of the spine and the pit of the stomach. Once activated, n/um can then be dispensed as healing power to the community, at both an individual and a group level (Katz, 1981, p. 41).

One healer interviewed by Katz, named Kinachau, describes the process in the following manner:

> You dance, dance, dance. Then, n/um lifts you up in your belly and lifts you in your back, and then you start to shiver. N/um makes you tremble, it's hot.... Your eyes are open but don't look around; you hold your eyes still and look straight ahead. But when you get into kia, you're looking around because you see everything, because you see what's troubling everybody.... N/um enters every part of your body right to the tip of your feet and even your hair. (Katz, 1980, p. 6)

During the dance, there is much body contact as dancers carry and support each other during different stages of trance. The dancers also exchange n/um in a concrete way by rubbing each other with their sweat, which Shostak describes as being "considered to be imbued with power" (Shostak, 1981, p. 292).

Once the n/um has come to a boil by means of the dance, it must be regulated by the healer, so that it is neither too hot nor too cold. Nor is the n/um for personal use. The healer dispenses the healing power to the community. Shostak offers this description of how one healer moves throughout the group, which is now sitting around the fire:

> In trance, a healer lays hands on and ritually cures everyone sitting around the fire. His hands flutter lightly beside each person's head or chest or wherever illness is evident; his body trembles; his breathing becomes deep and coarse; and he becomes coated with a thick sweat—also considered to be imbued with power. Whatever "badness" is discovered in the person is drawn into the healer's own body and met by the n/um coursing up his spinal column. The healer gives a mounting cry that culminates in a soul-wrenching shriek as the illness is catapulted out of his body and into the air. (Shostak, 1981, p. 292)

The healing power may also be directed more generally, not to heal particular individuals but to avert threats to the community's survival. Shostak tells how Nisa, a Ju/'hoan woman who was about fifty years old and a non-healer, describes her impression of what had happened to her father as he danced for this purpose when she was a child:

> My father entered a medicinal trance. While his body tranced, his spirit flew to the spirit world, to talk to the gods. Together, the spirits sent the lions away, because soon they left and went to another water hole far away. When my father came out of trance, he returned to us. Then we all slept. (Shostak, 1981, p. 101)

Wi, an old and experienced healer, speaks of learning to "see" in a particular manner as he dances, a skill that involves will and single-mindedness and that not everyone is able to master. Speaking of a less-experienced healer, Dau, who is attempting to learn, Wi says:

> What tells me that Dau isn't fully learned is the way he behaves. You see him staggering and running around. His eyes are rolling all over the place. If your eyes are rolling you can't stare at sickness. (Katz, 1980, pp. 7-8)

During kia, healers report being able to do things they cannot ordinarily do. Some are able to walk on hot coals; others, such as the blind healer, Kau/Dwa, can see. Kau/Dwa says:

> God keeps my eyeballs in a little cloth bag,...and now when I dance, on the night when I dance and the singing rises up, He comes down from heaven swinging the bag with the eyeballs to my eye level, and as the singing gets strong, He puts the eyeballs into my sockets and they stay there and I cure. And then when the women stop singing and separate out, He removes the eyeballs, puts them back in the cloth bag and takes them up to heaven. (Katz, 1980, p. 6)

Would-be healers also take part in the dance in an attempt to master their fear of n/um, for this is a "painful and mysterious [process that] is greatly feared" (Katz, 1981, p. 62). As another healer says, "N/um got into my stomach. It was hot and painful in my gebesi [i.e., the area between the diaphragm and the waist] like fire. I was surprised and I cried" (Katz, 1981, p. 45).

Not only is learning how to make the boiling n/um rise a physically painful process, it also is said to involve actually going through the process of dying, which is a fearful process in any culture. Katz describes how he struggles with his uncertainty about this notion of "dying," wondering whether it means the same thing to a Ju/'hoan healer as in Western culture. Thus Katz questions the healer named Kau/Dwa:

> "Kau/Dwa," I ask, "you have told me that in !kia you must die. Does that mean really die?"
>
> "Yes."
>
> "You mean die like when you are buried beneath the ground?" I am already struggling with my words.
>
> Yes," Kau/Dwa replies with enthusiasm. "Yes, just like that!"

"They are the same?"

"Yes the same. It is death I speak of," he affirms.

"No differences?" I almost plead.

"It is death, " he responds firmly but softly.

"The death where you never come back?" I am nearly at the end of my logical rope.

"Yes," he says simply, "It is that bad. It is the death that kills us all."

"But the healers get up, and a dead person doesn't." My statement trails off into a question.

"That is true," Kau/Dwa replies quietly, with a smile. "Healers may come alive again." (Katz, 1982b, p. 116)

Katz comes to believe that the Ju/'hoansi mean literally what they say. But regardless of how one chooses to take these words, it can at least be said that Ju/'hoan healers provide service from a transpersonal perspective, overcoming their own personal doubts and fears for the sake of providing the service of healing to their community.

In order to endure the pain and fear of the healing dance, Ju/'hoan healers help each other and those learning to become healers, often by literally supporting or holding each other up while in the throes of kia (Katz, 1982b). The notion of "carrying" is used to describe both the act of support during kia at the dance and the process of teaching a student healer to heal. And in a more general sense, "carrying can signify the general effects of a healer's work [and] powerful healers talk of how their efforts are 'carrying the camp' or keeping the camp healthy" (Katz, 1982b, p. 47).

As can be seen, the education of Ju/'hoan healers not only takes place within a community context; it actively involves the entire community as well. In fact, an important aspect of the community's involvement is the intensification that results from the joined energies of many individuals. For example, Katz notes that the level of intensity of the drumming and chanting varies with the amount of kia that healers are experiencing and is directly related to helping healers enter into kia. Thus, "if...the singers sense that someone is ready to go into kia, they may intensify their singing and clapping to give the student an extra push...[since] one person going into kia is usually a stimulant for others" (Katz, 1982b, p. 48).

In this passage featuring the old healer named Wi, Katz gives a dramatic sense of the energy that is experienced in this process:

> As it heats up, num expands, bursting beyond the limits of any one person. As Wi, old in the ways of healing, puts it, "Num comes up in me and bursts me open like a ripe seed pod." Wi waves his arms about and flicks out his fingers as he describes the action of the seeds being expelled from their ripe pod. He also speaks of the sparks which leap out in every direction from a fire, especially when it is disturbed. Num moves throughout the participants of a dance in just such a manner, bursting beyond one healer, leaping out to others. "I burst open my num and give others some," says Wi. (Katz, 1982b, pp. 197-198)

Wi's words also point to the synergistic quality that characterizes this intensification. As Katz says, "the total healing effect of num at a dance far exceeds the individual contributions toward activating that num. The healing energy released binds people together in harmonious, mutually reinforcing relationships" (1982b, p. 198). Thus,

> Num is not in limited supply. Individuals need not compete for its healing power. The activation of num in one person stimulates the activation in others. When num boils in one healer, more num becomes available to all. Num can be infinitely divided without anything being subtracted. (Katz, 1982b, p. 198)

From this ritual of transformation that empowers the community as a whole, Katz has identified what he terms a "synergy paradigm" among cultures characterized by education as transformation: "Within the synergy paradigm, a resource such as helping expands and becomes renewable" (Katz, 1983/84, p. 202) and accessible to all, rather than being depleted by use and thus being accessible to only a select subgroup.

In general terms, synergy describes a pattern by which phenomena relate to each other in a mutually enhancing way: "A synergistic pattern brings phenomena together, interrelating them, creating

an often unexpected, new and greater whole from the disparate, seemingly conflicting parts. In that pattern, phenomena exist in harmony with each other, maximizing each others' potential" (Katz, 1983/84, p. 202). Such "phenomena" include human interactions, which have been studied for their synergistic elements by various theorists (Benedict, 1970; Fuller, 1963; Katz, 1982a; Maslow, 1971, cited in Katz, 1983/84). Based on the work of these theorists as well as on his own research, Katz has further deduced a model of "synergistic community" as a framework for understanding the functioning of synergy within a community, and he has offered guidelines for increasing that synergy (Katz, 1983/84, p. 204). He defines synergistic community as one where: (1) "valued human resources are renewable and expanding" (1983/84, p. 204); (2) "mechanisms and attitudes exist which guarantee that the resource is shared equitably among community members" (1983/84, p. 204); and (3) the whole is greater than the sum of the parts. Thus, the community ends up with an abundance of a given resource, no matter how much it is used, rather than depleting the resource by utilizing it.

According to Katz, synergy is "an aspect or phase of every community," one that characterizes a particular point in time—perhaps only a moment—when a dynamic dialectic exists in which "relatively speaking there is more sharing and connectedness" (1983/84, p. 208) as well as abundance. Thus, synergy is not a fixed phenomenon, for "it exists in a necessary dialectical relationship with its opposite" (1983/84, p. 208), which we might perhaps term the forces of disconnection or disintegration and of scarcity.

Katz also asserts that synergistic community is established and maintained by "rituals of transformation" in which participants jointly experience a "transformation of consciousness" that connects the members of the community. While such transformations may be dramatic, as with the Ju/'hoansi, they may in other instances entail a more "subtle shift in perspective" (Katz, 1983/84, p. 208), as we will see in the case of the Fijians. This transformative experience most often involves "transcendence." The Ju/'hoan healer, for instance, must transcend his or her own fear of pain and death in order to activate, or "drink," the painful n/um, which in turn enables the healer to "see" illness in others and "pull out" their sickness (Katz, 1982b), while those who are ill must transcend their own suffering if they are to be healed (Katz, 1982b).

Another important aspect of the education as transformation model is the concept of "transitioning," which refers to the fact that the healer's career path has a strong dialectical element rather than being strictly linear. In other words, there is always movement in relation to the healing power, sometimes toward it and sometimes away from it, so that the healer experiences times when he or she does not connect as strongly with the n/um as at other times. Healers do, of course, become more adept and powerful over time, yet it is recognized that they each are constantly being tested and could lose the connection with the healing power at any time. Nonetheless, it is also believed that this connection can always be re-established, and both the healers and the community in general recognize this vulnerability and stand ready to support each other in their attempts to re-establish connection. This is in contrast to the more linear path by which doctors in the West are considered to progress, increasing steadily, in consecutive steps and discrete "stages," in their ability to offer healing as they acquire an ever-larger body of intellectual knowledge.

Returning briefly to the observation that the process of learning how to connect with the healing power may involve the healer's actually having to die and come back to life, it is perhaps not surprising that the career path may involve this transitioning toward and away from the healing power rather than a linear-stage model.

Profile of Ju/'hoansi Healers

How do Ju/'hoan healers compare with other community members? In order to answer this question, Katz applied some Western techniques to supplement his own observations and personal experiences within the culture he was studying. In the group of Ju/'hoansi with whom he was living, he gathered information on thirty-two individuals—sixteen healers who were matched by age with sixteen non-healers. Of the healers, eight were over forty years old and characterized as "experienced," and the other eight were between the ages of twenty and forty years old and characterized as "inexperienced" (1982b). Choosing two groups, one of healers and the other of non-healers, Katz administered two tests, an adapted Draw-A-Person (DAP) test and an adapted Thematic Apperception Test (TAT). For the TAT, each person was given a culturally appropriate, although somewhat unfamiliar and ambiguous, picture and asked to tell a story about it. Each then was asked a series of questions about how they viewed

themselves. These tests revealed differences between healers and non-healers as to personality, self-image, and the use of fantasy, with those who were disposed to become healers manifesting three unusual personality attributes: (1) they were more emotionally labile—"their 'heart [rose]' more" (xga ku tsiu) and they were more "expressive" and "passionate" (Katz, 1982b, p. 235); (2) they had a non-anatomically based body image (evidenced by their DAP self-portraits) and were "determined more by their own inner states" (p. 235); and (3) they could access a rich fantasy life (p. 235).

It would appear that these are characteristics that facilitate the transformation of consciousness that is required in order to connect with the healing power. As Katz points out:

> Kia demands from the healer an openness to the unfamiliar and a primarily intuitive and emotional response, rather than a logical and rational one. Only then can the healer accept the pain and mystery of the boiling num.... [And] it seems that healers must emphasize their fantasy-related capacities in order to enter the extraordinary reality of kia. (Katz, 1982b, p. 236)

In addition to these tests, the non-healers were asked to describe the healers, and their impressions were compared with the healers' own self-descriptions and impressions of their power as healers. From this, Katz found that healers and non-healers had similar perceptions of the healers' level of power. He also identified five signs of power among Ju/'hoan healers: (1) the ability to receive n/um in a special way, so that special knowledge is obtained from its activation; (2) adept control of the rapidly boiling n/um; (3) the effectiveness and drama of the individual's curing ability; (4) the ability to influence others charismatically during the healing dance; and (5) the individual's recognition as a healer by the community (1982b, pp. 240-242). He found that all five criteria for power are dynamically interrelated and "continually interact with the healers' ongoing work with n/um" (1982b, p. 242). As noted in Chapter One, however, for the Ju/'hoan healer power does not mean an elevation in status or the accumulation of possessions. Rather it represents the healer's capacity to drink boiling n/um and to channel it in order to provide service for the community.

Katz states that "seeking to become a healer is part of nearly every young man's and many women's socialization, and more than one-third of the adult population become healers" (1982a, p. 366). Both girls and boys play at being healers, imitating their elders. But while more men than women become healers, this is not based on a perceived difference in power between men and women, for the Ju/'hoansi "are an intensely egalitarian people" (Lee, 1979, cited in Katz, 1982b, p. 26). Instead, according to Shostak, it is probably due to the fact that women must refrain from drinking n/um during their childbearing years as it is dangerous to fetuses (Shostak, 1981). Indeed, some of the older women are respected as very powerful healers, and women are often initiated by an older female relative. Katz characterizes one elderly woman, Wa Na, as "a healer of 'real' or 'greatest power'" (1982b, p. 148) who is "soaked with n/um" (p. 243), having drunk n/um and healed so often and for so long that her life is imbued with an especially spiritual orientation. "Indeed, Wa Na is the standard of healing power" in her region of the Kalahari (p. 148).

Two healers whom Katz describes in detail are Kinachau, who embodies the attributes of the more traditional healer and limits his territory to his own camp, and his nephew Toma Zho, "a traditional healer in transition" (1982a, p. 257), who has begun to veer away from the traditional ways of Ju/'hoan healing because he wishes to expand his territory beyond his home camp and to charge for his services. Katz notes that Toma Zho "at times...seems to want to accumulate rather than distribute his num" (1982b, p. 177) and, unlike Kinachau, who only dances in order to activate his n/um to heal others, Toma Zho enjoys dancing for its own sake. In Katz's questioning of Kinachau about his impressions of Toma Zho, a profile of the latter unfolds. In particular, the reader senses that Kinachau, although guarded in his criticism of Toma Zho, does not approve of the way that Toma Zho dances because the latter dances merely for the pleasure of it, keeping his n/um from boiling and therefore not using it to pull out the sickness in community members. Instead, Toma Zho purposely waits until just before daylight to kia (i.e., to enter an altered state) because, as he says, "Every time I give num to a person, I lose a little of my own...so I stay out [of the dance] until after everybody is finished" (p. 183). Toma Zho's attitude thus negates the expansiveness of the synergy paradigm and instead is representative of a new, acquisitive orientation among some healers toward accumulating n/um for personal use. Katz describes Kinachau's "diplomatic response" as typical of the Ju/'hoansi, who seek to avoid dissension for the good of the larger group:

> Kinachau looks at me directly and in a soft voice says: "Toma Zho is my nephew. He and I dance much together. He has his type of num, and I have mine. Our types of num are

> different. It was his thing, and it's for him to tell you."...[On the other hand,] "Wi and I are the same type of healer, and when dances take place in the daytime, we can pull and pull and finish properly. But I can't speak for Toma Zho because he has his own type, and I was very surprised to see what he did." By his tone, Kinachau implies it was not a pleasant surprise. (Katz, 1982b, pp. 85-86)

Education as Transformation Among the Fijians: The Straight Path

In the healing practices of the Ju/'hoansi, we have seen a somewhat dramatic manifestation of transformation of consciousness. Among the Fijians, on the other hand, the altered state is usually much more subtle, happening within the context of a sacred ritual exchange and the primary emphasis is placed instead on the development of the healer's character to both access the healing power and to guide the use of that power. The Fijian model is known as "the straight path" (gaunisala dodonu), a term that emphasizes the moral qualities that are expected of healers and on which their healing power is based. Katz describes Fijian culture and the role of the healer, in particular, in his book, The Straight Path: A Story of Healing and Transformation in Fiji (1993).

Unlike the Ju/'hoansi, the Fijians of the South Pacific traditionally are subsistence farmers and fishermen (M. Katz, 1981; Nyacakalou, 1975, 1978, and Sahlins, 1962, cited in Katz, 1993). However, Fiji has undergone a wave of different migrations over the course of several centuries, and, consequently, its population comprises Polynesian, and Melanesian peoples who have brought along a variety of value systems and world views. More recently, in the nineteenth century, it has also been influenced by emigrating Indians and travelers from the West, including evangelical missionaries during the nineteenth century. Some aspects of these foreign cultures have been incorporated into traditional Fijian culture, such as the recognition that the Christian God is the same as the supreme God of the ancient Fijians, Kalou. Other aspects have come into conflict. For example, with the coming of industrialization in the nineteenth and twentieth centuries, the more competitive, entrepreneurial, and individualistic orientation toward business among Fijians of Indian descent has clashed with the noncompetitive community orientation of traditional Fijians, where resources are shared equally among all members and individual needs are deemphasized.

Within this rather complex cultural mix, a number of different types of traditional Fijian healers or doctors (vuniwai vakaviti) have emerged who have largely taken over the healing role from an earlier priest caste. One of the most respected types is the spiritual healer, or dauvagunu, and it is under this type that Katz studied. Other types are seers (daurairai), massage specialists (dauveibo), and herbalists (dausoliwai) (Katz, 1993, p. 59). But Katz notes that the elaborate rituals in Fijian healing are secondary in importance to the values embodied in the straight path.

The straight path encompasses seven main principles, which Katz has derived from the words of several different healers:

> Dauvakadina (telling and living the truth): The amount of truth in each person determines the power of your healing. You must speak to your patients only what you have been told by your guardian ancestor. If you elaborate on that, and add your own opinions, or try to show how much you know, you are just lying.
>
> Daululoma (love for all): In this healing work you should love everybody, whether a relative or a foreigner. They are all the same for you. You must help them all because of your love.
>
> I tovo vinaka (proper or correct behavior): The mana is getting weaker in Fiji because people are not now following ancient customs. We must observe these customs...if our behavior is to be proper.
>
> Sega ni vukivuki (humility): This work is your secret. Showing this work to everybody, even those who do not need your help, is boasting.
>
> Vakarokoroko (respect): Everybody must be respected. Each person deserves our love and help. And the traditional ways of the land must be respected. We show our true nature by such respect.
>
> Sega ni lomaloma rua (single mindedness): You must firmly and fully believe in your work and faithfully worship your guardian ancestor. Once you decide about something and judge

> what is right, you must stick by your word and seize the moment to act. No wavering or turning back.
>
> Veigaravi (service): The power is to be used only for healing and serving others. You cannot use it to harm or kill others, or for your own personal gain, to get money or other things. That must be very clear. If you do, the power leaves you. (Katz & Kilner, 1987, p. 210)

Katz and Kilner, a psychologist, point out in a joint article that "though these attributes are often phrased in terms of the healing work itself, they prescribe the way a healer in particular, and Fijians in general, must live" (Katz & Kilner, 1987, p. 210). This involves a moral attitude encompassed by the seven principles of the straight path. Thus, this model of healer education, the straight path, is also a model for human development in general, since "the characteristics of the ideal Fijian and those toward which the healer must aspire overlap [and] becoming a healer means striving toward Fijian cultural ideals" (p. 210). As Katz points out, in Fiji "healing is a central community ritual with significance far beyond effecting a cure" (Katz, 1986, p. 41), and "the concept of healing explored [here] suggests a transformational model which can be applied to understanding processes of education, development and community" (p. 43). Similarly, healer education among the Ju/hoansi looks very much like the process of healing itself. Thus, the education of healers is a community event whereby the whole community receives healing while healers are at the same time being educated.

As was the case among the Ju/'hoansi, one of the main aspects of this developmental model is the fact that it "is characterized by moving through transitions...[and] this movement is neither unidirectional nor the basis for permanent developmental gains" (Katz, 1993, p. 338). This lack of linearity and the possibility of encountering dead ends in the process of becoming a healer are aptly evoked by the experience of cutting a path in the Fijian forest, as Katz notes. But although the process as a whole may be nonlinear, or not straight, the healer's attitude within that process must be straight:

> A common metaphor for the straight path is a path cut by hand with a cane knife through heavy forest underbrush. In creating the path the healer at times reaches a dead end or finds a shortcut, following both torturously difficult passages and relatively easy ones, so that his or her movement fluctuates in rhythm and speed, sometimes circling back on itself. The Western understanding of development, including clear directions, linear progress, and success defined by levels of attainment, does not apply. "Straightness" refers not to a straight line but to a correct or "straight" attitude or motivation. Though the path itself is not straight, the way one travels it should be. (Katz, 1993, p. 64)

One of the most important aspects of the straight path is that the Fijian healer functions, in Katz's term, as a "moral explorer" to whom the whole community looks for guidance in the face of uncertainty and threats to survival. In this capacity, the healer "[seeks] to define anew what, until the advent of 'progress,' had been relatively set by tradition" (Katz & Kilner, 1987, p. 223). Although "the majority of cases [brought to the healer] are illnesses with accompanying physical symptoms," Katz observes that "in times of doubt, crisis, or illness, the spiritual healer is the primary community resource, [for] no problem is excluded from his or her domain" (Katz, 1986, p. 16). Continuing, Katz observes that

> Requests for help range from a boy with a swollen neck, to a childless woman who wishes to become pregnant, to a family seeking protection against another's evil intentions, to an entire village wanting to make amends for violating a sacred custom. As one villager remarked about the spiritual healer in her village: "He can't get sick, because without him we would all be lost." Compared to non-healers, healers are seen as significantly more "respected" and "hard working," and closer than most to the "ideal Fijian"; they remain fully contributing community members. (Katz, 1986, p. 16)

Counterbalancing these moral guidelines is the awareness that "all [healers] are at times tempted to stray off the path. As one travels along the straight path, along with the increasing power come increasing temptations to abuse that power" (Katz, 1993, p. 318). These major infringements include having sex with people seeking their help, accepting payment for healing services, and resorting to manipulative witchcraft to meet their own personal needs or the needs of another seeking help. Healers may also commit minor infringements, such as boasting of, or exaggerating their ability to access the healing power or mana. As a result, the education of Fijian healers seeks to sharpen the awareness of the choices they must make to maintain their integrity, and they are expected to take responsibility for their actions especially while undergoing temptations. Nonetheless, if corrective action is not taken when

necessary, it is believed that the result is a weakened access to and diminishing of that healing power, which is dispensed by the gods.

A Fijian healer usually receives the call to heal when in an altered state, specifically through a dream or vision in which someone, often an ancestor Vu, grants that person permission to heal. From that time onward, this person's education as a healer unfolds, often under the apprenticeship of a more experienced healer. Katz notes that approximately one-third of those who wish to become healers "offer their help out of appreciation for [a] cure [that they have received] and respect for the healing power [and] about half of the healers have a close relationship with an experienced healer at the beginning of their careers, someone who helps the apprentice with difficult cases and provides general guidance. Through his or her behavior, the teacher demonstrates the straight path to the student. By traveling the path, the student learns how to follow it" (Katz, 1993, p. 65).

Fijian healing ceremonies are characterized by three main elements: the Vu, or the ancestors; mana, or spiritual power; and yaqona, "a plant with sacred use" that is ritually prepared and within the healing ceremony, is exchanged in a sacred manner between healer and the one seeking healing (Katz & Kilner, 1987, p. 208). The sacred exchange causes the healer to enter an altered, or transcendent state, (A.S.C), thus allowing him or her to communicate with his Vu who brings mana to the exchange, while accessing the mana may cause the healer to reach a further altered A.S.C in a dynamic process (Katz & Kilner, 1987). The healing act is thus considered to have occurred in the ritual exchange of this sacred yaqona. By accepting it "on behalf of the ancestors from whom he or she draws her healing powers," the healer activates the mana, and "in [this] act of acceptance, the healing is accomplished" (1987, p. 208). Thus, when the ceremony is properly performed, healing takes place through this ritual exchange of yaqona, which opens a channel of communication to the ancestral gods or Vu. In this way, yaqona comes to represent more than the plant itself, symbolizing, indeed, the whole body of Fijian healing practices and moral guidance.

Katz observes that the same act, the presentation and imbibing of yaqona, is at times a sacred ritual involved in healing and at other times a purely social interaction, in which the participants may even with a preparation made from yaqona try to outdrink their friends and become quite intoxicated (Katz, 1993). Ratu Noa, the experienced Fijian spiritual healer under whose guidance Katz studies, explains to him that what determines the meaning of the act is the attitude of the healer and the person offering the yaqona. Ratu Noa further explains that for him and people he educates, it is the first two bilo (or cupfuls in a container made from a cocoanut) that constitute the sacred ritual act. After that, or in other situations, non-healers and healers alike drink yaqona socially. Thus, Ratu Noa differentiates between altered states, noting that some are more desirable for healing than others. He also points out that healers who wish to use the healing power or mana to harm people are able to introduce slight variations into the practice of the ritual, which escape the notice of all but the most observant healers and may distort the healing power in the direction of harmful witchcraft (1993), through which "unnatural" forms of illness may be inflicted.

Two Fijian Healers: Ratu Noa and Adi

In Fiji, as in the Kalahari, Katz collected ethnographic data through participant observation, spot observations, and interviewing, as well as administering psychological tests and attitude scales to matched samples of healers and non-healers to arrive at specific healer characteristics and to describe the characteristics of the healing system (Katz & Kilner, 1987, p. 207). From these various sources, Katz noted decided differences both among healers and between healers and non-healers. One such difference is in the way in which healers, unlike non-healers, are characterized by having a strong relationship with their Vu, whom they do not fear, accompanied by many contacts with them. Likewise, healers differentiate themselves

> significantly from nonhealers in their attitude toward *mana* (R. Katz, 1981). Healers associate *mana* more frequently with healing than nonhealers do, respect it more, and consider it more powerful. Because they seek the experience of *mana* and are more familiar with it, healers also feel less surprised, afraid, or anxious than nonhealers when *mana* comes to them. (Katz, 1993, pp. 63-64)

In other ways the differences are subtle, as in the degree to which a given healer embodies the attributes of an ideal Fijian or is able to interpret appropriately complex events, such as the mysterious deaths that Katz and his family encountered during their stay.

Following are descriptions of two healers whom Katz met during his two years in Fiji, in order to add a human element to the general principles offered above. The first, Adi, is a woman who has brought public performances of the ritual practice of firewalking (vilivili revo) to tourists in the hotels of Suvu, Fiji's capital city; the second, Ratu Noa, is the healer who becomes Katz's main guide in his study of traditional Fijian healing practices. (All of the material that follows about Adi, and some of that about Ratu Noa, is taken from an unpublished version of The Straight Path [1992] and is differentiated accordingly by chapter from information taken from the version published in 1993.)

Katz spent the first months of his two-year stay as a researcher in Fiji in search of a healer to guide him in his study. During this time, after meeting Ratu Noa but before that healer had become his main guide, Katz hears of a woman based in an urban area who, he has been told, has been responsible for extending the practice of firewalking to non-Fijians through performances in hotels, adapting an aspect of this ancient spiritual practice and transforming it into a means of bringing abundance to the people of a village, Korolevu. Katz has the opportunity to conduct one interview with this woman, Adi, who is a member of a powerful chiefly clan.

Summing up what Adi tells him during the course of this interview, Katz states that "her spiritual journey to the cave where Degei [a powerful serpent god] lives is fantastic; the economic influence of her visions, impressive. Her vision had led directly to the practice of firewalking by the Korolevu people and the influx of large sums of money into that village" (Katz, 1992, ch. 5, p. 4). But despite her reputation for an "overwhelming presence and...awesome though sometimes uncontrollable power" (ch. 5, p. 4), he also notes that "no one claims to know exactly what she does, or even if her healing work is totally authentic" (ch. 5, p. 4). He also finds that although the firewalking, which brings good money not only to the young men who are part of the troupe but also to the village as a whole, is approved by the elders on the village council, there is some ambivalence and they are "not entirely enthusiastic about the nature of these hotel performances" (ch. 5, p. 3). For instance, one village elder with whom Katz speaks expresses his misgivings about this change from the old ways:

> In the old days, we treated this firewalking as something special.... We did our firewalking to show our respect for [some important] chief because our firewalking was a way of showing the power of our Vu.... And we had to prepare for that firewalking, with no sex and special foods in the days before. We had to pray and be ready to meet our Vu.... And we were never paid for those performances. (Katz, 1992, ch. 5, p. 3)

In the course of the interview, Adi discloses much autobiographical data, including a detailed description of how she received permission to heal from the Vu. As she reportedly does with others, Adi immediately makes a forceful impression on Katz, who feels "engulfed by her presence. She rules the atmosphere" (Katz, 1992, ch. 5, p. 5). Continuing, he describes how "her story comes tumbling out, in bursts of eloquence, as if wound on a tight spring suddenly released. It is a story that is impatiently waiting to be told" (ch. 5, p. 5). He finds that "our conversation begins—but never unfolds" (ch. 5, p. 5), noting instead that, although he is the only other person in the room, she adopts a didactic lecturing style and directs herself as if to a large audience. Thus, "she tells her story to me but especially to all others who might listen to the tape which is recording her words; she is talking to the world" (ch. 5, p. 5): "Welcome to you all, gentlemen and ladies of Fiji. I'll begin my story with the activities I became involved in concerning mana (the spiritual power), the mana that is for the benefit of our people, the indigenous Fijians" (ch. 5, p. 5). She then immediately introduces the notion of money, indicating perhaps a Western influence: "We all understood that our land is poor and weak. It is difficult for us to obtain money" (ch. 5, p. 5).

Adi, in her decision to turn an ancient practice into a display for westernized tourists in return for financial remuneration as well as in her style of presentation, does not satisfy Katz's desire to understand "the more traditional context and basis of [Fijian] healing" (Katz, 1992, ch. 5, p. 12). Nonetheless, he is impressed by her spiritual journey and how it has "activated concrete social change" (ch. 5, p. 12) in her village. In addition, it should be noted that in certain ways she lives her life according to the traditional spiritual values of Fijian culture, living simply and with the hope that her work will benefit her people: "I want my people to survive to incorporate the chiefs' directions, which is to establish developments for the benefit of my people today and the future generation" (ch. 5, p. 11). She also states, in reference to the power to do firewalking, that "I am not boasting of myself. Here I am only boasting of the powers of our grandfathers, the foundations of being, the Vu" (ch. 5, p. 12).

Katz contrasts Adi's approach with that of Ratu Noa, a healer who, although he lives in the city of Suvu, maintains close contact with his students, who are rural spiritual healers on an outlying

neighboring island. Through Katz's account of his interaction with Ratu Noa and of the latter's behavior with his fellow Fijians, a portrait of this gifted healer emerges. Ratu Noa exemplifies through his ongoing instruction and meetings with Katz what being a good healer and walking the straight path entails in Fijian culture. In contrast to Katz's observation that, with Adi, "our conversation begins—but never unfolds" (Katz, 1992, ch. 5, p. 5), he characterizes his experiences with Ratu Noa as an "unfolding" of knowledge.

Ratu Noa is respected as a spiritual healer or dauvaganu of some experience, and many, including other healers, seek his help in times of vulnerability, both individual and collective. Yet Katz experiences him as a humble man who continues to carry on his everyday activities as a construction worker and lives in a humble dwelling with his wife, a nurse, and their family. Katz is struck by the lack of pretension and display of material gain reflected in his home, indicative of Ratu Noa's commitment to sharing what he has with his children and other relatives, in the traditional Fijian manner.

Ratu Noa becomes for Katz "a center point of reference in the midst of a variety of healers competing for recognition.... [For] where others broadcast and exaggerate their stories of healing and their healing powers, Ratu Noa unfolds his deeds and powers through discussing the principles of healing and his personal and direct commitment to them" (Katz, 1992, ch. 4, p. 1). Although Katz has a total of eighteen "conversations" with Ratu Noa during the course of his two-year stay, he finds that the healer spends very little time talking about himself. Instead, Ratu Noa always plays down his own importance in healing and in relation to the healing power, as he believes that he is simply a vehicle to channel healing from the ancestral gods or Vu to his fellow Fijians; the power does not reside in himself as an individual.

Although Ratu Noa is protective of the healing knowledge, he does not hoard that knowledge when he feels that someone, even an outsider such as Katz, has been proven worthy of receiving it. Thus, after first testing Katz to determine the strength of his commitment to learn, Ratu Noa makes himself available to teach Katz how to gain access to this knowledge, after having been instructed by his Vu that Katz's research is important and good for his people and that Katz can help to "tell our story" (1993). With characteristic humility he says, "Ask whatever you want, and I will try to answer as best I can. I will always answer only what I know, and if it's something that is beyond me, I will not give you just anything, just to make you happy. This work you are doing is too important for that. I now know that it is work that must be done, a work that will benefit we Fijian people and all the people throughout the world" (Katz, 1992, ch. 4, p. 4).

Ratu Noa, along with Tevita, another less experienced healer guiding Katz, also plays an important role in helping healers and non-healers alike to make meaning out of disturbing events that occur in a neighboring village during Katz's stay. This involves three mysterious deaths that have led to allegations of witchcraft, a serious charge in Fijian culture as it can lead to further disruption, such as retaliatory witchcraft or violence. Ratu Noa's greater experience allows him to have a more complete perspective from which to judge the reasons for these deaths, both in order to ascertain who is behind them and to determine if witchcraft is indeed involved. After considering all the factors, Ratu Noa determines that witchcraft is not the reason for the deaths. His explanation—that the deaths instead resulted from a series of actions and events that constituted a violation of the moral custom of the land—is still in the realm of the supernatural, in Western terms, yet the burden of a verdict of witchcraft is averted by this judgment. Thus, Ratu Noa, in his position as both an elder and a healer, serves an important role of keeping alive and passing on tribal practices and history in connection with events that occur in day-to-day life, in a continual renewal of tradition. His proficiency as a healer includes his knowledge of what has gone on before, which contributes to the meaning of what occurs in the present.

Katz also observes from Ratu Noa's example as he deals with this crisis that even if a healer or chief is believed to have transgressed by engaging in witchcraft, great care is taken not to directly accuse that person, for one does not wish to offend the Vu who are behind these acts of witchcraft. But this is more a matter of respect than of fear: one aspect of the Fijian straight path involves always showing respect, not only for other humans but also for the ancestor gods or Vu.

The Wounded Healer and the Teacher as Healer: Transcultural Symbols or Archetypes

Before summing up the education as transformation model and moving to a discussion of the Western model of healer education, we will turn to two recurring transcultural symbols, or archetypes,

that are found in the healing stories of many traditional cultures—those of "the wounded healer" (Achterberg, 1988) and the "teacher as healer" (Katz & St. Denis, 1991). Considering these related archetypes is to consider whether the price that must be paid in order to be a true healer is to have been wounded in some way, and then to have found the capacity within the self to transcend that experience and be healed.

Although Katz does not specifically use this terminology in his model of education as transformation, we have seen that the vulnerability of the healer is an important element of this model, just as it is a central element in the theme of the wounded healer. Therefore, as a concept from traditional cultures that deepens our understanding of the healer's vulnerability, it is relevant to our discussion.

Sussman, a psychologist, points out in an examination of the unconscious motivations of therapists that "the image of the wounded healer has a venerable tradition" (1992, p. 30). It has been studied anthropologically, among shamans (Achterberg, 1988; Eliade, 1964, and Lommel, 1967, cited in Sussman, 1992, pp. 30-31), and it is present in the folklore and mythology of numerous cultures, including such diverse cultures as ancient Greece and Babylon (Meier, 1967, and Guggenbuhl-Craig, 1971, cited in Sussman, 1992, p. 32).

Whether the wounding in question is of a physical nature—an illness or an injury—or it occurs at the level of the psyche or spirit, a central aspect of this concept is the struggle that the person must go through in order to transcend his or her pain and suffering. Thus, according to Achterberg, who has studied anthropological data on shamanism, the notion of the wounded healer "implies that some kind of personal transformation or inner work or crisis was encountered...[that] then directed a mission and imbued the healer with unusual knowledge about the way of things" (Achterberg, 1988, p. 116).

Being wounded, therefore, ideally provides an opportunity "that leads to personal transformation or spiritual awakening and ultimately to the wisdom to serve the community as a healer (Achterberg, 1988, p. 117). In this connection, we also find recurring themes in various cultures of "the teacher as healer" and, thus, of healers who use their acknowledged vulnerability in order to live according to the principles of a "shared tradition," in the process becoming of even greater service as both teachers and healers to their communities as they simultaneously empower both self and community (Katz & St. Denis, 1991). These may perhaps be thought of as wounded healers who, after acknowledging and transcending the pain of their wounds, have chosen to use what they have learned to be of service to others. One such wounded healer, a former institutionalized mental patient, not only succeeded in recovering, but continued on to receive a master's degree from the Harvard Graduate School of Education and has written a book about her experiences. While she is presently helping others, she nonetheless speaks in a positive way about her earlier experience:

> More than twenty years ago in a mental hospital I struggled through that terrifying regression into my childhood. As a woman, Marie, already in her mid-thirties, I became Pat, the child I once was at five years old. And I suffered through many other experiences both in and out of the mental hospital. Now, however, as I look back on my life, I can honestly say I wouldn't change it. The pain and suffering have brought me psychological understanding and spiritual strength. I still feel the pain when I reflect on those experiences, but while once they would throw me deeper and deeper into anxious despair, now they feed my desire to keep growing. (Balter & Katz, 1987)

In Katz's description of the Fijian healer named Tevita, we can see an example of a wounded healer who works through his wounds and resumes healing, walking his straight path no matter how painful the challenges he must face. For example, he undergoes a period of deep self-doubt when he cannot make the proper sense out of the events in his village that began with the mysterious deaths we have spoken of. At the same time, Tevita was facing public criticism from an evangelical Christian minister, Rev. Tale, who is "a critic of indigenous Fijian religion...as unChristian *[sic]*" (Katz & Kilner, 1987, p. 220). Following the principles of the straight path, Tevita desists from offering further healing while he considers what is the best thing he must do for the good of his community, rather than risk doing harm out of ignorance. Instead of denying his self-doubt, thus, he acknowledges his vulnerability and seeks advice from Ratu Noa, his teacher.

Ratu Noa, for his part, does not criticize Tevita, instead providing the support and encouragement for Tevita to continue his healing work. In addition, Katz and Kilner note that during the several weeks when Tevita was not practicing healing, "there was an unusual number of serious illnesses. Several persons said...'There is sickness in our land' [and] they also spoke about the value of Tevita's work" (Katz & Kilner, 1987, p. 221). Ratu Noa's affirmation, coupled with the words of encouragement

that Tevita receives from his community, allow him eventually to regain his confidence that indeed he is a worthy channel for the mana of his Vu and thus to resume healing. Having transcended his self-doubt, or his own healing crisis, Tevita sums up his experience in this way: "I see now that my work is in the right direction. Even though it is criticized by Rev. Tale, it is not un-Christian because it is given by God and made powerful by God's mana" (p. 221).

We should note, however, that the concept of the wounded healer also speaks to the question of the healer who is not able to transcend and learn from the experience of being wounded. This person may resort to what in Western terms would be called the defense of denial and, as a result, succumb to the temptation of abusing the healing power. We find examples of healers whose character is flawed among both Ju/'hoansi and Fijians educated according to the principles of education as transformation, and we find healers who are influenced by the influx of Western "progress" and choose to adapt the ancient forms, for instance by charging for their services. This goes against one of the model's principles: that one heals out of service, not for one's own advancement in status or for financial gain. Other healers practice harmful witchcraft, which violates the principle emphasizing that one must not use the healing power to inflict harm.

This traditional concept of the wounded healer brings us back to the question raised in Chapter One as to why some healers in the West, who train intensively to develop skills that could and should be used to help the individuals and communities they serve, instead find themselves abusing that power. We find an extreme example of a wounded healer who may be in denial in psychiatrists who engage in sexual relations with patients with the avowal that it is for the patient's own good (Kardener, Fuller, & Mensh, 1973, cited in Patenaude, 1994; McCartney, 1966, and Shepherd, 1971, cited in Sussman, 1992). Another example is that of the physician who is addicted to alcohol or drugs. We will look more closely at the end of this chapter at how this archetype of the wounded healer manifests in the West in the form of the "impaired physician" (Scheiber & Doyle, 1983), as well as noting how some have applied the idea in its positive sense to the process of becoming an effective therapist (Jung, 1946, cited in Sussman, 1992). Before moving on, however, let us summarize education as transformation.

Boiling N/um and the Straight Path: Two Cultures' Expressions of Education as Transformation

From this overview of how education as transformation adapts itself to two very different cultural niches, we may observe that among the Ju/'hoansi, it is *access* to the healing power that is emphasized (Katz, 1981, 1982a, 1982b, 1982c), whereas among the Fijians, the emphasis is on how the power is *used* (Katz, 1981, Katz & Kilner, 1987). Nonetheless, both involve a profound sense of a power to which the healer must connect, and this connection is facilitated by a transformation of consciousness (or A.S.C.) that allows greater permeability of consciousness on the part of the healer, so that he or she is then more connected with the consciousness of other individuals and/or with the group consciousness, the consciousness of the community as a whole. Indeed, this is the foundation upon which all the other principles are built. One cannot be a healer educated according to education as transformation if this transformation of consciousness is not present.

As noted in our discussion of the Ju/'hoansi, the altered state of consciousness involved in healing encompasses the notion of "transcendence." According to Menary, a psychologist who has taken a transcultural perspective in studying transcendence and healing among Ju/'hoansi healers and Catholic priests, "transcendence refers to the experience of moving beyond the ordinary structures of self and of reality" and involves "a state of awareness which is radically different from one's usual one...[in that] one's whole being is affected—one's perceptions, sensations, thinking, and emotions.... [Moreover,] the boundaries of the self and others dissolve or are shattered and in this dissolution a new experience of reality emerges" (Menary, 1982, p. 5). At its core, the experience of transcendence is often "beyond words" (p. 6). Menary finds that "transcendence not only transforms the individual, but also serves to shape the world in which the individual lives" (p. 6). She maintains, moreover, that transcendence "is the essential healing phenomenon in both religion and psychotherapy" (p. 3).

Katz cautions, however, that transcendence requires its own cultural context. One cannot transplant bits and pieces of the transcendence experience of another culture, such as isolated parts of rituals taken out of their original context. "When transcendence is pursued in isolation of any cultural supports, if it's experienced [under these conditions], it quickly dissipates, with very little effect on a person's daily behavior" (Katz, 1973, p. 224).

The Ju/'hoansi and Fijians, thus, move in and out of transcendent states, in a dialectical process, in the course of their development as healers. In a later chapter, as we listen to our community psychiatrists, we will look to see if they also describe such moments of transcendence while offering healing, or at other times. And if so, how do they translate this notion of transcendence in ways that are culturally appropriate in the West?

A second element of education as transformation that is particularly relevant to our concerns about the education of community psychiatrists in the West is the question of the vulnerability of the healer. In education as transformation, as we have seen, the notion of transitioning back and forth in relation to the healing power necessitates that healers be able to acknowledge their vulnerability—their pain and their fear—not only to themselves but to their communities. Rather than being something to be hidden from the community, this vulnerability may instead serve as an important source with which to teach by example, thus serving the community (Achterberg, 1988). This in turn entails that the healer be allowed to make "mistakes" while learning to relate to the healing power. Thus, healers are taught to look at what they do not know, or at what they must learn in order to be better healers, in an ongoing process of self-reflection within the context of community.

Education as transformation, in addition to being an educational model for healing, is thus a developmental model, and it differs from the Western view of human development, most notably the model described by Piaget that sees the various aspects of human development proceeding in linear, hierarchical stages (Katz & Kilner, 1987; Piaget, 1970, cited in Katz, 1993). While this might be seen as the dominant Western model of human development, other models exist, such as the "constructive developmental" model, which suggests that human development might better be described by a spiral or helix (Kegan, 1982). In this description we can see a similarity with the idea of transitioning.

Is there any way, then, that education as transformation, as a model that encourages the development of the healer through facing his or her vulnerability, might also teach psychiatrists about vulnerability and how to utilize it as a resource toward transcendence—and the healing potential that Menary (1982, 1988) asserts is inherent in transcendence—rather than deny its existence? For, as we have noted in Chapter One and will see in greater detail in the next section, the doctor-in-training in the Western allopathic tradition of medical education is encouraged to become less rather than more vulnerable, often with tragic consequences (Preven, 1983).

Finally, as we have seen, the character of the healer is a major element in the education as transformation model. Inner development, which is stressed over command of the technology of healing, includes such ideas as moral strength and leadership, character, and qualities of "heart"; the willingness to open to and connect with a larger consciousness, even at cost to the self; and the commitment to the idea of healing as a service that does not result in the healer's elevation in status or accumulation of wealth in relation to the rest of the community.

We will keep in mind these themes of education as transformation, including that of the wounded or "vulnerable" healer, in Chapters Seven and Eight as we listen to our community psychiatrists. Do they also describe such moments of transcendence while offering healing, or at other times? And if so, how do they translate this notion of transcendence in ways that are culturally appropriate in the West? How do they approach the question of vulnerability, both in relation to the healing power and to the community they are serving? How do they speak of character, service, and status?

This last issue, that of the status of the healer or doctor, is one that has played an important part in the history of the Western university-based medical model, as we will discuss in greater detail in the following section. Physicians in the United States initially struggled to rise in status as a profession, and, indeed, this desire for upward mobility might have motivated some to go into medicine, especially those who were not born into the moneyed merchant classes (Vogel, 1980), as medical education became university-based and medical schools began to supply hospitals with scientifically trained physicians. We might, in fact, look at this as one of the strengths of the allopathic model. Yet, as we will also see, this emphasis on status, and on the power that status confers, ties in with related issues of bias based on gender, ethnicity, and social class as well as with the stance of invulnerability that Gilligan and Pollak have spoken of.

We turn now to a discussion of the Western model of medical education. Although our primary focus is on community psychiatrists, these professionals are part of the larger grouping of psychiatrists in general, and they, in turn, are medical doctors who have been educated according to the larger allopathic model of medical education. Therefore, we will look first at the most encompassing aspect, medical

education in general, before proceeding to a consideration of psychiatry and finally to community psychiatry.

The Allopathic Model

History and General Overview

Psychiatry was a latecomer to the allopathic system, becoming a specialty only after the beginning of the twentieth century and taking several decades to gain credibility and find its place within the referral networks of allopathic doctors. Thus, at the time of Peabody (whose medical career spanned from 1903 when he entered the Harvard Medical School to a premature death in 1927), it was unusual to refer a patient with emotional problems to a separate specialist, a situation that meant that, ideally, general physicians would take into account their patients' emotional as well as physical needs. It is clear, however, that this situation was changing when Peabody (the Harvard-educated physician whom we met in Chapter One), in a 1922 address before the New York Academy of Medicine, differentiated between patients with organically caused disease and those with "functional" disease, or disease where there is "no objective evidence of its cause" (Peabody, 1922, cited in Paul, 1991, p. 152), and stressed the need for the physician to continue to attend to psychological factors: "Our duty is not to avoid the issue [of psychosomatic disease] or lay the burden on the psychiatrist, but to accept it as part of the field of internal medicine, and to try and instruct our students as to its significance and as to the satisfaction to be gained from its successful management" (Peabody, 1922, cited in Paul, 1991, p. 153). Peabody pointed out that the physician "is greatly helped by having something of the point of view of the psychiatrist and a little of the newer technic of psychiatry, but he should handle the patient as a practitioner of medicine," although he admitted that some "individual cases are, of course, too obscure for him and require the assistance of the specially qualified psychiatrist" (Peabody, 1922, cited in Paul, 1991, p. 154).

Psychiatry has undergone significant development since Peabody's death, yet in the early 1980s, almost sixty years later, the relationship between general medicine and psychiatry remained unclear, and much debate ensued at that time concerning not only the relationship between psychiatry and medicine (Brown & Zinberg, 1982; Leigh, 1982) but, even more fundamentally, how psychiatry should be defined (Langley & Hollender, 1982). As part of a period of examination and assessment by both insiders and outsiders to the field of psychiatry, Light, a sociologist, studied specifically the socialization of six psychiatric residents in a teaching hospital in the eastern United States (Light, 1980). While some of his observations applied to all medical students regardless of specialization, others concerned the specific problems of psychiatric residents.

Light's study took place at a time when there had been a decline in the enrollment of medical students choosing psychiatric residencies, a situation that had prompted both an assessment of psychiatric models and an effort toward recruitment (Pardes, 1982; Scully, Dubovsky, & Simons, 1983; Sierles, 1982; Weintraub, Balis, & Donner, 1982). Light attributed this decline in part to the large amount of "hostility" that he found existed on the part of the rest of the medical students toward those of their number who opted to become psychiatrists (Light, 1980). Yet an earlier study carried out at Tufts Medical School had found that, although only 10% of those in the study actually became psychiatrists, 58% of these had expressed an interest in psychiatry during their first year (Sharaf, Schneider, & Kantor, 1968). Moreover, this attitude of contempt existed despite the fact that all medical students are exposed to the general principles of psychiatry as a part of their undergraduate course work, and all psychiatrists first must have completed four years of medical undergraduate education before continuing with a psychiatric residency. Thus, although members of both groups should, in theory, share a common language and common goals, we see instead a hierarchical system in which psychiatry ranks at the bottom (along with general practice medicine) and a legacy of mutual distrust and division.

How did this legacy arise? To answer this question, it is useful to place the current situation within its historical context, examining briefly how, by the end of the nineteenth and beginning of the twentieth century, the allopathic model had become the preferred model for medical education in medical schools in the United States and how the doctor-patient relationship was viewed as medicine established itself as a profession.

This history involves three important institutional factors that helped shape medical education at the end of the nineteenth and beginning of the twentieth century: (1) the rise of the modern teaching hospital—both "voluntary" (e.g., Massachusetts General Hospital) and "municipal" (e.g., Boston City Hospital)—out of what used to be charitable dispensaries for the poor and the sick, along with the

emergence of "a patient class" (Vogel, 1980, p. 1); (2) the launching of scientifically based research in such hospitals based on the germ theory of disease that was articulated in the late nineteenth century, and (3) the rise of the university-based medical school (Starr, 1982). Speaking of the immediate post-Civil War period, Vogel, an historian, observes that the "patient class" just referred to was comprised "overwhelmingly of the poor and those without roots in the community," and that hospitals at that time were dependent on the philanthropy of the rich, who still were treated, for the most part, in the privacy of their own homes (Vogel, 1980, p. 1). By the end of the nineteenth and the beginning of the twentieth century, with the possibility of creating antiseptic conditions and the growth of scientific specialization, hospitals had become more socially acceptable institutions where rich and poor alike sought treatment, but different hospitals catered to different social classes. As Vogel points out, "physicians, themselves in many ways a product of the modernization of medicine, reshaped the hospital to fit their needs (p. 2).

Starr, a sociologist who has traced "the social transformation of American medicine," reminds us, however, that medical schools and medical doctors were not originally accorded the high status that they hold today (Starr, 1982). Surgeons, for instance, had to struggle to disassociate themselves from barbers, having originally belonged to the same guild in Europe. This transformation in status occurred as medical education in the United States in the latter half of the nineteenth century became increasingly tied to "elite" research-oriented universities (1982, p. 117), with the result that medical educators and students had to measure up to increasingly stringent and standardized academic requirements.

Before this university-based model was established, however, doctors educated according to a variety of standards and representing different strata of society competed among themselves while at the same time seeking to raise the status of their profession as a whole. During the nineteenth century, there was a diverse variety of competing models, including chiropractic, homeopathy, osteopathy, herbal medicine, folk medicine, and bonesetting, to name but a few, in addition to what became the allopathic model and, according to Starr, "sharp contrasts characterized medicine by 1900" (Starr, 1982, p. 116). Moreover, "the ports of entry into medicine were still wide open, and the unwelcome passed through in great numbers..., to the dismay of professional leaders, who thought such riff-raff jeopardized efforts to raise the doctor's status in society" (pp. 116-117).

Having begun our exploration of the allopathic model in Chapter One through the eyes of two Boston physicians, James and Peabody, both of whom might be considered to represent the upper-class "Boston Brahmins," we will continue with that focus in this section, highlighting two other physicians who were also educated at Harvard Medical School, one of whom was of Irish immigrant background. Boston was and is an influential medical center that has retained its influence in the allopathic system as a center of research and clinical practice, and as such, it will serve to illustrate, some important aspects in the development of the Western allopathic medical mode.

The term allopathy, it might be noted, stands in contrast to homeopathy, one of the major alternative medical models of the nineteenth century. According to Webster's New Collegiate Dictionary (1956), allopathy is "the theory or system of medical practice which combats disease by the use of remedies producing effects different from those produced by the disease treated" (p. 24), while homeopathy is "the theory or system of medical practice holding that disease is cured by remedies which produce on a healthy person effects similar to the symptoms of the complaint of the patient, the remedies being usually administered in minute doses" (p. 395).

In the eighteenth and early to mid-nineteenth century, those who could afford it had gone to Europe to study in the more established and more prestigious European medical tradition. The first medical school in North America was established by the College of Philadelphia (later the University of Pennsylvania) in 1765 by one such physician who had studied in Europe. From this beginning grew a number of medical schools with a variety of orientations, most of which were commercial medical colleges that were not affiliated with colleges or universities. Another form of training was through apprenticeships, in which physicians gathered willing students around them. It was a system where there were no general standards and where rivalries were often intense (Starr, 1982).

A number of converging factors in the nineteenth century resulted in bringing about the hegemony of this university-based allopathic model. The most important of these was the emergence of the germ theory of disease advanced by scientifically based laboratory research that had begun to occur in universities and hospitals. Scientific medicine had been firmly established in Europe with the discovery and development of the germ theory of disease based on discoveries in bacteriology by Pasteur and Koch in the 1860s and 1870s in France and by the founding of the science of pathology by Virchow in Austria in the mid- to late 1800s. Earlier models had held that "illness had no local origin in the body; it was a general disturbance caused by a disturbance of the four humors (blood, phlegm, yellow and black

bile)" (Starr, 1982, p. 38). Germ theory, on the other hand, "show[ed] that each true disease is an inherent, autonomous process with an identifiable course and a provable and specific derangement that could be located microscopically in the cells of the body" (Konner, 1993, p. 54).

It is interesting to note that along with the realization that germs cause specific illnesses, there was increasing awareness that poor social conditions breed disease. Thus, some of the early advocates of germ theory were also advocates of social medicine and the new science of "hygiene," later known as public health. Virchow, for instance, "double[d] as a public health advocate" (Konner, 1993, p. 54), maintaining that "medicine is a social science, and politics only medicine on a grand scale" (Virchow, cited in Konner, 1993, p. xiii).

The rise of the germ theory of disease along with the hygienist movement to improve social conditions was accompanied by the increasing social and political power of those who subscribed to this theory and wished to limit the power of competing theories (Starr, 1982). This process was accomplished, despite competition even among allopathic doctors vying for increased status among themselves, both by the establishment of university-based medical schools subscribing to germ theory and by the trend toward licensure of all professions and the establishment of standards for practice (Starr, 1982), which proponents of the allopathic model believed was necessary. Interestingly, the movement toward licensure within the ranks of allopathic physicians came from those who were not born into the upper classes and thus were upwardly mobile. Having been educated in university-based medical schools, they then wished to differentiate themselves from lay and non-allopathic healers such as homeopaths as well as to have some means to hold their own with established physicians (Starr, 1982). As a result of this trend toward licensure and establishment of standards, many medical schools based on competing models began to close in the last decades of the nineteenth century.

Charles Eliot, who became the president of Harvard in 1869 (and was an uncle of Peabody), was instrumental in this process through the affiliation of the Harvard Medical School with the university in that same year, thus ensuring the development of the medical school's curriculum in a university-based direction (Starr, 1982). At the same time, Eliot put an end to the financial independence of the medical school's professors, who until then had been paid directly by students, thus retaining autonomy. Now they were answerable to the Harvard Corporation, which paid their salaries. This development helped to establish a trend that favored conducting medical education in affiliation with established colleges and universities.

Another important event in the development of the university-based model occurred in 1893, when the Johns Hopkins University established a medical school with a new four-year curriculum that became the model for others, an important element of which was the fact that all entering students were required to have a college degree (Starr, 1982). Again, it was Johns Hopkins's president, Daniel Coit Gilman, who, like Eliot, led the reform of medical education. These two events were major steps in the efforts of academically based doctors to limit the number of those ministering to the ill without university-based education.

In 1904 the American Medical Association established a Council on Medical Education. In addition to beginning to evaluate medical schools and establish standards, the council commissioned an outside organization, the Carnegie Foundation, to study and evaluate medical education in the 160 existing medical schools. The publication of the Flexner report in 1910 was a watershed event in that it strongly advocated university-based medical education and contributed to the already established trend of the closing of non-university based medical schools (Starr, 1982). With the publication of this report, the hegemony of the university-based, allopathic model of medical education was firmly established. Even prior this, however, non-university-based medical schools had begun to close, having fallen from a high point of 162 in 1905 to 131 in 1910, just prior to the report's publication. By 1915, the number of schools that had survived the Flexner report was only 95 (Starr, 1982).

With fewer medical schools there was also more competition for the available openings, with the result that minorities and women experienced greater difficulty getting accepted into medical schools (Starr, 1982). Prior to the Flexner report, there had been seven black medical schools; after its publication, only Howard and Meharry survived (Starr, 1982). Later in this chapter we will hear the reaction of black students to the ethnocentrism of the psychiatric residency.

Relative to the status of women in the medical system, Starr remarks that although "Flexner thought that the declining numbers of women reflected declining demand for women doctors or declining interest among women in becoming physicians, [o]thers...have since pointed to the active hostility of men in the profession" (Starr, 1982, p. 124). Nadelson and Tighe, both psychiatrists, remind us that in the mid-nineteenth century it was still believed to be injurious to women's health to develop their

minds: "She (woman) has a head almost too small for the intellect but just big enough for love" (Nadelson and Tighe, 1986, p. 274, citing an 1848 textbook in obstetrics). They also cite Dr. F. W. VanDyke, president of the Oregon State Medical Society, who said in 1905: "Educated women could not bear children with ease because study arrests the development of the pelvis at the same time it increased the size of the child's brain and therefore its head. This causes extensive suffering in childbirth" (p. 274). This was the climate of opinion regarding women's health, intellect, and fitness for entering such professions as medicine that influenced the thinking of the men who wrote the Flexner report and dominated allopathic medicine well into the twentieth century.

It is interesting to note that what allowed for the establishment of the Johns Hopkins Medical School in 1893 was a large endowment given by a group of wealthy women under the stipulation that women would be eligible for admission to the school on equal terms as men (Nadelson & Tighe, 1986). Thus, as Starr points out, "in effect, American women were forced to buy their way into elite medical education" (Starr, 1982, p. 117). Prior to this, women were admitted to some medical schools for men and, in fact, represented 10% or more of students at nineteen coeducational medical schools by 1893-94 (p. 117). But admission was on far-from-equal footing, and as a result most women medical students in the second half of the nineteenth century attended non-university-based medical schools for women, seventeen of which were established in that period. Many of these were subsequently dissolved or merged once women were able to be accepted on theoretically equal footing into the elite medical schools, such as at Johns Hopkins. Thus, ironically, in the service of attaining equal opportunity, the alternative option of medical schools specifically for women had been largely eliminated by the time of the Flexner report. Only three survived by 1909.

One might think that, by now, the situation regarding gender and ethnic biases would have been rectified. Yet studies in the 1970s showed that women medical students still felt "excluded, isolated" and "not regarded as serious" (Nadelson & Notman, 1983, p. 15). Another problem that female physicians face is sexual harassment. A recent Canadian study identified sexual harassment of female doctors by male patients as "appear[ing] to occur frequently, and it is therefore an important topic to address in medical school and professional development" (Phillips & Schneider, 1993, p. 1936). This same study found that it "may underestimate the actual extent of harassment...[for] harassment by coworkers or colleagues was specifically excluded...[and] behavior that some might describe as harassment was excused by others as inevitable or unremarkable" (p. 1938). Although the study chose not to consider sexual harassment of male physicians, such "documentation would not alter the abuse that women experience...[in] a society in which suffering sexual harassment is sufficiently common that it becomes part of becoming a woman, and is therefore ignored" (p. 1938).

The trend toward denying women and minorities equal access did not begin to reverse itself until the last ten years, when medical schools began to make a decided effort to increase the number of women and minorities entering, following societal trends such as affirmative action. By 1986, women comprised 32% of all medical students (Nadelson & Tighe, 1986), the number of women faculty on all levels had increased, and women were increasingly entering specialties that they had not before (Nadelson & Tighe, 1986).

While the allopathic, scientifically based model had prevailed over other medical models by the early part of the twentieth century, however, it by no means always formed a united front. Within its ranks there was competitive in-fighting, both between rivals from the same class, as occurred in Philadelphia (Starr, 1982), and between those from different classes, as occurred in Boston (Vogel, 1980). Regarding the latter, we noted earlier that one of the great strengths of the allopathic medical model is that one can attain success, regardless of the circumstances of one's birth, by achieving academic and clinical excellence. Thus, for some, one impetus to enter medicine was to attain a higher status (Vogel, 1980). As allopathic medicine grew in intellectual stature and as medical education became university-based and medical schools began to supply hospitals with scientifically trained physicians, doctors from different social classes could rise to the top as academic excellence was rewarded. But just as there has been significant bias based on gender and ethnicity, there has also been bias based on social class as the established class began to be challenged by newer immigrants as they competed for the same positions or sought to control hospital boards of trustees (Vogel, 1980). As Vogel has described the situation in Boston:

> The Boston hospitals of 1870 were also instruments of status ascription within the medical profession. Henry J. Bigelow, Boston's leading surgeon, spoke in 1871 of the "two classes of the profession," differentiating those who simply practiced medicine from those who contributed to its development. The latter group was the medical elite; in Boston this group

> benefited from—and defined itself, in part, in terms of—hospital and dispensary experience. (Vogel, 1980, p. 17)

In Boston, rivalries emerged between those in the medical profession who came from immigrant backgrounds and those who had been born into the moneyed merchant or Brahmin class (Starr, 1982; Vogel, 1980). A major focus of this rivalry centered on the question of the control and organizational structure of hospitals. Private hospitals such as the Massachusetts General, which sought incorporation, were run by boards of trustees and physicians who came from the moneyed merchant class (Vogel, 1980). The public urban hospitals, such as the Boston City Hospital, on the other hand, were becoming the stronghold of the politicized immigrant class, predominantly Irish in Boston, which had begun to organize an effective local political machine. Vogel describes one interesting circumstance in 1880 when two graduates of Harvard Medical School, one a Brahmin, the other an Irish immigrant, were vying to prevail in the struggle to determine whether the Boston City Hospital would incorporate, which was fundamentally a question of "which social classes should the city's institutions be responsible" to (p. 31).

The former, Cheever, was described by Vogel as "a member of one of Boston's dynastic medical families" (Vogel, 1980, p. 29): both Cheever's grandfather and father were physicians. He favored incorporation and wished to retain a board of trustees at the city hospital that would be appointed by the mayor, who "was responsible to a citywide constituency," rather than by the city council, which "was responding more and more to the immigrant wards" (p. 31). These board members would tend to be from the same background as Cheever and thus "would be more congenial to Cheever and the hospital staff than the politician-trustees" (p. 30) who represented the immigrant wards. This would, in principle, remove the hospital from the growing influence of municipal political groups developing from the ranks of the Irish, who not only had greatly increased Boston's working class population but also had created the need for this hospital, which, unlike the Massachusetts General Hospital, was intended to serve the needs of everyone regardless of ability to pay (Vogel, 1980). Gavin, an Irish immigrant who had graduated from the Harvard Medical School, wished instead to fill the seats with trustees appointed by the city council, which was controlled by Irish politicians who, he felt, were more responsive to the needs of its largely immigrant patients (Vogel, 1980).

In 1864, when the Boston City Hospital opened, Gavin had succeeded in winning an appointment as house officer. At that time Cheever was a visiting surgeon, but in 1867 he became the first president of the hospital's medical staff and for the next forty years, until his retirement in 1907, "more than any other physician, Cheever dominated the Boston City Hospital" (Vogel, 1980, p. 29). In 1872, the Boston City staff, with Cheever as chief, blocked Gavin from joining the staff, despite the fact that the latter had passed a competitive oral exam for the position. In 1879, the Boston City staff again opposed Gavin, along with a Jewish councilman named Israel Cohen, this time in his council-backed appointment to the hospital board. Gavin succeeded in overcoming this opposition, however, and in 1879 became a member of the board of trustees and subsequently voted against incorporation in 1880, opposing Cheever and his colleagues (Vogel, 1980, p. 29). Nonetheless, Cheever and "the moneyed Brahmin elite" (p. 30) ultimately prevailed when the state legislature voted to incorporate the Boston City Hospital later in 1880.

Vogel points out that Cheever, in exercising his influence over the Boston City Hospital as a distinguished surgeon and administrator, was an exemplar of the more conservative values shaping the medical institutions and medical education of his time. From Cheever's memoirs, for instance, we can see both class and gender bias as well as disapproval of non-allopathic modalities. Vogel notes Cheever's respect for doctors who are "gentlemen": "Social and medical authority exercised by gentlemen was proper. Acknowledging for example, that the use of patients in clinical teaching created a socially awkward situation, he [Cheever] noted 'the doctor in command, if a gentleman, can much alleviate the inconveniences'" (Cheever, 1911, cited in Vogel, 1980, p. 57).

Cheever also found "the possible admission of women to Harvard Medical School 'hideous' and 'the most repulsive form of co-education' [and] he complained that 'in the City Hospital municipal influences induced the trustees to admit both women and homeopaths to the [operating] amphitheatre'" (Cheever, 1911, cited in Vogel, 1980, pp. 57-58). And Cheever noted in his memoirs "that women medical students were still not admitted to hospital wards and that 'one distinguished surgeon [presumably Cheever] never operated before mixed classes'" (Cheever, 1911, cited in Vogel, 1980, p. 58 [bracketed note added by Vogel]). In a similar vein, Vogel also notes that the Tufts Medical School, "in an unsuccessful plea for a limited teaching affiliation [with the Massachusetts General Hospital]...felt compelled to promise that none of its female or black students would enter the hospital" (letter from Dr. William M. Conant to Dr. Richardson, November 1911, cited in Vogel, 1980, p. 46).

It might be noted, however, that another researcher has taken a more sympathetic view of Cheever, stating that, besides being "known for his meticulous technique," he also had a reputation for "his gentle handling of patients" (Beecher & Altschule, 1977).

The opinions of Cheever and those like him continued to influence medical education and clinical training well into the twentieth century. The Harvard Medical School, for instance, did not admit women until 1946 (Nadelson & Tighe, 1986). We will see how this conservative influence can still be felt both in general medicine and in psychiatry, especially with, but not restricted to, the experiences of women doctors and doctors-in-training.

The preceding historical overview has focused on the psychosocial context that has affected those who have aspired to become doctors. We may see in this history some of the roots of the difficulties encountered still by women entering medicine that studies such as Gilligan and Pollak's (1988) (mentioned in Chapter One), have pointed out. We may recall that they observed that "the dangers of isolation remain comparatively uncharted in medical practice and education" (1988, p. 245), and that this "may be of particular consequence for women" (p. 261).

It is also helpful to place the doctor-patient relationship, one of our main concerns also introduced in Chapter One, in this same historical context. One of the major elements in this history has been a deliberate distancing between physician and patient. This distanced stance is of particular interest to us in our quest to understand the nature and importance of empathy in the healing relationship—although we may wonder whether, indeed, a distanced stance might also be empathic in certain situations.

As Starr points out, there was a decided trend at the end of the nineteenth century that encouraged this distancing between doctor and patient, and it reflected the "status anxieties of late nineteenth century doctors" (Starr, 1982, p. 85). For instance, the author of a popular manual for medical practice, The Physician Himself, published in 1881, recommended that "physicians...not allow people to get overly familiar with them" and further noted that "conviviality...'has a leveling effect, and divests the physician of his proper prestige' " (Cathell, 1890, cited in Starr, 1982, p. 86). Cathell went on to recommend that the physician should strive to be viewed as something other than an "ordinary person": "Appearing in public in shirtsleeves, unwashed and unkempt, was unwise because it would show 'weakness, diminish your prestige, detract from your dignity, and lessen you in public esteem, by forcing on everybody the conclusion that you are, after all, but an ordinary person' " (Cathell, 1890, cited in Starr, 1982, p. 86). This was intended to help raise the status of physicians, who were having difficulty at that time achieving the same respected status as their British and German counterparts, who were considered members of the privileged class in a class-stratified society (Starr, 1982).

Another aspect of the doctor-patient relationship was the paternalistic attitude that developed in the context of hospitals that were "intended as charities for the poor and dependent" (Vogel, 1980, p. 3). Vogel notes that they "generally were moralistic and authoritarian even as they were benevolent and humanitarian" (p. 3), and the patients, as a result of being related to in such a "paternal[istic]" manner, "could easily feel patronized and degraded" (p. 3).

Yet, at the same time, the importance of the doctor-patient relationship was beginning to be recognized by some. Williams James, for instance, while clarifying in a letter to his cousin in 1864 that the practice of medicine did not interest him other than for its intellectual challenge and questioning the effectiveness of the science of medicine in his day, nonetheless emphasized, albeit in a backhanded way, the importance of the "moral" presence of the physician in effective treatment:

> My first impressions are that there is much humbug therein [in the practice of medicine], and that, with the exception of surgery, in which something positive is sometimes accomplished, a doctor does more by the moral effect of his presence on the patient and family, than by anything else. (Letter from W. James to J. Gourlay, Feb. 1864, cited in R. B. Perry, 1935, p. 73)

James was speaking nearly a half century before the Flexner report. Francis Peabody, writing around fifteen years after that event, offers us a further look from a historical standpoint at how the profession of medicine was handling the question as to how to balance caring with appropriate distance and subjectivity with objectivity. As has been noted in Chapter One, his observations and insights are still remarkably germane. Believing the doctor-patient relationship to be of central importance in the practice of medicine, Peabody concluded his famous lecture, "The Care of the Patient," by saying that "one of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient" (Peabody, cited in Paul, 1991, p. 119). Elsewhere he stated that

> the good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. (Peabody, cited in Paul, 1991, p. 173)

Peabody began to address this question of how to relate effectively to patients in an earlier talk to medical students in 1923 in which he stressed "the great value of 'a long talk with the patient' to learn about 'his life, his troubles, anxieties, hopes, and fears' " (Peabody, cited in Paul, 1991 p. 115). He subsequently further developed this idea of the importance of the psychological aspects of general medical practice in his talk on "The Care of the Patient" given in the fall of 1925. He emphasized this not only with patients where there was an organic cause but also in the case of patients with "functional," or psychosomatic, disease:

> It is not my purpose...to go into a discussion of the methods of treating functional disturbances, and I have dwelt on the subject only because these cases illustrate so clearly the vital importance of the personal relationship between physician and patient in the practice of medicine. In all your patients whose symptoms are of functional origin, the whole problem of diagnosis and treatment depend on your insight into the patient's character and personal life, and in every case of organic disease there are complex interactions between the pathologic processes and the intellectual processes which you must appreciate and consider if you would be a wise clinician. (Peabody, cited in Paul, 1991, p. 173)

In differentiating between the treatment of disease in humans and in animals, he observed that in the case of humans, the physician must take into account emotional factors. Indeed, he went so far as to say that this aspect of treatment is integral—rather than antithetical—to a "scientific" approach in medicine:

> Disease in man is never exactly the same as disease in an experimental animal, for in man the disease at once affects and is affected by what we call the emotional life. Thus, the physician who attempts to take care of a patient while he neglects this factor is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment. (Peabody, cited in Paul, 1991, p. 173)

Because of this concern for the quality of the doctor-patient relationship, Peabody also addressed the problems of medical education that he observed in the 1920s. They are very similar to contemporary critiques. He spoke of the difficulties that medical students encounter when they graduate and

> discover that in the actual practice of medicine they encounter many situations and problems which they had not anticipated and which they are not prepared to meet effectively. These difficulties, which often are very perplexing, have to do, not so much with diagnosis, as with therapeutics, and they indicate that there is some justification for the frequently repeated criticism that medical students learn a great deal about the treatment of disease in general but comparatively little about the actual care of the individual patient. (Peabody, cited in Paul, 1991, p. 117)

He then went on to note the loss of the ideal of service that frequently occurs in the process of medical education, an observation that is particularly interesting when we recall that one of the principles of education as transformation is to provide service to the community:

> There is no question but that the great majority of young men enter the study of medicine, not with the idea of becoming scientists, but with the ideal of personal service. Why is it, then, that when they graduate they are so apt to have such an academic and impersonal conception of therapeutics? (Peabody, cited in Paul, 1991, p. 117)

Writing in 1991, Oglesby Paul, Peabody's biographer, reflects that "one would have supposed, perhaps naively, that [this essay's] wise and understanding message would have been equaled and probably surpassed many times by other outstanding perceptive physicians. But such does not seem to have been the case" (Paul, 1991, pp. 118-119).

Instead, various studies conducted concerning medical discourse (Mishler, 1984), the medical life history of physicians (Paul, 1991), and "illness narratives" of patients (Kleinman, 1988a) have described a distanced, impersonal, objective-descriptive stance toward patients on the part of the physician (Havens, 1987). Not unlike Peabody, these researchers have suggested that such a stance impedes the therapeutic

interaction, in that the patient does not feel truly cared for, and they have raised questions concerning the advisability of training physicians to adopt this impersonal stance, whether by design or as an "unanticipated consequence of training," as Light (1980) has suggested.

Mishler (1984), a sociologist, studied "the language of care" in the interaction of physicians with their patients in an attempt to determine "what constitutes a humane practice" (p. 6). In analyzing transcripts of medical discourse he asked, "What type of relationship between patient and physician does [the transcript] express and affirm?" (p. 5). He concluded that physicians and patients appear to have different

> understandings related to differences in general perspectives, on the one hand, of physicians framing questions and making recommendations with the technical-scientific standpoint of the biomedical model, and on the other hand, of patients with orientations grounded in the concerns of daily life. (Mishler, 1984, p. 6)

Mishler thus identified two very distinct voices. The voice that represents "the technical-scientific assumptions of medicine" he termed the "voice of medicine"; that which represents "the natural attitude of everyday life" he called the "voice of the lifeworld" (1984, p. 14). He also questioned "whether current forms of clinical practice are consistent with and affirm criteria of humane care, that is, respect for the dignity of patients as persons, and recognition of their problems, within the contexts of their lifeworlds of meaning" (p. 6).

Kleinman, a psychiatrist and medical anthropologist, analyzed the accounts of eight physicians who were treating chronically ill patients, from which he has identified a number of different positions or stances in relation both to the practice of medicine and vis-à-vis their patients. Thus the "voice of medicine" is perhaps more than one voice. He pointed out that "who the practitioner is as a person is as essential to care as the personality of the patient.... Where care is the subject, the relationship between patient and practitioner properly moves to center stage" (Kleinman, 1988a, p. 210).

Kleinman's account faulted the usual "externalist academic accounts [which], for all of their analytical power, leave something out which is of vital salience to them [i.e., doctors]: namely, the internal felt experience of doctoring" (Kleinman, 1988a, p. 210). Such "externalist" research is "more concerned with the influence of social forces...than with the actual workings of care" (p. 210), and most frequently "examine[s] either the socialization of the physician in medical school and residency training or the influence of professional norms and personal preoccupations on the patient-physician encounter" (p. 210). Some examples of such research cited by Kleinman include "how physicians learn to deal with uncertainty or with failure (Fox, 1959; Bosk, 1979),....problems in the application of technology or ethical dilemmas in practice (Reiser, 1978; Veatch, 1977),...[and] the transformation of formal textbook knowledge into the rank-and-file professional's working technical knowledge (Freidson, 1986)" (Kleinman, 1988a, p. 210).

Furthermore, Kleinman asserted that the essence of medicine, and indeed of all types of healing, is moral:

> There is a moral core to healing in all societies that I take to be the central purpose of medicine. That structure is luminously revealed by the experience of illness and by the demands made on the patient-doctor relationship; it is clouded over by a narrow examination of the nontherapeutic aspects of healing. (Kleinman, 1988a, p. 253)

Continuing, Kleinman addressed the question of the purpose or primary focus of medicine and concluded that "neither the interpretation of illness meanings nor the handling of deeply felt emotions within intimate personal relationships can be dismissed as peripheral tasks. They constitute, rather, the point of medicine" (1988a, p. 253).

Kleinman's work is not only a critique of contemporary biomedicine, "whose failure to address these issues is a fundamental flaw in the work of doctoring"; it is also a critique of medical education, which fails to "place care at the center of medicine" (1988a, p. 254). Echoing Peabody's comments, he lamented the fact that students usually enter medical school with high ideals about kind of doctor they hope to become and the kind of help they hope to provide their patients. By the time they finish medical school, many have lost these ideals (p. 254).

Thus, we find voices both within medicine and outside the profession, as far back as the 1860s and into the 1990s, that are, first, arguing for the importance of the relationship between doctor and patient in providing effective healing in any medical practice and, second, pointing out the danger that

under the duress of medical education as it is currently offered, the importance of that caring relationship may be lost, along with the desire to serve one's fellow human beings.

Psychiatric Education Within the Larger Medical Model

Of all the medical specialties, psychiatry is the one in which the relationship between doctor and patient is most obviously all-important. Yet psychiatrists are educated according to the university-based model of medical education, and this model, as we have seen, has been criticized for creating distance between doctor and patient, based at least in part on a need to be in command of a large and complex body of specialized knowledge. We may, thus, reasonably ask how the medical educational process facilitates—or fails to facilitate—learning this skill of relating to patients, which is particularly central to the role of the psychiatrist. We will, therefore, turn more specifically to a description of psychiatric education within the larger medical education model, as well as to a discussion of community psychiatry and the provisions—or lack of provisions—for educating community psychiatrists in particular.

Light (1980) has delineated what he termed the "university-based model" of medical education to describe the prescribed means of educating allopathic physicians according to the guidelines laid out in the American Medical Association's Directory of Accredited Residencies, commonly known as the Green Book. (This volume undergoes periodic revision, and the 1977-78 edition was current at the time of the publication of Light's book.) Under this system, medical students spend four years in medical school, with curricula structured according to Green Book guidelines, followed by a one-year internship and a three-year residency in a specialization such as radiology, surgery, pediatrics, neurology, or psychiatry.

Light noted that all medical school candidates are selected for their high scores on tests and in science courses and that a biomedical approach emphasizing the physiological bases for disease is emphasized (Light, 1980). In addition, he found that medical education in general, and psychiatric education specifically, foster a tendency toward "omnipotence" and "training for control," which in turn results in "immunity to criticism" (p. 295). Overemphasis during medical and psychiatric training on the acquisition of a large body of intellectual knowledge and technical expertise, coupled with a lack of emphasis on the intricacies of therapeutic interaction with patients can make medical professionals "oblivious to the needs of patients as patients define them" (p. 295). Indeed, Light asserted, these problems are "the unanticipated consequences of [medical] training programs" (p. 295). Light's study lent support to the findings of two psychologists, Sharaf & Levenson, who, in an earlier study critiquing medical and psychiatric education, had observed that it encouraged feelings of omnipotence and grandiosity. The results of these two different research studies call to mind the second of the two dangers that Gilligan and Pollak spoke of in Chapter One—"the danger that perfection of knowledge and skill will distance the doctor from human relationships" (Gilligan & Pollak, 1988, p. 245)—as well as bringing to mind the ideal of the Western physician as embodied by Peabody.

Light delineated five phases of socialization in the psychiatric resident's career: (l) managing patients; (2) doing therapy; (3) exploring one's own countertransference —i.e., the resident's own emotional reactions to the material the patient is discussing; (4) knowing the unconscious, as delineated in the psychoanalytic model; and (5) developing one's own personal style (1980, p. 113). In the course of the process of making the transition from medicine in general to a psychiatric specialization, however, Light observed that psychiatric residents feel a progressive discontinuity. Following the lead of Goffman (1959, 1961), who studied what he termed the "moral career" of the psychiatric patient that occurs in the course of their socialization process in asylums, Light has described the socialization process of psychiatric residents as "the moral career" of the psychiatric resident (1980, p. 243). Although Light admits that to compare two such seemingly different groups as psychiatric residents and mental patients "may stretch the credulity of some...yet the process of stripping and reconstituting [one's identity] are similar" (p. 243).

Specifically, the emphasis within the overall medical education system on having exact answers, on learning to categorize patients according to a detailed diagnostic system, and on being in control at all times has several negative consequences for psychiatric residents, in particular, who spend "a great deal of time overcoming feelings of inferiority and uncertainty" (Light, 1980, p. 292) as they attempt to apply standards of certainty and exactitude to the less-than-certain realm of the human psyche. After having studied the physiological and anatomical approach to disease for four years in a highly structured classroom environment with their fellow medical students, psychiatry residents must then make the transition to an out-of-classroom learning environment and apply what they have learned about medical

procedure to this uncertain realm, learning psychotherapy by doing it under supervision. Under these circumstances, it is not surprising that residents report feelings of loneliness and isolation as well as uncertainty.

Perhaps to counteract these feelings, residents struggle to master the art of psychiatric diagnosis, attempting to impose the level of certainty that is required by a system that does not allow much room for acknowledging vulnerability and uncertainty. In terms of the psychiatrist's relationship with his or her patients, Light also noted that a distancing process can result from overemphasis on diagnostic skills, such that the patient may seem to become more of an example of a disease category than a fully human being. These problems are exacerbated, Light said, if the psychiatric resident does not attempt to get in touch with his or her own emotional reactions when, for instance, a patient commits suicide (1980).

A researcher who conducted an earlier study of medical residents noted a similar difference between psychiatric residents and surgical residents in the way they approached the question of how to judge their own knowledge and performance (Burkett, 1974, cited in Light, 1980). For example, the lack of certainty inherent in the field of psychiatry created anxiety in one psychiatric resident (who, it might be noted, also appeared to distinguish psychiatry from the rest of medicine in his reply):

> That's a very anxiety-producing question (laugh). It's not like medicine where you can feel that, ah, your medical acumen is sharpening and, ah, whereas before you couldn't diagnose, uh, now you can do it, uh, because you have more experience and have had more patients with that disease. In psychiatry, it's just—the whole field is so vague.... So a lot of it's just your own evaluation of yourself and how you're doing and how you're affecting your patients. (Burkett, 1974, cited in Light, 1980, p. 292)

An orthopedic surgery resident, in contrast, felt that he knew how well he was doing because the results of the treatment were much more clear-cut and easily verified, based as they are on physiological indicators:

> Well, we have, you know, there's several things. First of all, you have the means that every doctor has at his disposal, and that's how well your cases are turning out. (Burkett, 1974, cited in Light, 1980, p. 292)

Psychiatric residents must also cope with the perceived inferiority of their branch of medicine within the medical hierarchy. In addition to being the branch of medicine that is perhaps the most ambiguous or least certain, psychiatry is the one that is accorded the least status, and psychiatrists are paid fees 10%-15% lower than any of the other medical subspecialties, with the exception of general practitioners (Light, 1980, p. 12). Thus, Light noted that psychiatric residents in particular feel pressure to adopt a more "objective" diagnostic approach in order to appear like "true physicians" in the eyes of the rest of their medical colleagues (1980).

Light also saw an increasing sense of isolation as medical students moved into their psychiatric residencies. Noting that "the structure of residency training...greatly influences the values and practices of psychiatrists who go through it," he observed that this structure does not encourage group solidarity or cohesion (1980, p. 271). Instead of bonding with their psychiatry peers, at least one of the residents felt closer to people he had known before his psychiatric residency, and another felt that he has no idea of how his peers were working with patients. Light uses pseudonyms for three psychiatry residents as they discuss their experiences below:

> Ned Reich: I don't feel I've gotten to know people well this year. Compared to internship, I haven't had time to kibbitz. I don't feel, as I did last year [during his internship], I know how different doctors handle their patients.
>
> Ken Reese: I've felt this all year. In a way, we know each other well, but it's highly professionalized.
>
> Ned Reich: I have spent very little time over coffee, eating, or walking home with someone.
>
> Mark Raskin: It was looser, much looser, last year.
>
> Ken Reese: I still have more going with friends from last year than ones I have gotten to know this year. (Light, 1980, pp. 270-271)

Thus, according to Light's findings, the medical educational model in psychiatry appears not to encourage residents to seek group support from or to open up to their peers, to make mistakes, or to

show their vulnerability. Katz has made a similar observation among another category of advanced medical students, a group of students in a combined M.D.-Ph.D. program. When asked what they would like to change about their education, the replies of many in this group indicated that they did not like the fact that they could not admit to being vulnerable or be open about expressing their feelings (Katz, personal communication, 1992).

In addition, Light noted the prejudice that black psychiatry residents experienced, despite the fact that, in an earlier study, medical students who became psychiatric candidates had scored low on psychological tests measuring racism and authoritarian attitudes (Holt & Luborsky, 1958, cited in Light, 1980). For instance, Light cites a letter from black residents referring to their entrance into

> an ethnocentric white middle-class, psychoanalytic world that is foreign to blacks and the needs of the black community [and where] in training, race was simply not mentioned. In a society filled with racial tension, they found this omission amazing. Residents tended to incorporate and identify with this form of "white institutional racism" [and] "the black resident chosen for these training programs must demonstrate a willingness to accept the institution's values and biases." (Jones, Lightfoot, Palmer, Wilkerson, & Williams, 1970, cited in Light, 1980, p. 32)

Light concludes that, "given the colorblind, class-biased nature of psychiatric theory and the great position of power upon the psychiatrist, one is not sure what low scores on racism and authoritarianism mean" (1980, p. 32).

Listening to students such as these, black and otherwise, we may remind ourselves of the second part of Gilligan and Pollak's warning—namely that "the dangers of isolation remain comparatively uncharted in medical practice and education" (1988, p. 245). Other researchers, themselves psychiatrists, have pointed out the lack of provision in psychiatric educational programs for helping residents to cope with their own emotional needs (Ford, 1963; Garetz & Garetz, 1974; Holt & Luborsky, 1958, cited in Light, 1980). Although research has indicated that psychotherapy is effective in helping residents cope with emotional problems, it is not prescribed by psychiatric training programs and, as a result, not every resident chooses to engage in it, often with disastrous results (Pasnau & Russell, 1975). These include the above-average incidence of suicide, especially among women physicians, and the prevalence of substance abuse on the part of physicians.

This lack of provision for therapy on the part of therapists exists despite the fact that Freud clearly emphasized the importance of the ongoing process of self-reflection in analysis and understood the power of countertransference vis-à-vis the analysand. Thus, Freud stated that the analyst must "submit himself to a psychoanalytic purification...[in order to] become aware of those complexes in himself which would be apt to affect his comprehension of the patient's disclosures" (Freud, 1912/1963e, p. 122). Freud, in fact, felt that the most important factor in becoming an analyst is undergoing one's own analysis (which, it should be noted, is not the same thing as supervision). How could analysts understand others' struggles and inner processes without taking the time to examine their own? How could they guide others in the process of making meaning of their lives if they had not done the same? It should be noted that self-analysis <u>is</u> required as the core of the training process for those who choose to enter psychoanalytic institutes in order to become analysts in the Freudian tradition, which occurs after the completion of the psychiatric residency. However, only a small percentage of psychiatric residents choose to undertake the further rigorous study required to become an analyst (Sussman, 1992).

Since Light's study, many have noted that psychoanalysis has diminished in importance in the psychiatric curriculum and have downplayed the importance of psychodynamic psychotherapy as a part of the psychiatrist's role (Michels & Marzuk, 1993). Instead, they note an increasing reliance on pharmacotherapy, which addresses the biochemical bases of mental disease, and the increasing popularity of briefer forms of therapy, such as cognitive-behaviorally oriented forms of psychotherapy (Michels & Marzuk, 1993).

Yet psychotherapy and psychoanalytic theory have not been abandoned in the practice of contemporary psychiatry. Indeed, although the kinds of psychotherapy have proliferated, and there has been a growing popularity of briefer forms (Corsini & Wedding, 1989), post-Freudian psychoanalysis continues to develop in new directions (Lichtenberg et al., 1984a, 1984b), including some that are relationally based (Myers, 1992) but provide different emphases for "the self, the other, and the space in the middle" (Mitchell, 1988, p. 33) than the more traditional Freudian model. In addition, a conference concerning future directions for psychiatry, "Psychiatric Education in the 1990s," held in Raleigh, North Carolina, in 1986, resulted in reaffirming the need to keep the learning of psychotherapy at the center of

the core curriculum for psychiatric residents despite all the changes in psychiatry that have affected its identity, including the increasingly biological and psychopharmacological emphasis (Nadelson & Robinowitz, 1987). Nonetheless, judging from Light's (1980) and Pasnau and Russell's (1975) findings, many residents and psychiatrists may never have experienced psychotherapy or psychoanalysis themselves.

Another problem that has been noted with psychiatric education is that it lacks a uniform curriculum and has recently been described, unlike general medicine, as being characterized by a variety of "sects," which have only recently begun to coalesce into more substantial "schools" (Havens, 1987). Thus the student is offered different and often conflicting theories and methodologies. Havens, a psychiatrist/analyst, has described the confusing situation facing psychiatric residents. Confronted by representatives of these different points of view, "the new man coming on the psychiatric scene is hawked at like a circus-goer and wanders where his fancy, his temperament, or the allure of his teachers leads him" (Havens, 1987, pp. 277-278).

Within the past decade, however, there have been signs that some of the problems addressed by Light, Mishler, Kleinman, and others are beginning to be addressed in psychiatric education. One textbook (Waldinger, 1984) that is now widely used by medical students interested in psychiatry (as well as by students of other mental health professions) utilizes a multidimensional approach in expanding beyond psychodynamic theories. While this text appears, on the one hand, to lend support to Light's observations as to what is emphasized in the teaching of psychiatry—a psychodynamic approach that is supplemented both by other forms of psychotherapy, including group approaches, and by pharmacotherapy—it also signals a new direction by encouraging self-reflection on the part of the student, especially regarding his or her emotional reactions to treating patients.

Waldinger states in the preface that he "wrote this book because I wished it had been written for me":

> When I was a medical student, I was skeptical of psychiatry with all its jargon, and I was bewildered by the complicated illnesses and profound emotional distress that I encountered among psychiatric patients during my first experience in mental health care. (Waldinger, 1984, p. vii)

Thus, he decided to write a short book "that would give me the basics...and would do so in plain English" (Waldinger, 1984, p. vii). Of particular interest is Waldinger's focus on the reader's own internal reactions; indeed, he actively encourages the psychiatrist-in-training to acknowledge his or her own vulnerability in confronting human psychological pain and suffering:

> A goal of this book is to help you make sense of your reactions to what you see clinically—because your feelings about patients and their problems often provide you with crucial diagnostic information. And the experience of working with people who are in severe emotional distress can be grueling, particularly when you are new at it. In order to take care of other people, you have to take care of yourself—and that means paying attention to your own reactions to clinical work and knowing when to get emotional support from friends, colleagues, and teachers. Throughout these chapters, I have tried to focus on yourself as well as your patients. (Waldinger, 1984, p. viii)

In addition, more humane, "meaning-centered" models of medical education are being developed, such as Harvard Medical School's "New Pathway in Medical Education," which includes the study of "illness narratives" that offer insight into how patients make meaning out of their illness (Kleinman, 1988a). In another program for psychiatric residents at Massachusetts General Hospital, the "Autognosis" Training Program taught by Messner, a psychiatrist, residents concentrate on writing down their own uncensored countertransferential reactions as a part their analysis of themselves as they relate to patients, and they then share them with each other (Messner et al., 1989).

Although such directions and emphases as these are promising, we would do well to note the observations of one psychiatrist about the underutilization of psychiatry in medical education, a fact that we might tie in with the generally low status of psychiatry within the overall medical profession. While emphasizing psychiatry's potential to help train better doctors, Eisenberg, a psychiatrist and professor of social medicine at Harvard Medical School, notes that this resource is, unfortunately, underutilized in medical education in general. He states that the definition of patient care and illness taught in medical education is too narrow, thus hampering the physician's ability to provide that care (L. Eisenberg, 1977,

p. 10), and he believes that one factor contributing to this difficulty in providing appropriate patient care is the "insufficient attention given to psychiatry" in medical training (p. 10).

Community Psychiatric Education

Having surveyed the literature critiquing the university-based model of medical education, both in general terms and as it relates specifically to the education of psychiatrists, we now turn to a discussion of community psychiatry in particular, as it is community psychiatrists that may be most appropriately compared to traditional healers educated according to the principles of education as transformation (Katz, 1981). We will examine what community psychiatry entails in relation to other medical specialties, including private-practice psychiatry in the United States, and the kind of community psychiatric curricula that exists in medical education. We will note in the literature that community psychiatrists are considered to be on the level of "lowbrow" (Rogow, 1970, cited in Light, 1980, pp. 7-8) psychiatrists, we will also listen for any indications that psychiatrists in our subsample do not feel respected by other medical colleagues.

Community psychiatry is a relatively new subspecialty within psychiatry, growing out of what might be viewed as a movement within psychiatry in the United States in the years following World War II and establishing its own separate professional organization, the American Association of Community Psychiatrists, only in 1984. In its original vision, community psychiatry was similar to the viewpoint of Virchow, the nineteenth-century pathologist and public health advocate, in that it stressed the need to address the social aspects of disease and sought to provide treatment, including preventive treatment, to all community members. Correspondingly, this original vision represented the antithesis of the elitist viewpoint expressed above.

The term "community psychiatry" lacks a clear definition, and a number of related terms have been used. For example, certain researchers differentiate between "community psychiatry," "social psychiatry," and "neighborhood psychiatry" (Macht, Scherl, & Sharfstein, 1977). Caplan (1964), himself a community psychiatrist, utilizes the term "preventive psychiatry," which focuses on the idea of reducing the incidence of disorders within the community ("primary prevention"), reducing the duration of such disorders when they do occur ("secondary prevention"), and reducing the impairment resulting from these disorders ("tertiary prevention") (1964, p. 17).

Caplan has traced the history of this subdiscipline as it developed out of the movement toward deinstitutionalization that occurred during the heightened social awareness of this time. During this period, mental patients were gradually discharged from state hospitals and the trend in mental health care shifted toward treating patients within their community contexts, specifically through the creation of community mental health centers (Caplan, 1964; Grunebaum, 1970; Light, 1980; Rappaport, 1977; Zwerling, 1976). By the early '60s, proponents of these ideas had joined with other related professionals in an attempt to influence public policy, and in 1963 they met with success with the passage of the Community Mental Health Centers Construction Act, signed into law only a month before President Kennedy's death, to meet the needs created by deinstitutionalization.

According to Grunebaum (1970), those who drafted this legislation—a cross-disciplinary group of professionals from the medical, mental health, public health, welfare, education, and social science fields (Caplan, 1964)—hoped that it would address broad issues of social injustice and inequality in the delivery of mental health care and that these changes would be reflected in new directions in the education of psychiatrists and other mental health professionals (Caplan, 1964; Lief & Brotman, 1968; Rappaport, 1977; Zwerling, 1976). Among other things, the act's proponents hoped to reach those who were traditionally neglected by the mental health care system—minorities and the poor—and placed emphasis not only on "previously or currently mentally disordered persons but on those who might become sick" (Caplan, 1964, p. 270)—i.e., on prevention of mental illness as much as on treatment of those who are already mentally ill.

Psychiatrists until this time had worked only in private practice or in mental hospitals. Now, however, as some psychiatrists began working within community contexts, both in the newly created community mental health centers and in existing hospitals, some saw the necessity of adopting a stance toward the community itself, in addition to that of the private relationship between physician and patient. Caplan, writing just after the passage of the Community Mental Health Centers Construction Act, stressed this need for community psychiatrists to change their role in relation to other professionals and to community members as they made the transition from hospital- or privately based practice to

community psychiatry, stating that the community psychiatrist must acquire knowledge of social, economic, political, and administrative issues, "which will enable him to plan and implement programs that focus not only on individual patients but on the community problems of which they are a part" (Caplan, 1964, p. 17). Furthermore, he pointed out, this might entail an "egalitarian" or even "subordinate" stance:

> The challenge for the clinician is to retain his professional objectivity, self-awareness, self-control, and sensitivity to the nuances of personal interaction, and, at the same time, to give up the relative aloofness and superiority of the physician role and replace it by the egalitarian role of the consultant or by the subordinate role of the community servant. (Caplan, 1964, p. 275)

Thus, Caplan, writing in the 1960s, was suggesting that there was a need for a shift to a less distant stance on the part of community psychiatrists to include an orientation centered on the idea of community service, as well as a combination of a kind of subjectivity, or "sensitivity," that would serve to balance the more traditionally objective stance towards patients. His words remind us of Peabody, who emphasized to medical students in the 1920s that "the practice of medicine in its broadest sense includes the whole relationship of the physician with his patient" (Peabody, cited in Paul, 1991, p. 156). Although Caplan was applying to larger groups what Peabody had highlighted as being important in dyadic doctor-patient relationships, one could argue that he, like Peabody, Mishler, Kleinman, Gilligan, and Pollak vis-à-vis medicine in general, was also arguing for a more relational stance on the part of psychiatrists who work in the public sector or within community contexts—or for the building of what might be considered a relationship between psychiatrist and community.

Where is community psychiatry now in relation to the original vision under which it was created? Although a new subspecialty of psychiatry was indeed created as a result of the 1963 legislation with the intention of providing the resource of healing to all community members regardless of their ability to pay, the hopes of its proponents have been only imperfectly realized. Part of the problem lies in the way that the original funding for the community mental health centers was stipulated, for federal funding was allotted for the first three years only, at which point other (vaguely specified) sources for funding would have to take over (Bloom, 1977).

Katz's 1981 article, in which he suggested that Western medicine might benefit from the insights of a transcultural perspective, was written in the climate following the 1978 President's Commission on Mental Health "Report to the President" concerning the status of community mental health services. This report had indicated that large groups of the population—notably blacks, Hispanics, Asian-Americans, and Native Americans—remained underserved fifteen years after the passage of the 1963 legislation (L. Perry, 1982). The years that have passed since then have only exacerbated these problems, including a tremendous increase in the numbers of homeless mentally ill and of the medically uninsured (Konner, 1993), which include but are not limited to people of different ethnicity and culture (Kleinman, 1988b). For instance, the continuing problems of access, participation, and representation of minority populations in regard to social services that affect them and are intended to serve them were pointed to in a joint study conducted by members of the American Personnel and Guidance Association, published in 1982. In this report, Perry, a psychologist, advocated for "increased participation...both in planning and in evaluation of needed services...from socially stigmatized populations or culturally different subgroups" (L. Perry, 1982, p. 64) as well as the training of qualified professionals and paraprofessionals from both these groups and "the development of expertise in cross-racial, cross-cultural, and cross-sex counseling" (p. 64). Yet, notwithstanding such calls for a multicultural approach to community mental health professional education, the foundation of the curriculum for the education of community psychiatrists remains the "university-based" allopathic medical model, including its Freudian and post-Freudian psychoanalytic and psychopharmacological underpinnings. Thus, in looking for reasons for the difficulties that continue to affect the community mental health system, we must look at how those services are viewed within the larger psychiatric and medical system of which they are a part.

Within the public sector, community psychiatrists, as medical doctors, rank at the top of the hierarchy of community mental health professionals (Light, 1980), a group that includes psychologists, social workers, psychiatric nurses, and others. They are differentiated from these other professionals by their authority to prescribe medication and to hospitalize patients as part of treatment for mental illness. Typically, the principles of psychiatry formed then, and still form, the core curriculum for all mental health workers, including community mental health workers (Cheever, 1984; Light, 1980). Community psychiatry, thus, takes orthodox psychiatry into community contexts, and this, by extension, impacts all community mental health professionals, who are educated by the same curriculum as those psychiatrists

who work in private practice only (Cheever, 1984). This is confirmed by a brief overview of current community mental health curricula (Adams et al., 1978; Bloom, 1977; Caplan, 1964; Cranshaw, 1969; Glasscote & Gudeman, 1969; Light, 1980; Macht, et al., 1977; Nason, 1977). Such findings suggest that psychiatric education is the prototypic way in which community mental health professionals are educated in the United States (Cheever, 1984). Thus, psychiatry in community contexts plays an important role both hierarchically, in terms of how services are delivered, and academically, in terms of its impact on the education of all community mental health professionals. However, Light (1980) points out that, in fact, many community psychiatrists have cut back on their hours at community mental health centers, and this has left the way open for psychologists and social workers increasingly to take over their management. The fact that community psychiatrists find themselves transitioning into positions other than community mental health center staff is of interest to us, as inherent in the career path of the healer educated with the principles of education as transformation is the idea of transitioning back and forth, rather than a sequential ascent up the career ladder.

Light's review of the 1977-78 Green Book, which gave guidelines for medical education fifteen years after passage of the Community Mental Health Centers Act, indicated that there were no set curricula for community psychiatry in particular. Such guidelines as were given were vaguely stated and varied from program to program, although most often psychiatry residents were required to do a rotation in community psychiatry. Since the time of Light's study, the 1983-84 edition of the Green Book acknowledges that exposure to community psychiatry is necessary in psychiatric training, but the provisions remain vague, stipulating only that there should be "exposure to community psychiatry" and that such exposure "should include experience in community-based programs" as well as an "opportunity to consult with at least one community agency." Thus, there does not appear to be a clearly defined, standard "community psychiatry curriculum."

Additionally, Light found that very few psychiatric residents opt to make a career out of community psychiatry, preferring to build a career in private practice (1980), and he argued that, in making this choice, psychiatrists tend to become elitists by not addressing the needs of the disadvantaged (1980). Indeed, he found that psychiatrists, who already rank lower in status than other physicians, extend this hierarchy further within their own specialty by ranking psychoanalysts at the top as the "highbrow," private-practice physicians as the "middlebrow," and public mental hospital psychiatrists as the "lowbrow" element in American psychiatry (Rogow, 1970, cited in Light, 1980, pp. 7-8). Community psychiatry was not even named in this listing but would certainly be considered "lowbrow." Light maintained that psychiatric residents are conditioned to look down on community psychiatry because it does not conform to the purely psychoanalytic perspective (Light, 1980).

Perhaps as a result of this lower status, the trend in psychiatric positions in community mental health contexts has been toward holding more than one part-time position, a situation that "has led to the profession's diminished power as psychologists and social workers have assumed more of the full-time positions" (Light, 1980, p. 13). In fact, Light asserted that the psychiatric profession had, in effect, "abandoned the community mental health movement when it threatened professional identity by deemphasizing the medical aspects of care and giving nonphysicians a prominent role" (p. 10). Thus, although on the one hand psychiatry continues to wield a great deal of power and influence "over the structure of mental health facilities and over the modes of treatment delivered" (p. 13), on the other hand, community psychiatry itself is given a low priority within the larger profession.

Although many studies have been conducted with medical students and general psychiatric residents, there appears to be very little information about those who opt to become community psychiatrists—a fact that is probably not unrelated to community psychiatry's low status and priority within psychiatry and medicine. Thus it will be interesting to see how similar our subsample of eight community psychiatrists is to the profile of other psychotherapists and other general psychiatrists/analysts that we have presented and where they differ. Among other things, having observed that community psychiatrists tend to be looked down on by other psychiatry residents, we will look for reasons, whether clearly stated or inferred, as to why this group has chosen a lower-status branch of the profession. Are there any patterns that emerge in the educational stories of our community psychiatrists that might provide an answer to this question? And do the community psychiatrists in our sample view themselves as "wounded" physicians by such a choice, and, if so, do they choose to discuss openly such wounds with the interviewer? Or do they regard this choice as self-empowering rather than wounding?

The Impaired Physician and the Wounded Physician-Healer

Within the last thirty years there have been a great many studies looking at the adjustment of medical students and physicians, and from these has developed the concept of "the impaired physician" (Scheiber & Doyle, 1983). Returning to the image of the wounded healer, we might think of the impaired physician as a type of wounded healer in the West who has succumbed to, rather than transcended his or her wounds. Perhaps the most extreme instance of wounded healers succumbing is when they take their own lives; another example is when physicians become substance abusers.

Achterberg (1988), from her studies of the shamanic tradition of the wounded healer, has observed that a major factor in healing, according to that tradition, is finding the capacity within the self to in some way come to terms with one's own vulnerability and thereby transcend the illness experience. Relative to Sussman's evidence that those who choose psychotherapy as a profession often do so because of their own unresolved emotional issues (Sussman, 1992, p. 239), and thus that they are in that sense "wounded," we note that among Western therapists as well there is evidence of this inner impulse to transcend the illness experience. In addition, an essential ingredient of this process is that they must first acknowledge their own vulnerability to themselves. Indeed, this very vulnerability may provide an important tool for helping others.

Sussman notes that some in the West have applied this idea of the wounded healer to the process of becoming a therapist. Jung, for instance, "appear[ed] to follow this tradition when he suggest[ed] that the therapist need[ed] to be vulnerable to the patient's illness in order to be of help" (Jung, 1946, cited in Sussman, 1992, p. 32). Concerning therapists who work with children, Sussman observes that "therapists who faced numerous problems in childhood were especially effective in empathizing and assisting their clients" (Poal and Weisz, 1989, cited in Sussman, 1992, p. 32). Moreover, prospective analysts should not necessarily be rejected for having "neurotic difficulties," for "such disequilibrium may allow for a perspective unavailable to others who are more stable" (Sharpe, 1947, cited in Sussman, 1992, p. 33). Furthermore, Sachs "suggest[ed] that when such imbalance is present, [it] may allow for greater intuitive understanding and empathy for the mentally disturbed [although]...it comes down to a question of degree, rather than an either/or choice" (Sachs, 1947, cited in Sussman, 1992, p. 33). Sharpe and Sachs were discussing prospective analysts. Do their findings have any bearing on community psychiatrists? Again, we will bear this in mind when we listen to our psychiatrists in Chapter Seven.

We have observed that in the Western allopathic tradition of medical education, the doctor or doctor-in-training is rarely allowed to openly acknowledge vulnerability and, additionally, that there is an increasing sense of isolation from their peers as those medical students who have chosen psychiatry move into their psychiatric residency. As noted in Chapter One, Gilligan and Pollak have stated: "In American medicine, ideals of heroic achievement increasingly have overshadowed the value of nurturance and close personal affiliation," and this has resulted in "technological advances [that] have repeatedly been gained at the expense of the doctor-patient relationship" (1988, p. 246) and, we might add, at the expense of the doctor's relationships both with colleagues and with the self. We may ask, then, as we look at studies about wounded and impaired physicians and medical students, what price is paid by doctors within a system that places invulnerability, or at least detachment, and perfectionism in maintaining standards of excellence over "nurturance and close personal affiliation"? Although we might note that a certain amount of detachment is necessary in order not to become overwhelmed when in the presence of others' pain, we still must ask what happens when vulnerabilities cannot be expressed openly, either in the educational environment during medical training or afterwards, as the newly graduated doctor or psychiatrist moves into the challenges of carrying on a private practice or of working within a community context. Also, what sort of problems arise when senior psychiatrists, having hit the rocky period of midlife losses and disappointments (Scheiber & Doyle, 1983), experience isolation of a different sort, as they continue to see patients but without any supervision?

In 1964, an editorial was published in the British Medical Journal concerning the apparently higher-than-expected suicide rate for physicians, and this, along with a drop in the number of applicants to psychiatric residency programs, prompted many studies and articles over the next decade sounding the alarm (Blachly, Osterud, & Josslin, 1963, Craig & Pitts, 1968, De Sole, Singer, & Aronson, 1969, Freeman, 1967, and Rosen, 1973, cited in Preven, 1983). Other authors (Bergman, 1979, Steindler, 1981, and Von Brauchitsch, 1976, cited in Preven, 1983) subsequently found this claim about the physician suicide rate to be unsubstantiated after subjecting the studies to more sophisticated methods of statistical analysis. Preven (1983) has pointed out, for instance, that one drawback of most of these early studies was that they lacked comparison groups of non-physician controls of comparable professional background.

Nonetheless, he concluded in a metanalysis drawn from an extensive review of the literature that although the rate of suicide among male physicians in the United States is the same as among age-matched controls, female physicians do have a suicide rate three to four times that of age-matched controls, although the rate is the same as for male physicians. In addition, "psychiatrists appear to be overrepresented in the percentage of physician deaths due to suicide" (1983, p. 41), although Preven was careful to point out that at least one study reporting this higher incidence had too small a sample size to demonstrate significance (Craig & Pitts, 1968, cited in Preven, 1983).

Concerning the high rate of suicide among female physicians, Pitts and colleagues made the controversial claim that 65% of all female physicians have an affective disorder (Pitts, Schuller, & Rich, 1979, cited in Preven, 1983), but others were critical of their methodology (Zuk, Miller, Champagne, et al., 1979, cited in Preven, 1983). Nonetheless, we are reminded of the gender differences that Gilligan and Pollak found among medical students, with women more often yielding projective data indicating that relationships were viewed as safe but achievement as unsafe, and men more often indicating the opposite (1988). In addition, they noted that the women's responses more frequently showed themes of isolation (1988). Taking this information in conjunction with the evidence about suicide among female physicians, it is perhaps reasonable to suggest that psychiatry residents or medical students who are more relationally oriented—whether they are male *or* female—have more difficulty adjusting to a rigorous academic atmosphere where individual achievement, invulnerability, and a power-over model are reinforced and where intimacy, vulnerability, and power-with are discouraged.

In addition to the problem of physician suicide, there is also evidence of problems with substance abuse among physicians. Based on studies of disciplinary actions taken by state boards of medical examiners, the figures for alcoholism are 2.3%-3.2% of registered physicians; for drug dependence, 0.9%-2.0%; and for other mental disorders, 0.9%-1.3%. Scheiber notes, however, that these constitute "gross underestimates of these problems since medical examining boards become involved in only the most serious problems with the most overt behavioral deviations" (Scheiber, 1983, p. 4). Indeed, the American Medical Association has offered higher figures, estimating that the number of doctors who now are or will become alcoholics is 7%-8%, "an estimated 10,000 alcoholic physicians" (p. 4). As for drug addiction (to sedatives, tranquilizers, and stimulants more than to narcotics), "over 4,000 physicians in the United States, or 1.5% of practicing doctors, are known addicts" (p. 5). Scheiber adds that "estimates [of the real number of physician addicts] range from 30 to 100 times the rate of the general population" (p. 5). He also notes that "nine percent of physician addicts commit suicide" (p. 6) and that suicide rates as reported in the Journal of the American Medical Association indicate that there are more than 100 physician suicides per year, "the equivalent of the size of an average graduating class of medical students" (pp. 4-5). One study found that psychiatrists were overrepresented in a group of recovered alcoholic physicians (Bissell and Jones, 1976, cited in Webster, 1983, p. 32).

It is interesting to note that the qualities of the typical allopathic doctor, if carried to an extreme, can lead to his or her demise. The typical medical student has been described by Scheiber as "overly ambitious, upwardly mobile, highly competitive, and obsessional in his studies without allowing for a diversity of interests. The [typical] physician has worked long hours and has been in solo practice, with no relief for night call and nobody accessible for immediate consultation. He frequently was found in short supply in underpopulated areas" (Scheiber, 1983, p. 8). In addition,

> some personality traits of the "good doctor," including obsessionality, lack of pleasure seeking, and feelings of indispensibility *[sic]*, lend themselves to depression. With declining energies of middle life and the subsequent inability to maintain the pace of the "good doctor," the vulnerable physician is prone to depression. (Scheiber, 1983, p. 6)

This evidence about depression, suicide, and substance abuse among physicians points to the ways in which physicians in general, and particularly women in medicine and psychiatrists, outwardly manifest their woundedness. But what is the nature of this woundedness, and how does it manifest at a deeper, psychological level? Modlin and Montes's (1964, cited in Scheiber, 1983, pp. 6-7) studies of addicted physicians are of particular interest in terms of our relational perspective, for they found that at the basis of these addictions were relational wounds. "Only 3% held their fathers in esteem and only 13% felt warmth toward their mothers.... They were sickly as children, having had disorders such as cholic, enuresis, and other systemic illnesses; they tended to be compliant youths. More than 50% had alcoholic fathers and 75% have unsatisfactory marital relationships" (Scheiber, 1983, p. 6).

Here we may also turn to the experience of psychotherapists, for this subgroup of Western healers, which includes psychiatry, is comprised of individuals who are particularly interested in the

motivations behind and meanings within human experience. Specifically we turn to a psychotherapist who has undertaken to investigate the unconscious motivations of those who choose this profession.

Sussman, a psychologist although not a psychiatrist, was educated from a psychoanalytic object relations and self-psychological perspective, and his findings about the underlying motivations of therapists are relevant to our discussion both about how to educate healers and about how to prevent abuse of the healing power and of the self. His investigation grew out of his own experience as a psychotherapy patient, where he discovered that "much of what these therapists did met their own needs rather than mine. Even more disturbing was the realization that this aspect of my therapeutic relationships had remained totally unacknowledged and unexplored" (Sussman, 1992, p. xiii).

He attributes this to the fact that "there appears to be a stigma within in the profession against therapist self-disclosure, not only in relation to clients, with whom such a prohibition can often be justified, but also in relation to students and colleagues, with whom it usually cannot" (Sussman, 1992, p. xv). He humbly says that "the difficulties that I confronted in attempting to come to terms with my own problems eventually spawned my interest in the underlying motives of psychotherapists" (p. xiii). Although he regretted these difficulties at the time, he ultimately came to thank his therapists even for "their blunders and peculiarities, [for without these] I would have never written this book" (p. xiv). Sussman hopes that "the rejection of such a stigma [against therapist self-disclosure may] add momentum to the trend toward greater openness regarding the therapist's contribution to the therapeutic process" (p. xv).

From interviews with nine different kinds of psychotherapists, Sussman developed an in-depth profile of each, including an analysis of their unconscious motivations in choosing to become psychotherapists. He examined these motives from the standpoint of three major orientations within psychoanalysis: instinctual aims, narcissism and the development of the self, and object relations. While he points out that many of the motivations he encountered were positive ones, including the frequently expressed need to be of service, there were also negative motivations, and he reminds us of Freud's belief that an aggressive urge, as well as "sadism transformed into compassion," often lay beneath the desire to become a doctor (Freud, 1926, cited in Sussman, 1992, p. 72).

In an attempt to create a character profile of psychotherapists in general, Sussman cites some of the same studies of medical students and psychiatric residents that Light did in 1980, but he also includes more recent studies focusing on intrapsychic as well as psychological characteristics. One aspect of this character profile, noted in a number of these studies, is the fact that many therapists have some degree of narcissistic disturbance and that this has influenced their choice of profession (Claman, 1987, Finell, 1985, Miller, 1981, and Sharaf & Levenson, 1964, cited in Sussman, 1992). When taken to a pathological extreme, narcissistic personalities exhibit "great ambition, highly unrealistic goals, intolerance of failures and imperfections in themselves, and a nearly insatiable craving for love, attention, and admiration, upon which their self-esteem is based" (Nemiah, 1961, cited in Sussman, 1992, p. 100). In a similar vein, Kernberg notes that the main traits of the narcissist are "grandiosity, extreme self-centredness, and a remarkable absence of interest in and empathy for others in spite of the fact that they are so very eager to obtain admiration and approval from other people" (Kernberg, 1967, cited in Sussman, 1992, p. 100). Sharaf and Levenson (1964) also reported medical students' tendencies toward grandiosity.

This potential characterological weakness on the part of therapists, including psychiatrists and psychiatrists-in-training, is of particular interest in light of the question of the abuse of power on the part of medical professionals that we raised in Chapter One. How a person interacts with the pain of his or her woundedness can vary from denying it completely to some level of acknowledgment—whether only to the self or to one or more other people—of that person's vulnerability and fears. Healing is contingent on some level of acknowledgment and self-acceptance, and is more likely to occur with the support of others. Jordan et al. (1991) have noted the importance of developing self-empathy. Self-empathy appears all the more important in that, as we have seen, the allopathic medical model tends to encourage a distanced stance in psychiatrists toward both patients and colleagues and, additionally, psychiatrists are not required to undergo their own therapy to work through the unresolved issues that Sussman indicates are common. Thus, when a therapist with unresolved issues, or even unacknowledged ones, moves into the complex interactions with another person involved in psychotherapy, serious problems may arise.

This complexity is due in part to the interacting valences of transference and countertransference between therapist and client. For instance, if a narcissistically defended psychiatrist reacts countertransferentially to a borderline patient who in turn is reacting transferentially utilizing a different kind of defense than the psychiatrist, the interaction is indeed complicated. Yet countertransference is an issue that, according to Sussman's extensive research, often goes underreported and underaddressed in

supervision (1992), and if the psychiatrist is not aware of his or her own countertransference, either with or without supervision, the situation becomes even more complex. We will listen to what psychiatrists say or do not say about their own countertransference issues in Chapters Six and Seven.

Recent research by one psychologist (Celenza, 1990) has indicated that there might be certain defense styles that would interact better with one another in the therapeutic dyad, not to mention the supervisory dyad, and conversely, there might be defense style that clash. Celenza describes such a possibility when she points out that "individuals with flexible defensive styles in regulating object ties are associated with the greatest capacity for emotional empathy and those with an intolerance for affective longings or primitive separation fears are associated with a poorer capacity for emotional empathy" (1990, p. 15). Celenza also observes that narcissistic patients tend to retain the cognitive aspects of empathy, while borderline patients tend to retain the affective aspects. Thus, in the author's opinion, it may be possible to predict, based on the type of characterological weakness that a person may manifest, which aspects of empathy will be manifested and which will be less developed. Moreover, we might suggest that a therapist with narcissistic tendencies, for instance, might experience cognitive dissonance, or, perhaps more accurately, affective dissonance, with a borderline patient. We will examine the implications of these findings further when we consider different views of empathy in Chapter Three.

From his interviews and his review of other studies, Sussman has pointed out that many therapists, representing all therapeutic orientations, discover in the course of their training, if not earlier, that they themselves have been wounded (1992). Yet, as we have noted, this vulnerability, if appropriately utilized, can be one of their greatest strengths, one that can enhance their capacity to be of service of others (Burton, 1972, cited in Sussman, 1992, p. 30), whereas denying its existence can lead to the possibility of causing harm to others or to the self. On the one hand, therefore, Sussman's findings lend support to the idea that healers, especially those who are drawn to practice psychotherapy, are in some way "wounded"; on the other hand, he maintains that being wounded does not mean that one is necessarily "impaired," nor does it mean that one should not become a psychotherapist. Instead, it points to the fact that in order to be a "good" healer, one must often learn how to heal oneself, and this, in turn, may involve developing self-empathy, or a felt sense of what one's own needs are, emotional or otherwise. Indeed, such a connection with the self may be a necessary condition in order for the therapist to be truly and helpfully empathic in relation to the patient.

Thus, a part of the empathizing process appears to be the therapist/analyst's ability to associate to his or her own experience before connecting with a client. Freud perhaps pointed in this direction in his 1912 paper, "Recommendations for Physicians on the Psychoanalytic Method of Treatment," in which he noted that the psychoanalyst must attune his or her unconscious to the patient's unconscious:

> Expressed in a formula, he [the analyst] must bend his own unconscious like a receptive organ towards the emerging unconscious of the patient, be as the receiver of the telephone to the disc. As the receiver transmutes the electric vibrations induced by the sound-waves back again into sound-waves, so is the physician's unconscious mind able to reconstruct the patient's unconscious, which has directed his associations, from the communications derived from it. (Freud, 1912/1963e, p. 122)

A contemporary psychiatrist/analyst has offered another apt image, that of the ocean, to describe the therapist-patient relationship, but in a way that also points to the elements of mutuality and reciprocity that potentially exist within that relationship:

> Patient and therapist together connect the stirrings of the wind upon the surface with the groundswells and undertows beneath, and ultimately elucidate the tides in their seasons. But they do not bathe in such awe of oceanic majesty that they lose sight of the specific details to be encountered upon that particular surface, which it is their lot to encounter and to examine. (Binstock, 1986, p. 284)

Binstock's image creates a feeling of the dynamic movement in the therapeutic relationship that is similar to a continuous swell in an ocean of great depth. As the interaction between therapist and client unfolds at the surface, the movement is characterized by circularity or recursiveness, in which the therapist associates to his or her own similar "groundswells and undertows," including "specific details," as he or she resonates with the client. We must keep in mind, however, that within the empathic connection are varying levels or ways of interacting and of responding, and that how a therapist responds is dependent not only on the developmental level of the patient but also on his or her own developmental level.

In our discussion of the nature of empathy in Chapter Four, we will end with a vignette of an interaction between a therapist and her client that illustrates this circularity in the process of empathic relating, not only at a conscious level but at the unconscious level as well. This vignette will help us observe how much our ability to empathize with another is dependent upon our ability first to recall a similar experience of our own and then to resonate with the other's experience, sometimes in a way that we are not even conscious of.

The Physician as Moral Explorer

Although we have painted a picture of medicine, psychiatry, and community psychiatry that emphasizes its problems, we cannot neglect to mention some of those within the profession—especially among those with a community psychiatry perspective—who capitalize on its strengths in continuing to look for a larger, more inclusive vision. For instance, Pierce, a community psychiatrist, has drawn attention to the moral nature of the role of the community psychiatrist, especially in confronting racism. Describing racism as "a contagious and lethal mental and public health disease which is characterized by a perceptual distortion and false beliefs about skin color" (Pierce, 1974, p. 516), Pierce has stated that community psychiatrists, insofar as they model behavior toward their patients and colleagues that confronts racist attitudes and practices inherent in Western society, can educate people to relinquish these attitudes.

Stone, a past president of the American Psychiatric Association whom we cited at the end of Chapter One as calling attention to the lack of existing cultural structures addressing the problem of sexual misconduct (1984), has echoed Pierce's plea for psychiatrists in general to take such a position concerning racism, but he goes further by also taking a stand against discrimination against homosexuals and women. In his presidential address to the APA in 1980, entitled "Conceptual Ambiguity and Morality in Modern Psychiatry," he stated that "I intend today therefore to speak about the ambiguity of our eclectic medical model and my concern that having overcome the tyranny of narrow orthodoxy we are now in danger of retreating behind new walls...[as regards] subjects familiar to you all: racism, homosexuality, and the situation of women" (Stone, 1980). He goes on to challenge his fellow psychiatrists "to take a stand on human values":

> these are all issues which have confronted us in our practice, challenged the moral assumptions that lie concealed in our theories, and confounded us with disputes and acrimony in our Association. It is as we attempt to deal with this kind of issue that the new walls are being built, and it is no accident that each invites psychiatry to take a stand on human values. Human values after all are a crucial link in the chain that binds the self to society. To take a stand on them reveals something about our own selves, our own relation to society, and our own vision of what it means to love and work. (Stone, 1980, p. 5)

In these calls to confront some of our more invidious cultural biases, there is perhaps a parallel with one of the principles of education as transformation. For as we have seen, the healer educated according to education as transformation is a "moral explorer" for his or her people (Katz, 1986, 1993; Katz & Kilner, 1987). Can we say that community psychiatrists in the United States in any way see themselves playing a similar moral role to that of Fijian or Ju/'hoan healers? May we find this principle of education as transformation present in the words of Pierce or Stone? And will our subsample of community psychiatrists raise similar issues and concerns?

In Chapters Seven and Eight, we will look at the psychiatrists in our sample in a way similar to that in which Katz viewed healers educated according to education as transformation. As we observed with Kinachau and Toma Zho, the Ju/'hoan healers, and with Ratu Noa and Tevita, the Fijian spiritual healers, we will consider each psychiatrist's view of his or her relationship to the healing power. Does he or she report altered or enhanced states of consciousness in the course of conducting psychotherapy or otherwise? What does he or she consider healing or helping to be? How does each view him- or herself in relation to self, colleagues, patients, family, and community? What does each find most challenging about being a psychiatrist? Given the importance of empathy in psychotherapy cited in the literature, as well as in the model of education as transformation, how does each feel about empathy in relation to healing? And is empathy mentioned directly or is an empathic stance inferred from what each is saying? In the next chapter, we will look more closely at the elusive nature of empathy, as it has been described in the literature, as well as at the elusive nature of a "self."

Chapter Three:
Empathy as Relational Process

Why is empathy important to examine? One psychodynamic psychologist has pointed out that "accurate and empathic responsiveness...is the very precondition for all curative effects in psychotherapy" (Ducey, 1986, pp. 47-48). Thus, to provide a context within which both to view our findings and to examine the appropriateness of the Mehrabian and Epstein Questionnaire Measure of Emotional Empathy (1972), we need to understand more clearly the nature of empathy, somatic and otherwise. In this chapter, then, we will explore how empathy has been viewed and measured in the literature, looking with particular interest at how empathy develops in the mother-infant relationship, inasmuch as some psychoanalysts attempt to draw parallels between the nature of the relationship that patients have experienced with a chief caregiver in childhood and the relationship that later develops between them and their analyst or psychotherapist (Bollas, 1987; Modell, 1968; Winnicott, 1965). To shed further light on what empathic interaction entails, we will observe what is, in the writer's opinion, empathy-in-action in the interchange that takes place between a somatic educator and his client. We will then present a vignette illustrating some of the more elusive elements of empathic interaction between a therapist and her client. We will close the chapter with the writer's suggestion that the elusiveness of the empathic self-in-relation can be visualized as a Möbius strip, a topological figure in spatial geometry.

In 1986, at a conference on psychiatric education sponsored by the American Psychiatric Association, a respected psychiatrist/analyst who played a definitive role at the conference asserted that "intensive psychotherapeutic supervision and experience are necessary, as is the direct teaching of interviewing skills" (Frazier, 1987, pp. 9-10). Furthermore, he asserted that notwithstanding the increasingly biological emphasis in psychiatry, the nature of the psychotherapeutic relationship remains important, especially in the treatment of "more difficult" patients, and that an important constituent of creating such a psychotherapeutic relationship with anyone, but especially with such patients, is empathy (p. 10). Empathy, he continued, develops in psychiatric residents as a result of the supervision they receive and the interviewing skills they are taught, and as a result of empathy, they "learn how to connect with difficult patients, and to interpret what is communicated during the interview" (p. 10).

From Frazier's words one might conclude both that teaching "empathy" is not difficult and that teaching it is already a component of the current curriculum that teaches psychiatry residents how to conduct a psychiatric interview. But, as we will see in greater detail in this chapter, empathy has long proven an elusive concept, and it involves much more than good interviewing skills. We get a sense of the elusive or ambiguous nature of empathy in the words of Sullivan, an early proponent of the interpersonal school of psychiatry, an outgrowth of psychoanalysis, when he referred to the process by which "anxiety in the mother induces anxiety in the infant...[as] thoroughly obscure...a gap, [a] failure of our grasp on reality" and explained that "I bridge the gap simply by referring to it as a manifestation of an indefinite—that is, not yet defined—interpersonal process" (1953, p. 41). Furthermore, we find that discussions concerning the nature of empathy have often been divisive, as can be seen by Schwaber's plea for a "nonpolemical" discussion of the subject of empathy at the beginning of a two-volume compendium on the subject within psychoanalysis (Schwaber, 1984). Perhaps, in fact, developing a quality, or "capacity" (Stark, personal communication, February 1993) such as empathy involves a different kind of development than the intellectual competency emphasized in the university-based model of psychiatric education (Light, 1980). Additionally, it may be that some of the more popular methods of measuring empathy may not be based on a full appreciation of the complexity of this crucial concept.

We find that in seeking out a psychotherapist for themselves, psychotherapists involved in one study (Grunebaum, 1983) emphasized the quality of the relationship as an important factor in choosing a therapist, and all emphasized, among other things, the importance of qualities often associated with empathic connection. Grunebaum, a community psychiatrist, conducted a study in which twenty-three psychotherapists (including eleven psychiatrists), most of whom had had personal experience as a patient/client with at least two different therapists, were asked what criteria they used in seeking out a competent therapist for themselves. Grunebaum concluded that "they sought a therapist who had a reputation for 'competence,' whom they would not encounter frequently outside of therapy sessions, whom they experienced as warm and caring, and who talked rather then remaining silent during the

sessions" (Grunebaum, 1983, p. 1336). Although the word "empathic" was not specifically used, the descriptions "warm and caring" and the idea of an analyst/psychotherapist who talks rather than remains silent nonetheless evoke an empathic atmosphere, or at least one where two people are able to relate comfortably.

One might indeed wonder whether empathy is an important part of the "glue" that holds the psychotherapeutic relationship together, thus contributing to the creation of the "helping alliance," the establishment of which researchers have found to be one of the important ingredients for successful therapeutic outcome (Luborsky et al., 1988). Thus, it would appear from such findings that psychiatrists, psychiatrist/analysts, as well as other psychotherapists, by the very nature of their work, need to actualize empathy in order to create effective psychotherapeutic relationships with their patients. In addition, empathy may be important to psychiatrists as an antidote to the overactivation of their own reactive defenses, or countertransferences, vis-à-vis their patients (cf. Chapters One and Two). The question, however, is how to teach something whose meaning remains so elusive.

Perhaps some of empathy's elusiveness or ambiguity is the result of the dichotomous way in which mind, body, and consciousness have been viewed in Western thought. We will therefore briefly examine this historical context as we continue our considerations about method before turning our attention to a special focus on researchers and theorists who speak in various ways of the dynamic, interactive, and recursive qualities that are involved in empathic relationships, in order to provide a context for examining the findings in the present study. When considering these studies of empathy, both within and outside of psychotherapeutic outcome research, it will be seen that empathy has been found to be a relational concept (Myers, 1992), which comprises both affective and cognitive modes of relating (Buie, 1981; Celenza, 1990; Jordan et al., 1991). Indeed, as one psychiatrist/analyst has said, "without the capacity to empathize with the feelings of another, we would just be bodies located physically in space alongside one another—no interhuman connection would exist at all" (Agosta, 1984, p. 49).

Somatic Views of Empathy (Somatic Empathy)

Some researchers argue that the particular kind of meaning-making and "movement-in-relationship" (Jordan et al., 1991) that empathy entails is best viewed from an integrative body-mind perspective rather than from a perspective that dichotomizes mind and body. This view suggests that a theory seeking to explain the nature of empathy, as well as to increase its effectiveness in the psychotherapeutic relationship, must explain what constitute not only empathic verbalizations on the part of the therapist but also empathic nonverbal and somatically based interactions. For instance, one can experience empathy nonverbally through mutual silences, yet these same silences can also be construed as unempathic depending on the context of psychiatrist and patient, the co-evolved meaning of the therapeutic situation, and the developmental level of each (Book, 1988; Havens, 1986). Likewise, through the therapist's mirroring of the patient's body position, the therapist can strengthen rapport (Steere, 1982).

In 1959, Bleuler, a psychiatrist who specialized in schizophrenia, noted the effects of attuning one's movements to those of the patient. He recounted the example of what happened when someone interacted with a catatonic patient on her terms:

> The balancing catatonic was completely rigid, mute and unresponsive until someone joined her in her balancing act as if dancing. All of a sudden, she was transformed; one could hardly recognize her as the same patient. She told us everything we wanted to know about her love affair and her life-story, with complete clarity, like any healthy person. (Bleuler, 1959, quoted in Havens, 1986, p. 17).

In his book Making Contact: Uses of Language in Psychotherapy (1986), Havens, a psychiatrist/analyst speaks to empathy as "a capacity to participate in or experience another's sensations, feelings, thoughts, or movements. Finding the other, therefore, means finding appropriate sensations, feelings, thoughts, and movements; these are the data of empathic work" (1986, p. 16). In the vignette at the end of this chapter, we will look more closely at a situation that demonstrates not only the therapist's permeability to the patient's experience but also the patient's apparent permeability to the therapist's experience.

When we apply a nondichotomizing model of the body-mind to empathy, we thus include its somatic (body) in addition to its mind (verbal) aspects. Indeed the origins of empathy are somatically

based, as seen in the mother-infant relationship (Bowlby, 1969; Tomkins, 1962, 1963). Thus, we will look not only at clinical empathy, which focuses on the verbal interactions between therapist and client (Havens, 1978, 1986), but also at somatic empathy (Ginsburg, 1984, in press), which has also been termed the "felt sense" (Gendlin, 1962, 1969, 1978, cited in Corcoran, 1981) or "experiential empathy" (Corcoran, 1981).

Corcoran points out that empathy is an emotional state and therefore is a "body phenomenon, since emotions are themselves body phenomena" (p. 33). He cites Feldenkrais (1949), who contended that

> "the voluntary muscular patterns corresponding to emotions are preceded by a sensory experience"...through four steps: (a) the neurological impulse reaches the thalamus, then travels to (b) the striated motor system, © the sympathetic nervous system, and (d) the cortex. Theoretically, this process elicits an involuntary motor reflex at the striated motor system, an emotional response at the sympathetic nervous system, and awareness or recognition at the cortex. (Feldenkrais, 1949, cited in Corcoran, 1981, pp. 32-33).

Hanna, a somatic educator, has clarified the meaning of the word "soma" to denote the embodied sense of self in an attempt "to transcend the ancient and pernicious division of the human person into something called 'mind' and 'body'—a false and dehumanizing distinction" (Hanna, 1975, p. 83, cited in Ginsburg, 1984, p. 70). Thus,

> Human self-awareness [is] not a vacuous and disembodied "epiphenomenon," but [is] a holistic awareness of the self which [is] embodied and always aware of the state of its embodiment.... Self-awareness (or self consciousness) is the function of experiencing the whole state of one's organic structure, [and] as that organic structure changes, so does our basic self-awareness—and vice versa. (Hanna, 1975, p. 83, cited in Ginsburg, 1984, p. 69)

Empathy and the Paradox of Self-Reference

Perhaps another way of asking what empathy entails from a body-mind perspective is to question the nature of the relationship of two "selves" interacting empathically. From a holistic or systems perspective, Feldenkrais has pointed out that "the unity of mind and body is an objective reality, that they are not entities related to each other in one fashion or another, but an inseparable whole while functioning. To put this point more clearly, I contend that a brain without motor functions could not think or at least that the continuity of mental functions is assured by corresponding motor functions" (Feldenkrais, 1964, p. 47). Thus, in this view, mind and body are inseparably linked within the empathic process as well.

In fact, Ginsburg, a somatic educator writing from a biological systems perspective, maintains that "the notion of a self is basic to biological existence" (1984, p. 68). But what exactly is a "self," and where does it originate? Or even more to the point, where does one self leave off and another self begin? Is it possible to locate the self within an individual's biological structure—in the brain circuitry, for instance? As one cognitive neuroscientist, grappling with this problem, has quipped about such a perspective:

> You enter the brain through the eye, march up the optic nerve, round and round the cortex, looking behind every neuron, and then before you know it, you emerge into daylight on the spike of a motor nerve impulse, scratching your head and wondering where the self is. (Dennett, 1984, pp. 74-75)

The biological systems perspective holds, instead, that the self is somehow an emergent property arising out of the totality of the individual's biological structure. Ginsburg (1984), building on the thinking of Varela (1979), Maturana and Varela (1980), and Feldenkrais (1981), has suggested that "by transcending the mechanical descriptions of organisms, which are limited, one can show that autonomy and self are emergent characteristics of that particular state of organization that we recognize as a biological organism" (Ginsburg, 1984, p. 68). Thus, although "one can describe subsystems of an organism as if they were machine-like in the ordinary sense, such descriptions will always fail to include the system itself" (p. 68). Indeed, something will always be left out unless one also takes into account these emergent "system characteristics of an organism" (p. 68). In an article entitled "Toward a Somatic Understanding of the Self" (1984), Ginsburg points out the paradoxical nature of the self in that it is a "living system": "The very process of the formation of living systems creates paradox and...we suppress

this to our own loss" (p. 91). He points out the paradox inherent in George Herbert Mead's definition of "the self as that which can be an object to itself" (p. 73). Ginsburg sums up this paradox of self-reference in the following way: "If the self arises out of being an object to itself, then there is not itself for it to be object to. On the other hand, if there is an itself, it cannot arise out of being an object to itself for it was there already" (p. 74). This paradox results from the fact that there is an emergent property of a "self" within any given biological system, and this self is more than merely the sum of its parts. Thus, there is not only an elusiveness, as we will see, in empathy; there is also an elusive property of the self, as illustrated by the paradox of self-reference, an old problem of a two-step logic system that can never get outside of itself (Ginsburg, 1984; Hofstadter, 1979).

Although this concept is relatively new in Western philosophy, it is interesting to note that Tibetan Buddhism is a cultural tradition that, over the centuries, has developed these principles involving paradox in a very rich and complex way. The Tibetan Buddhist also views the self as paradoxical, but here the image of the self that is depicted is that of the reflection of a woman looking at her made-up face "in a mirror or clear water" (Guenther, 1977, p. 173). Speaking of the treatise called the Samadhirajasutra, Guenther (1977) states that

> the appearance of the whole of reality subsumed under the headings of Samsara, i.e., the world of appearance and of possible life forms, and of Nirvana, is not found to exist either without (i.e., as an external object) or within (i.e., as an idea) or in between.... The *Samadhirajasutra* says:
>
> Know all things to be like this:
>
> When a woman looks at her made-up face
> In a mirror or clear water,
> Although there is a reflection
> It neither is nor is not. (Guenther, 1977, p. 173)

We will bear in mind the question of the paradoxical nature of the self as we observe two selves in interaction in the vignettes at the end of this chapter and when we observe Katz's interaction with a Fijian Vu (or ancestor-god) in Chapter Four. With this in mind, let us turn now to the historical origins of empathy.

The Legacy of Descartes: Dichotomy and Interaction

In the early part of this century, prior to its expropriation into psychiatry by way of psychoanalysis, the concept of empathy developed in Europe within the field of aesthetics. The German word "Einfühling," or "feeling with" (Basch, 1983) or "feeling into" (Schwaber, 1984), subsequently translated as "empathy" in English, was originally used by Theodore Lipps to characterize the artistic experience. The term was then introduced into psychology in the United States by Titchener, an Englishman who helped establish the introspectionist school in America during the latter part of the nineteenth and the first part of the twentieth century; this school focused on mind as opposed to sensory functioning and reaction times (Boring, 1950; Olinick, 1984, p. 150). Olinick, a psychiatrist/analyst who has traced the concept's nonpsychoanalytic origins, states that the term "empathy" initially was intended

> to suggest motor mimicry and kinesthesia as the basis for understanding, first, the arts, and later, other people. Through his own reactions, the observer imitates the forms and patterns suggested by the art object or by the other person; the observer "projects" his reactions onto the external object or person, thereby perceiving the object's qualities as external. (Olinick, 1984, pp. 151-152)

Thus, empathy in its original meaning was viewed in a manner that might be called "holistic" today, incorporating mind with body, including the kinesthetic sense among other senses, such as vision, and including nonverbal as well as verbal components. This somatic component, however, was not developed as the term took hold as a psychological concept, despite the physiological interests of such early psychologists as William James, and in empathy research in the decades since then, the somatic component has generally been underemphasized. What, then, is the historical context in which mind and body have become dichotomized in Western thought such that the splitting off of somatic empathy from psychological thinking occurred? Rogers of the client-centered school of psychology understood the

somatic foundation of empathy (Ginsburg, 1984) but left it for others to develop (Corcoran, 1981, citing Feldenkrais and Gendlin).

If, from a larger perspective, we can say that empathy is a form of "consciousness," we will see that it is perhaps affected by the ambivalent way in which Western science has dealt with the problem of mind and consciousness, that "ongoing flow of reflections that we...associate with our identity" (Maturana & Varela, 1987, p. 231). We will explore this "mind-body problem" more fully in this chapter, along with the corollary question of the nature of the mind-body relationship. For although some have considered mind or consciousness to be a valid part of the science of psychology, the larger current has chosen to ignore it, as an "epiphenomenon" of brain circuitry or as a "black box"—an unknowable realm—that is not considered the province of true science; this has been the case particularly in the neurosciences (Schiller, 1982). If empathy, then, is a form of consciousness, the lack of clarity in defining empathy may perhaps reflect a condition that has characterized Western medicine and psychology in general, namely, difficulty in pinning down the relationship between the body/brain (or biological substrate) and consciousness/mind (or mental processes).

Although now increasingly mind and consciousness are being addressed, the fact that, until recently, the role of mind or consciousness has been kept out of medicine, and science in general, is perhaps in part due to the legacy of dualism that is most directly attributed to Descartes in the seventeenth century. Descartes indeed took a dualistic position, positing that mind and body are two different substances, and he conceived of the body as a "machine," basing this conception on the discoveries in physics and biology of his day, such as Harvey's discovery of blood circulation in 1628, knowledge of the agonistic versus antagonistic relation of muscles in movement, and a basic understanding of the relation of nerves to sensation and movement (Boring, 1950, p. 162). Nonetheless, he also believed that these two substances "interact with each other in the human organism, body affecting mind and mind body" (p. 162). As to the locus of this interaction, he believed it to be the pineal gland or "conarium," which Descartes considered to be the only "unitary" part of the brain, but, at the same time, he also held that "the soul is united to all parts of the body conjointly," for "the entire body is its seat so long as the body remains intact" (Descartes, cited in Boring, 1950, p. 164). Thus, Descartes arrived at the model of a mechanistic body with which a nonmechanistic soul, encompassing mind, interacts, and in this way he avoided a clash between his scientific and religious beliefs (Boring, 1950, p. 162). Indeed, as we have previously noted, Descartes agreed to leave "the soul, the mind, the emotions, and consciousness to the realm of the church" (Pert, cited in Moyers, 1993, pp. 179-180) in return for being allowed to continue to engage in scientific pursuits.

But although Descartes has been regarded as the originator of the dualistic view of the mind-body relationship, which has gained force as a paradigm in the three centuries since his time, it would appear that there is a paradoxical tension in the way that he viewed the mind-body relationship. For while it may be that there is some contradiction between his belief that, on the one hand, "the soul is united with all of parts of the body conjointly" (Descartes, cited in Boring, 1950, p. 164) and, on the other, that the seat of interaction between soul and body is in the pineal gland, both positions nonetheless are based on his belief in the interaction between soul and body, which is seemingly at odds with a strictly dualistic separation of mind and body. Indeed, Boring maintains that Descartes, in addition to being a dualist, was "also the father of the mind-body theory of <u>interactionism</u>" (p. 162). In addition, Ginsburg notes that, according to Wilbur, Descartes "was actually trying to salvage Man and his spirit from western science" (Wilbur, cited in Ginsburg, in press). Nonetheless, it is the dualistic aspect that has been his enduring legacy to Western philosophical and scientific thought.

By the late nineteenth and early twentieth century, as psychology developed as a science, one can identify two extremes regarding the relationship of mind to behavior, with many intermediary positions. On the one hand the phenomenologists, following Husserl and Kohler, and then Merleau Ponty, believed that the understanding of mind and consciousness was at the very heart of psychology and that the "qualitative analysis of experience" or the "free description of immediate experience, without analysis into formal elements"—i.e., introspection—was the necessary means to understand the nature of mind (Kohler, cited in Boring, 1950, p. 601). At the other extreme, the behaviorists, such as Watson, were arguing by 1913 that there is no such thing as mind or consciousness—or, at least, that they were irrelevant for psychology. One could only observe the acts, or behaviors, of a given organism, whether animal or human. According to Boring, behaviorism grew out of "objective psychology," which he characterized as "any psychology which purports to consider the mind and yet excludes consciousness from its consideration" (Boring, 1950, p. 631).

Experimental psychology began in Germany as a philosophical stance, introspective phenomenology, joined with a laboratory approach based on the physics and, to perhaps a lesser extent, the biology of the day. Among the most important of the early researchers were Fechner, who had been influenced by the physicist Helmholz, and Wundt, who established the first psychology laboratory in 1878 in Germany, using introspection as the approach to inquiry (Okun, 1990). Initially, this partnership between philosophy and laboratory science resulted in a "taxonomy of consciousness" and the creation of a "morphology of mind" (Boring, 1950, p. 21). Attempting to cultivate the "abstract attitude of the scientist and the philosopher" "as an outside observer would" (Varela, Thompson, & Rosch, 1991, p. 32), introspectionism involved the subjects "objectively" standing outside of their phenomenological experience and "decomposing their experience" (p. 32). Disagreement between laboratories ensued, however, because they could not arrive at a common means to discover the elements of the mind through introspection, and introspectionism consequently broke down as an approach that could meet the established standards for scientific inquiry (Varela et al., 1991). According to Okun, the introspectionist viewpoint became "too subjective and not at all compatible with the scientific method of experimentation necessary if psychology were to become more of a science than a philosophy" (Okun, 1990, p. 117). A somewhat different view is taken by Varela, a contemporary systems biologist, and his colleagues. They suggest that the introspectionist approach failed because, in order to observe the phenomenological mind, one has to practice a different sort of attitude toward mindfulness and awareness than that required by the Western scientific method. They point to Buddhist ways of thinking and liken the phenomenological method to what Buddhists have called thinking about thinking rather than observing mind as it unfolds (Varela et al., 1991).

Thus, German experimental psychology soon came to be dominated by the analytical, scientific, objective influences of the psychophysical approach while the earlier philosophical strand, with its interest in consciousness and mind, was losing influence. By the end of the nineteenth century, Okun says,

> two tracks of scientific psychology had begun to emerge: (1) the rigorously scientific track based on the dualism of mind and body [based on the philosophical assumptions of the British empiricists Locke and Hume] that evolved from structuralism to behaviorism; and (2) the functionalism of William James, which opposed the dualism of mind and body and embraced the dynamic interactionism and interdependence of mind and body, which could be understood only by the stream of consciousness. (Okun, 1990, p. 117)

The first of these two tracks—the "rigorously scientific" approach—was the more influential of the two. This approach, which might also be called the psychophysical structuralist approach, posited physical laws for every aspect of human experience, including consciousness. Schiller, a professor of clinical neurology at the University of California, San Francisco, writing in the early 1980s, notes that this influence even now continues to be felt in the neurophysiological measurement of mind:

> To this day, the instruments employed in physics have remained part of the methodology of researching the psyche. To measure mind in the precise terms of the stimuli that make it tick is still basic to neurophysiology and the behavioristic approach. (Schiller, 1982, pp. 12-13)

In psychiatry, this approach is reflected in "objective descriptive psychiatry," growing out of the tradition of Kraeplin, a classifier of mental diseases, and Charcot, the teacher of both Freud and James in his case presentations at the Salpêtrière. Juxtaposed with this are the more recently developed "approaches to the mind" in psychiatry (Havens, 1987): the "interpersonal" (represented by Sullivan), "object relations" (represented by Fairbairn, Klein, and Winnicott), "existential" (represented by Binswanger), and "self psychology" (represented by Kohut). In addition, outside the field of psychiatry, but related to it, is the school of "client-centered" psychotherapy (represented by Rogers). We will explore further the differences between some of these approaches to psychiatry in relation to empathy.

The result of such a predominant objective descriptive emphasis in the study of the physiology of the brain and behavior, however, was that the problem of consciousness was ignored altogether, for it was too elusive a thing to be captured by these researchers' instruments and methodology. Instead, the behaviorists, most notably Watson and Skinner, who grew out of this tradition and came to dominate experimental psychology by the early part of the twentieth century, focused much of their work on the behavioral responses of animals, which they then adapted to humans, developing a science based on the idea of conditioning through stimulus and response (Okun, 1990, p. 117). One might argue that this approach has succeeded only in describing certain neurological functions, such as the spinal reflex of Sherrington, or in producing detailed studies on the nature of the reaction times for the different senses,

but that it by no means encompasses all that the study of neuroanatomical functioning or psychology, the soma, or the psyche, entails.

The Mind-Body Relationship as Seen by James, Freud, and Möbius

This bias notwithstanding, the interest in philosophy and inner experience that had characterized the introspectionists continued in the less influential track that Okun has identified with William James in particular (Okun, 1990, p. 117). James felt intuitively that mind was not possible without body, nor was body possible without mind—a position that is a bellwether to Bateson's Mind and Nature: A Necessary Unity, published in 1979, almost seventy years after James's death. James had studied both medicine and philosophy at Harvard, so it is not surprising that he could forget neither his neurological nor his philosophical background. Yet, limited by the neurophysiological understanding of his day, he was frustrated by his inability to find convincing scientific evidence to the contrary, and he never succeeded in identifying the biological substrate of consciousness, or "mindstuff" as he referred to it in his textbook, Principles of Psychology (1890/1950). To James, as we have seen, psychology was "the science of mental life, both of its phenomena and their conditions" (James, 1890/1950, vol. I, p. 1). The phenomena were "such things as we call feelings, desires, cognitions, reasonings, decisions, and the like" (p. 1); the conditions, he felt, must incorporate physiology. Thus, James believed that the study of mind and consciousness was the proper task of psychology. And while he was, at the same time, very concerned with behavior, he conceived of behavior as what the mind does, rather than divorcing it from mind as the behaviorists later did. James's position concerning mind and consciousness might be considered as falling somewhere between the two extremes of phenomenology and behaviorism, although certain seeds of both can be found in his thought.

Among the early scientifically based psychologists, then, William James and those who would later become the behaviorists represented two opposing views regarding the relationship of mind to body—even though, ironically enough, the behaviorists also claimed James as one of their antecedents (Boring, 1950)—and this view of the body-mind relationship (or lack thereof) was inextricably connected to underlying assumptions about what constitutes valid science. Psychology, however, also encompasses the clinical observations of analysis and psychotherapy, where theory evolved out of case studies of patients who, with the help of the analyst/therapist, delve into their own unconscious processes. Freud, the most famous early proponent of this method, was well aware that he was vulnerable to charges of being unscientific. That he felt compelled to adopt a defensive attitude in response to this is evident in his 1904 paper "On Psychotherapy":

> To many physicians, even to-day, psychotherapy seems to be the offspring of modern mysticism and compared with our physico-chemical specifics which are applied on the basis of physiological knowledge, appears quite un-scientific and unworthy of the attention of the serious investigator. Allow me, therefore, to defend the cause of psychotherapy before you, and to point out to you what may be described as unjust or mistaken in this condemnation of it. (Freud, 1904/1963d, p. 64)

If we look at Freud's assumptions concerning the mind-body relationship, we will see that, especially in his early work about hysteria, he was more advanced for his time than is generally thought, although fairly early in his career he altered the expression of his theory in response to the social and political pressures of his times, in order to be heard by his fellow scientists (Herman, 1992). Herman has recreated the context in which Freud, in "The Aetiology of Hysteria" (1896), "made a dramatic claim: 'I therefore put forward the thesis that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience'" (Freud, 1896, cited in Herman, 1992, p. 13). In this paper, he reported on eighteen case studies on hysteria, building on what he had learned from the French neurologist Charcot at the latter's case presentations to packed audiences (which included William James) at the Salpêtrière in Paris. Freud stated that, not only was hysteria a neurosis whose sufferers frequently manifested neurological symptoms, but these symptoms resulted from actual sexual abuse or other physical violation by male relatives or other forbidden males. But there were serious implications to taking literally the reports of so many young women in Vienna—daughters, sisters, cousins of powerful men such as his medical colleagues—who were exhibiting hysterical conversion symptoms, i.e., symptoms of pain or paralysis with no apparent physical or physiological cause, and Herman notes that

"within a year, Freud had privately repudiated the traumatic theory of the origins of hysteria" (Herman, 1992, pp. 13-14). She further notes that "by the first decade of the twentieth century, without ever offering any clinical documentation of false complaints, Freud had concluded that his hysterical patients' accounts of childhood sexual abuse were untrue: 'I was at last obliged to recognize that these scenes of seduction had never taken place, and that they were only fantasies which my patients had made up'" (Freud, 1925, cited in Herman, 1992, p, 14).

Herman points out that before he abandoned his original idea, Freud truly had befriended the women who sought his help. But with the abandonment of that idea, he also stopped fully listening to and believing them. Herman cites the case of Dora, a young woman diagnosed as hysteric by Freud who prematurely terminated with Freud (much to his surprise), as the turning point in this process. According to Herman, "Freud refused...to validate Dora's feelings of rage and humiliation [at having been encouraged by her father to receive the sexual advances of his friend] [and] instead...insisted upon exploring her feelings of erotic excitement, as if the exploitative situation were a fulfillment of her desire" (Herman, 1992, p. 14). As a result of his "recantation" of belief in his patients' reported experiences (p. 14), Herman concludes that the psychological theory that Freud went on to create "was founded on the denial of women's reality" (p. 14):

> Out of the ruins of the traumatic theory of hysteria, Freud created psychoanalysis. The dominant psychological theory of the next century was founded on the denial of women's reality. Sexuality remained the central focus of inquiry. But the exploitative social context in which sexual relations actually occur became utterly invisible. (Herman, 1992, p. 14)

Indeed, it is unfortunate that Freud, due in part to the public and professional pressure of the times, did not continue with this line of thinking in regard to hysteria, which indicated an awareness of the depth of the connection between the mind and the body. Instead, he retreated from substantial consideration of the body or the somatic part of the self as he laid the foundations of psychoanalysis, and this retreat has undoubtedly influenced the subsequent development of psychological theory. In later writings, we might note, Freud recognized the centrality of the body in the development of the ego, as is confirmed by his linking of psychological development, including meaning-making, with the location of body zones—oral, anal, phallic, etc. Yet as Krueger, a psychiatrist/analyst, notes in his book, Body Self and Psychological Self (1989), there is a basic irony in Freudian psychoanalysis. Notwithstanding the fact that Freud "recognized the ego as first and foremost a body ego" (1989, p. 3), and thus that this sense of "body self" is "the foundation for subsequent ego development" (p. ix), Krueger maintains that "the body and its evolving mental representation have been largely omitted from developmental and psychoanalytic theory" (p. ix). And this, he continues, is unfortunate, because "our patients speak most vividly; their lexicon is emotional, behavioral, and psychosomatic symptomatology; while their bodies are often their language" (p. ix).

Notwithstanding Freud's ambivalence, the writer suggests that Freud, in his early writings, was manifesting a somewhat integrative perspective in acknowledging the intimate relationship between psyche and soma, or between mind and body, as exemplified in hysteria. Might we say that he carried the seeds of, or laid the foundation for, a more holistic view than was common in his day, where mind and body are viewed as interacting with each other and affecting each other's state, although he left it for others, such as Reich (1933/1972), to develop?

Before ending our discussion of this early period in the history of psychology, it is interesting to take note of one other thinker who, perhaps better than most others, recognized the reductionist and dichotomizing tendencies of the experimental science of his day and advocated reintroducing mind or mental life into medicine (Schiller, 1982). Paul Möbius, a German neuropsychiatrist and contemporary of Freud, succinctly pointed out the drawbacks of the experimental psychological approach when he noted that "no matter how useful in various ways the results may be, they are, 'to say it crudely, just scrappy little odds and ends.... No amount of detail will ever stop the gaps that riddle introspection' " (Möbius, citied in Schiller, 1982, p. 26). Instead of Cartesian dualism, with its accompanying dichotomization of mind and body, that was popular among scientists of his day, Möbius subscribed to an "idealistic" as opposed to "materialistic monism," believing that all mind was nature, and all nature was mind (Schiller 1982). Schiller points out that Möbius's characterization of the relationship between mind and body as an "everlasting riddle" (1982, p. 2) is similar to that of the seemingly two planes of a Möbius strip, a mathematical form that had been invented by Paul Möbius's grandfather, August Möbius. As Schiller explains,

> An amazing puzzle, an amusing little paper trick—with implications in spatial geometry (topology) too deep for the nonmathemetician to fathom—the famous Möbius strip is invoked...as the perfect symbol of the everlasting riddle of the mind-body relationship. As the eye or finger follows the strip's shifting planes, *up* becomes *down*, *in* turns to *out*, and *two* merges into *one*; just as study of mind inevitably leads to pursuit of body, and vice versa. (Schiller, 1982, pp. 1-2)

Schiller goes on to state that "the inventor's grandson, Paul Julius Möbius (1853-1907), personified that problem as it presented itself around the turn of the century. The double helix of psychiatry and neurology, practice and philosophy, reached a high point in P. J. Möbius' writings" (1982, p. 2). Moreover, his use of this imagery a century ago is particularly interesting in terms of certain modern currents of thought that we will discuss in more detail below.

Although Möbius espoused ideas that were a challenge to the main thrust of scientific thought of his day, he was nonetheless a respected figure. Freud credited Möbius with an important role in the "modern history of psychotherapy," for although the latter had "unfortunately died early,...his studies on suggestion had borne much fruit" (1909, interview for Boston Evening Transcript). Likewise, Kraepelin, the psychiatrist who classified psychosis in the late nineteenth century, considered Möbius to occupy an important place in German psychiatry in having achieved a "breakthrough" in the understanding of hysteria as a psychogenic condition (Schiller, 1982, p. 3).

Having looked at some of the currents that affected the early development of the science of psychology, specifically in relation to the questions of consciousness and mind-body interaction, we turn now to a consideration of relevant developments in the wider scientific community that have contributed to the ongoing transdisciplinary development of the idea of mind-body interaction. These scientific developments, most notably in physics, biology and neuroanatomy, and the fields of cybernetics and systems theory, have contributed to initiating what many see as a "paradigm shift" (Kuhn, 1970) in Western thought, and it is a process that is still ongoing. Like Newtonian physics before it, twentieth-century discoveries in physics, in particular, have begun to affect the way that reality is viewed in other fields (Bohm, 1957/1980, 1980; Grof, 1983). In psychology, this post-Newtonian world view has given rise to such movements as the Gestalt world view and Gestalt therapy, group psychology, and family systems theory. A Gestalt world view emphasizes that it is not only the individual objects, or, by extrapolation, persons, themselves that are of interest but how these objects, or persons, interrelate. Thus, "how we perceive an object...is determined by the total field in which the object is embedded" (Hall & Lindzey, 1978, p. 383). This field approach has been applied to group psychology (Bales, 1970; Lewin, 1939). Likewise, certain schools of family therapy, such as those advocating systems theory, have been influenced in their relational view of reality by a post-Newtonian view of physics and a biological systems perspective (Anderson & Goolishian, 1988; Dell, 1985; Efran, Lukens, & Lukens, 1988; Hoffman, 1990; Lewis, 1989; Parry, 1991).

Since Freud's influence has been such a dominant one in the development of mainstream psychiatry, we return now to a discussion of his view of empathy as indicated in his widely published writings and to how this has been developed over the years within the psychoanalytic school of psychiatry.

Freud's Psychoanalytic Perspective

Freud was a leading figure in the developing "science" of psychoanalysis within the young sciences of psychology and psychiatry when the term "empathy" was first introduced in the field of psychology. While it should be noted that he rarely mentioned the word "Einfühling," or empathy, and, according to one psychiatrist-analyst who has recently undertaken an examination of the nature of empathy, "Freud felt the process [i.e., empathy] remained a neglected and unsolved theoretical problem" (Margulies, 1989, p. 4), he nonetheless wrote at length about the psychotherapeutic relationship and spoke of the "rapport" that must develop between analyst and patient.

In his writings on transference in "Further Recommendations on the Technique of Psychoanalysis" (1913/1963b), Freud attempted to define what psychotherapy is by describing the roles of the analyst and the analysand and the relationship that develops between them. In this description, he differentiated between suggestion, which does not reveal the patient's unconscious and which therefore does not overcome the patient's resistances, and psychoanalysis, the primary goal of which is to move through this resistance and uncover the unconscious through the patient's free associations (Freud,

1912/1963e, p. 124). He asserted that the "fundamental rule of psychoanalysis" is "to encourage the patient to communicate everything that occurs to him without criticism or selection" through free association (p. 118). In other words, neither the analyst nor the patient is to be judgmental of what is verbalized. Maintaining that the analyst/psychotherapist must listen to all that is said with "evenly hovering attention" (p. 118), Freud advised that the analyst should then use all that is uttered "for the purposes of interpretation and recognition of what is hidden in the unconscious, without substituting a censorship of his own for the selection which the patient forgoes" (p. 118).

But although the analyst must be open to whatever the patient communicates, Freud also counseled that the analyst should avoid "too intimate an attitude" toward the patient (1912/1963e, p. 124). Rather, "the physician [i.e., the analyst] should be impenetrable to the patients, and, like a mirror, reflect nothing but what is shown to him" (p. 124). The analyst should be like a "surgeon who puts aside all his own feelings, including that of human sympathy, and concentrates his mind on one single purpose, that of performing the operation [such as interpretation] as skillfully as possible" (p. 121). On the other hand, Freud also emphasized, in using the term "identification," the need for the analyst to be emotionally responsive to the patient, for he saw "identification" as "the earliest expression of an emotional tie" with another person (1921/1959a, p. 39). Furthermore, Freud emphasized that "the establishment of a dependable transference, a well-developed *rapport"* determines "when it is time to unfold to [the analysand] the hidden meaning of his thoughts and associations" (1913/1963b, p. 152).

From this analytic ambience, Freud posited that a particular "attachment" would develop:

> The first aim of the treatment consists in attaching him to the treatment and to the person of the physician. To ensure this one need do nothing but allow him time. If one devotes serious interest to him, clears away carefully the first resistances that arise and avoids certain mistakes, such an attachment develops in the patient of itself, and the physician becomes linked up with one of the imagos of those persons from whom he was used to receive kindness. (Freud, 1913/1963b, p. 152)

For Freud, the word "attachment" involves the notion of a positive connection forming, at least initially, between the analyst and analysand, because the analysand is to associate the physician with someone from whom the analysand has received "kindness." Freud called this form of attachment "transference." He discovered what he termed the "transference template" after detailed study of countless analytic sessions in which he noted that among his patients,

> as we should expect, [the] accumulation of libido will be attached to prototypes, bound up with one of the clichés already established in the mind of the person concerned, or, to put it in another way, the patient will weave the figure of the physician into one of the "series" already constructed in his mind. (Freud, 1912/1963a, p. 107)

Success in analysis, Freud asserted, is thus ultimately dependent, first, on the development of this all-important transference, this "affective relationship to the physician" (Freud, 1910/1963c, p. 94), and then on its proper analysis. As transference develops in patients, so does resistance, signaled by "a cessation in the flow of associations" (p. 110). Thus, as the relationship develops, transferences may also be negative because of resistance on the part of the analysand.

Although Freud found that it was difficult with some patients to develop a therapeutic relationship—i.e., a relationship in which a positive transference on an affective level develops between patient and analyst—when it did develop, it did so partly as a result of "empathy." In one of the few places where Freud actually used the word "empathy," in Group Psychology and the Analysis of the Ego (1921), he stated that empathy is related to "identification," which he defined, as we have seen, as "the earliest expression of an emotional tie with another person" (1921/1959a, p. 185). Thus Freud saw "the process which psychology calls 'empathy' [as that which] plays the largest part in our understanding of what is inherently foreign to our ego in other people" (p. 186). He also maintained that "a path leads from identification by way of imitation to empathy, that is, to the comprehension of the mechanism by means of which we are enabled to take up any attitude at all towards another mental life" (p. 188). However, we will see that Rogers later drew an important distinction between empathy and identification that Freud in this passage did not draw (Rogers, 1959, cited in Hart and Tomlinson, 1970).

Empathy is also all-important in helping the analyst to know when to offer an interpretation to the analysand. To do so involves a kind of intersubjectivity. As Agosta points out, it is through paying attention to the quality of the interaction and resonating with the other's affect that the therapist/analyst arrives at an interpretation:

> The interpretation asserts that my feeling is not of endogenous origin, does not come from me alone, but originates with the other and, by implication, with my interaction with him. It is a function of our situation and intersubjectivity. Further negotiation with the other person about the accuracy of this interpretation then becomes possible according to the standard criteria laid down in "Constructions in Analysis." (Freud, 1937, cited in Agosta, 1984, pp. 55-56)

Stark, a psychiatrist/analyst, describes empathy in a manner that conveys the idea of an oscillatory movement on the part of the therapist where he or she "must decide from moment to moment, whether the patient wants to be understood, or, rather, wants to understand. The therapist must be ever attuned to, and respectful of that tension, that balance" (Stark, 1994, p. 51). To be truly empathic, also, the therapist must avoid premature interpretation:

> At such times it behooves the therapist not to badger the patient with premature interpretations but instead to resonate empathically with where the patient is so that he will know that he is being listened to and understood. Although the therapist may want the patient to understand, the patient is not at the moment interested in understanding. That is the therapist's agenda, not the patient's, and the therapist must exercise restraint. (Stark, 1994, p. 51)

She cites Balint (1968), who "encouraged therapists to assume an 'unobtrusive' stance, so that the patient would be able 'to discover his way to the world of objects—and not be shown the 'right' way by some profound or correct interpretation' " (Balint, 1968, cited in Stark, 1994, p. 51). By the same token, Winnicott "learned to be more patient and to wait, resisting his temptation to ply the patient with clever interpretations." Winnicott says humbly that by such premature interpretation, he "did more to show the patient the limits of what he knew than anything else" (Winnicott, 1958, cited in Stark, 1994). Thus Stark reminds us that empathy is a transient state, in that it entails continual movement in relation to the client, for the therapist must be "ever attuned to" the fact that sometimes the patient does want to understand and in this case is ready for an interpretation by the therapist.

Thus empathic relating is a dynamic process, a continual oscillatory movement, necessitating not only that the therapist sense where the patient is from moment to moment. What allows the therapist to understand is also the fact that he or she resonates with a similar experience, in what Agosta (1984) has called "double representation." It is this oscillatory movement that sets empathy apart from sympathy, because "the therapist must remain attuned, on a moment-by-moment basis, to whether the patient is interested simply in having his experience understood or is interested in observing his experience and understanding it" (Stark, 1994, p. 53). This involves "the therapist direct[ing] the patient's attention elsewhere (in order to help the patient understand)" (p. 53).

Let us return to our discussion of an appropriate paradigm to characterize and describe the empathic process. What was Freud's view? As Basch (1988), a psychoanalyst, has pointed out, Freud originally used mainly the metaphor of a steam engine as he tried to come up with an appropriate model to describe his theory of human motivation, thus reflecting the influence of the industrial age in which he lived. In all of Freud's models of motivation (1895, 1900, 1923), the brain is conceived as functioning like a steam boiler that is constantly under excess pressure and needs to discharge continuously, through thought or action, the excess energy produced by the sexual instinct and by the aggressive instinct (Basch, 1988). However, in describing the relationship between the analyst and the analysand in "Recommendations for Physicians on the Psychoanalytic Method of Treatment" (1912/1963e) Freud appeared to be exploring a different way to characterize this special sort of psychotherapeutic relating which includes empathic relating. In this 1912 article, he appears to focus instead on the interactional nature of the relationship between analyst and analysand, reflecting perhaps this attempt to get beyond a purely instinctual basis. As we saw in Chapter Two, Freud used the imagery of vibration rather than that of the steam engine when he spoke of the "receptive organ" of the unconscious of the analyst "bend[ing]...towards the emerging unconscious of the patient...as the receiver of the telephone to the disc" (Freud, 1912/1963e, pp. 121-122).

As we will see, this metaphor of vibration can be seen in contemporary characterizations of empathy as involving resonance. Margulies, a psychiatrist/analyst writing from a self psychological perspective, suggests that empathy may be divided into passive and active modes, which he names "resonant empathy" and "imaginative empathy." He uses a metaphor of musical vibration, similar to Freud's metaphor of the vibrating receiver and the disc, likening resonant empathy to the effect caused

when a string is plucked, yet differentiating this form of empathy from another more "active, searching" kind of empathy which involves one's imagination:

> Plucking one string of an instrument creates resonant vibrations in a second. Imaginative empathy, on the other hand, stresses, the active, searching quality of entering the other's world. Imagination constructs a new world, one not immediately accessible to the observer. (Margulies, 1989, p. 18)

We should keep in mind, as we look at the changing conceptualization of empathy over the years, that there is a basic ambiguity present in Freud's thinking about the foundation of human motivation. Specifically, his view initially was that all human motivation could be tied to two biological instincts, sex and aggression, or, after he had further developed the notion of instincts in psychoanalysis, Eros and Thanatos, the life and death instincts. According to some, this earlier instinct-driven model was superseded by a more relationally based view of human motivation, hinted at in his writings, which holds that, as a primary drive, we seek relationship with other humans as a part of our survival mechanism from birth; that is to say, we are object-seeking (Fairbairn, 1952). Others say that although this tension was present in Freud's writings, he ultimately stood by his instinctual theory (Mitchell, 1988), while still others say that Freud never resolved this tension between an instinctually driven theory and a relationally based one (Guntrip, 1973). We will return to this ambiguity and its effect on the development of psychiatric thought later in this chapter, and we will see how the psychiatrists in our sample regard psychoanalysis and its influence on their education. We will also consider the Freudian view of the self in contrast to the view of the self in the various schools of psychoanalysis—self psychological, object relations, and interactional—as well as in client-centered counseling and in the relational theory of the Stone Center (Jordan, et al., 1991), which comes out of a feminist perspective—and see how each view, in different ways, conceives of the empathic process.

The reader was perhaps struck by the difference between the two qualities—emotional detachment and emotional responsiveness—that Freud counseled the analyst to cultivate to develop a facilitating analytic context. On the one hand, the analyst is to be like an emotionally detached "surgeon"; on the other, he or she is to be emotionally responsive, in "rapport" with the analysand through identification. Granting that Freud did show some ambivalence on this point and that this has in part led to the problem Freud's followers have had in determining how much to emphasize the relational aspects of psychotherapy, analysis, or empathy, Bettelheim offers certain insights suggesting that this ambivalence has perhaps been heightened by inadequate translation of Freud's writings.

According to Bettelheim, the standard English translation of Freud "distort[s] much of the essential humanism that permeates the originals," a fact which has, in turn influenced the practice of psychotherapy in England and the United States (Bettelheim, 1982, p. 52). According to Bettelheim, a native German speaker himself, Freud's translator of the Standard Edition, Strachey, sought to bring psychoanalysis more in line with "scientific," objective, positivistic ways of thinking than Freud's words conveyed in the original. Thus, he believes, certain of the most important original concepts of psychoanalysis have been inadequately translated. For example, he points out that Freud was preoccupied with the soul and "showed us how the soul could become aware of itself" (p. 52). Indeed, the Greek word "psyche," on which "psychoanalysis" is based, means "soul." Bettelheim states,

> In his work and in his writings, Freud often spoke of the soul—of its nature and structure, its development, its attributes, how it reveals itself in all we do and dream. Unfortunately, nobody who reads him in English could guess this, because nearly all his many references to the soul, and to matters pertaining to the soul, have been excised in translation. (1982, p. 52)

As a result, Bettelheim maintains that "psychoanalysis becomes in English translation something that refers and applies to others as a system of intellectual constructs. Therefore, students of psychoanalysis are not led to take it personally—they are not moved to gain access to their own unconscious and everything else within them that is most human but is nevertheless unacceptable to them" (1982, p. 52). He deplores the fact this translation

> makes Freud's direct and always deeply personal appeals to our common humanity appear to readers of English as abstract, depersonalized, highly theoretical, erudite, and mechanized—in short, "scientific"—statements about the strange and very complex workings of our mind. Instead of instilling a deep feeling for what is most human in all of us, the translations attempt to lure the reader into developing a "scientific" attitude toward man

> and his actions, a "scientific" understanding of the unconscious and how it conditions much of our behavior. (1982, p. 52)

We may wonder at the implications of the fact that several generations of English-speaking psychoanalysts have been educated through studying Freud in this translation, which would appear potentially to reinforce a certain intellectual distance within themselves as well as between them and their patients. It is also interesting, and ironic, that psychiatric residents are not required to undergo therapy themselves as a part of their training, and that countertransference is often reported as underanalyzed in supervision (Sussman, 1992) since it was through Freud's deeply personal process of analysis of his own dreams—including their countertransferential implications—that psychoanalysis and its cousin, psychoanalytically based psychotherapy, began as a "science."

Early Ambiguity Concerning Empathy in Psychoanalysis

Human relating begins nonverbally, with human contact through touch when we are infants, and, through our interactions with both our chief caregiver and our environment through our senses, we learn how to organize appropriate motor responses. But how does one go from such basic wired-in behaviors as rooting, grasping, and sucking to developing the complex interpersonal capacities involved in empathy? In the remainder of this chapter, we will consider varying views of this process both within and outside of the field of psychoanalysis as we explore the nature of empathy in the psychotherapeutic relationship. With these as a backdrop, we will then consider the Mehrabian and Epstein (1972) emotional empathy measure in Chapter Seven, looking more closely at the content of the questionnaire, the nature of the questions it poses, and the assumptions on which it is based.

A lack of clarity regarding the nature of empathy and the role it plays in the psychotherapeutic relationship has been present since the beginnings of psychoanalysis, at the end of the nineteenth and beginning of the twentieth century, and this lack of clarity persists even into the present as researchers continue to try to reach a fuller understanding of the nature of empathy. The science of psychiatry was over half a century old, for example, when Reik, a psychoanalyst who had learned from Freud, spoke with exasperation about the lack of clear conceptualization of empathy. The tendency of psychologists of his day, he said, was to use the term glibly, with the result that it "sounds so full of meaning that people willingly overlook its ambiguity.... [Thus] empathy sometimes means one thing, sometimes another, until it does not mean anything" (Reik, 1948, pp. 356-357). Likewise Sullivan, a contemporary of Reik, remarked on this problem with impatience in The Interpersonal Theory of Psychiatry (1953), raising the issue of the inadequacy of existing scientific models in defining empathy:

> I have had a good deal of trouble at times with people of a certain type of educational history; since they cannot refer empathy to vision, hearing, or some other special sense receptor, and since they do not know whether it is transmitted by the ether waves or air waves or what not, they find it hard to accept the idea of empathy. But whether the doctrine of empathy is accepted or not, the fact remains that the tension of anxiety when present in the mothering one induces anxiety in the infant; that theorem can be proved, I believe, and those who have had pediatric experience or mothering experience actually have data which can be interpreted on no other equally simply hypothetical basis. So although empathy may sound mysterious, remember that there is much that sounds mysterious in the universe, only you have got used to it; and perhaps you will get used to empathy. (Sullivan, 1953, p. 41)

Sullivan thus believed that in order to understand the nature of empathy, one only needed to observe how mothers and infants interact with one another and pass on their affect as one empathizes with the other. As he has pointed out, when there is anxiety in the mother, there is soon anxiety in the infant.

Winnicott also focused on the nature of mother-infant interaction. He was one of the first to conceive of the relational self, going so far as to say that "A baby cannot exist alone, but is essentially part of a relationship" (Winnicott, 1985, cited in Davis & Wallbridge, 1981, p. 34). Winnicott (1971) was one of the first to articulate this split between the drive-based and the more relational models, placing the primacy of the developing self in relation to others rather than conflictual drives at the heart of human development. He pointed out that empathy is involved in the mother's anticipation of her infant's needs. Thus, a mother who shows compassion toward her screaming child by returning the teddy bear that has been dropped over the side of the crib is empathizing with her child when she infers what the child is

crying about and acts on it. Nonetheless, as she cannot always succeed in providing what her child is seeking, she is only a "good enough" mother, not a "perfect" one (Winnicott, 1965). In fact, Winnicott maintains that as the child matures it is necessary, in order for optimal development to occur, for the mother to "fail" the infant so that he or she may develop a growing sense of autonomy, rather than remaining fused with the mother (1965).

Both Winnicott and Sullivan emphasized that the mother empathizes with her child, but, since their time, there is a growing body of evidence from videotaped mother-infant dyads, that, as development proceeds, the infant is a full participant in this process, mutually empathizing and engaging with the mother or other caretaker (Beebe & Lachmann, 1988; Demos, 1984; D. N. Stern, 1985). The question then arises as to where the process starts, with mother or infant, and we find ourselves encountering the questions of "circularity" and "recursiveness" that were introduced in Chapter One, and echoed by Lynn's words in Chapter Three when she was trying to describe her dialectical interaction with her patient:

> It's hard to find words for this...feeling—there's a quality to what's going on and a feeling of what I'm feeling in response to what they're doing, to what I'm picking up from them, what goes back and forth between us as to what's happening, and sensing that and knowing that and working with that is very important. And it's attending, being tuned, being there...being tuned in, if you will. Being there, being aware, knowing this person over time or coming to know this person, coming to sense what the movement means, what the affect is I'm picking up, how they're saying whatever they're saying—it's more than theory.

Interactive Views of Empathy

We will look more closely now at how theorists both inside and outside the field of psychoanalysis have described empathy before looking at its interactional or relational components. Their views will reveal the complexity of empathy which some theorists say calls for new paradigms to sufficiently describe it (Corcoran, 1981; Jordan, 1991).

There have been periods when psychoanalysis has focused considerable attention on empathy, perhaps most notably in the 1950s (Schwaber, 1984). This was followed by somewhat decreased interest during the '60s and '70s, until a resurgence of interest in and appreciation for the complexity of the concept of empathy began to occur again in the 1980s. At that time a controversial discussion as to its nature began in the psychoanalytic journals in the United States, in response in part to Kohut's posthumous paper (1984/1981), which led to the publication in 1984 of a two-volume compendium entitled Empathy I and Empathy II. As we have mentioned, Schwaber, a contributor to the first volume, in recognition of its long and controversial history, appealed to readers for a "nonpolemical" discussion of the subject (Schwaber, 1984). She also called for a different paradigm. In volume I, Schwaber introduces the notion of relativity in relation to empathy in psychoanalysis:

> "Empathy," a word used in this modern era to refer to the nature of psychoanalytic observation, addresses the scientific revolution of our century and the struggles that go into such a revolution. The psychoanalytic paradigm is a paradigm of relativity in depth psychology, and empathy signifies this illusory nature of reality—defining the domain of psychic reality as all we can aspire to know. (Schwaber, 1984, p. 29)

Schwaber believes that with Freud's abandonment of seduction theory for neurosogenesis, psychoanalysis entered a period of relativism (1984). Mitchell, agreeing with this, points to Freud's position in his "Introductory Lectures on Psychoanalysis" that what actually happens in neurosis is not as important as what the patient believes or fantasizes had happened (Freud, 1916-17, cited in Mitchell, 1988). While Mitchell and Schwaber emphasize thus the relativity of the patient's reality, certain writers from different schools within psychoanalysis have also reminded us that the reality of the analyst/psychotherapist is relative—especially with the phenomenon of countertransference, where the individual therapist's reactions will be colored by his or her own relational experiences.

Just as the individual realities of the patient/client and doctor/therapist (or of any human being) are relative, so is the process of empathy that acts as a connector between them (Agosta, 1984). This process involves, in part, a temporary identification or "trial identification" (Fliess, 1942) with the patient's affect, through the therapist/analyst's resonating in kind, often by evoking the memory of a situation that was accompanied by a similar affect in the therapist/ analyst's own life.

Kohut considered empathy to be "vicarious introspection" and "a cornerstone" of self psychology—a more recent development in psychoanalytic theory (Kohut, 1977, cited in Margulies, 1989, p. 4). The self psychologists, like Kohut, who expanded the notion of empathy to occupy a more central role in the curative process, are also interactional. They differ from object relationists and relational theorists in where they place the emphasis, whether in the intrapsychic realm, the interpersonal realm, or the relationship itself, i.e., "the self, the other, or the space in the middle" (Mitchell, 1988).

Margulies notes that since the time of Kohut and the growth of self psychology, it is "almost as if its [i.e., empathy's] importance were being rediscovered" (1989, p. 4). It would appear that one aspect of this "rediscovery" process is the search for new models to describe empathy, ones that take into account its relational nature (Hackney, 1978; Jordan et al., 1991; Myers, 1992). Some of these researchers believe that to describe empathic relating appropriately may actually necessitate a paradigm shift, similar to the one that has occurred to explain particle-wave phenomena in subparticle physics (Jordan et al., 1991).

According to Basch (1983), a psychoanalyst with an object relations and cognitive developmental perspective, much of the difficulty in understanding empathy results from a basic misunderstanding of the broader meaning of the word Einfühlung, from which the English word "empathy" is derived, and this has resulted in wrongly "limiting empathy to affective resonance" (Dratman, 1964, and Shevrin, 1978, cited in Basch, 1983, p. 111). Basch instead posits that empathy has both affective and cognitive components. He defines empathy as "the ability of one person to come to know first-hand, so to speak, the experience of another [or] metaphorically, to step...into another person's shoes" (Basch, 1983, p. 110). Although there is an obvious affective component to this ability, he maintains that it also includes cognitive aspects, such as "inference, judgment, and other aspects of reasoning thought which are equally important to the concept of Einfühlung. Essentially, empathy means "finding or searching one's way into the experience of another without specifying or limiting the means by which this occurs" (pp. 110-111).

Some contemporary mainstream psychiatrist/analysts appear to emphasize that empathy—whether in the mother-infant relationship, everyday relationships, or the psychotherapeutic relationship—is a complex interpersonal phenomenon. For example, Margulies has called it "a complex mental and interpersonal process that includes several phenomena under its umbrella" (1989, p. 17). In the same vein, Buie (1981) has divided empathy into four components: (1) "conceptual empathy," involving a cognitive understanding of what the patient is experiencing; (2) "self-experiential empathy," describing the memories, feelings, and associations that the therapist experiences when listening to a patient; (3) "imaginative imitation empathy," involving the therapist's fantasizing as to the nature of the patient's inner world; and (4) "resonant empathy," or "affective contagion," in which the therapist experiences feelings that are emotionally similar to those of the patient (1981). Buie's description of the complex phenomenon of empathy speaks to a dynamic tension where one is neither fully merged with nor fully separate from the other.

The Origin of Empathy in Mother-Infant Interaction

Schwaber, a psychiatrist/analyst, maintains that empathy should be viewed "as a mode of listening [and] gathering clinical data" and should be distinguished in the clinical situation from its use in ordinary everyday life (Schwaber, 1984, p. 26). She defines empathy as "a fundamental mode of relatedness, an essential nutrient of growth and development" (p. 26). Demos, expanding on this from her research observing mother-infant dyadic interaction, states that "empathy involves going beyond the perceptions of behaviors produced by the other, and attaching a meaning to these behaviors that is consonant with the meaning experienced by the other" (Demos, 1984, p. 10). Viewing empathy through the lens of affect, her study focused on the phenomenon of "affect attunement" (p. 10). In their observation of twelve infant-mother pairs during the first two years of life, she and her research team adopted an approach in which they attempted to view the world from the infant's vantage point, noting that "in any effort to empathize with another [infant or otherwise] one is always in the position of trying to make inferences about the other's inner state from a particular set of observable behaviors" (p. 10). They concluded that affect attunement takes place through a process of mutual engagement and involves a complex series of motions synchronized to a greater or lesser degree between mother and infant. The ways in which attunement occurs are through mutual gaze, appropriate physical contact and ways of moving together, and appropriate verbalization.

Demos brings home to us once again the holistic nature of empathy—as did Olinick above—in that in being empathic, one is communicating a kind of meaning both verbally and nonverbally, in an

expression of mind and body in action that involves verbal and nonverbal interaction as well as somatic components. In addition, empathy involves being able to make appropriate inferences from one's perceptions of the other:

> Even in seemingly straightforward verbal exchanges between adults, where words convey conventional meaning, inferences about the other's psychological state are made on the basis of the particular choice of words, their timing, the voice quality, and intensity, its pitch, gaze behavior, facial expression, and prior knowledge of the other. In other words, empathy involves going beyond the perception of behaviors produced by the other, and attaching a meaning to these behaviors that is consonant with the meaning experienced by the other. (Demos, 1984, p. 10)

Empathy with infants involves a similar relational process as with adults, except that during the first two years of life, communication between infant and caregiver is largely nonverbal. Infant and caregiver infer meaning from each other's "vocalizations, facial expressions, and motor behaviors" (Demos, 1984, p. 11). Demos considers empathy to be an essential part of the therapeutic and developmental process (p. 9) which is often cited to account for a successful outcome in both situations.

Like Demos, Stern, a psychoanalyst with a background in child development and pediatrics, and colleagues have conducted dyadic mother-infant research. Their findings are showing how, in the highly complex and individualized interactions between human infants and their chief caregiver, the experience or presence of the other is a fundamental factor in the development of a sense of self (D. N. Stern, 1985). We interact with one another, from infancy onwards, through the modalities of all of our senses including touch, through what Stern has called "cross-modal" processing (1985), developing our kinesthetic awareness as well. Touching someone involves the felt experience of being touched as well—in other words, touching someone else involves the sense of oneself simultaneously being touched. Perhaps this is how we begin to sense how to touch the other, in symbolic as well as literal ways, through a nascent form of empathy whereby we experience what kind of touch we like, and by feeling into the experience of the other, while referencing our own, we infer how he or she would like to be touched as well. In addition, there are ways of establishing contact between selves without touching. One of these, as noted also by Demos (1984), is through mutual gaze, which begins in infancy between chief caregiver and infant (Stern, 1985). Yet another is language. Verbal relatedness is added to nonverbal interaction patterns at fifteen to eighteen months, and it is at this time, according to Stern (1985), that the capacity we know as empathy actually begins to emerge.

Taking a more neurological approach, Basch traces the development of affect as a precursor to empathy, building on Tomkins's theory of affect (1962, 1963), in which he delineated nine innate affects from his study of mother-infant pairs, and on Bowlby's attachment theory (1969). Bowlby, who was one of the first to study attachment behavior between mothers and infants, focused on the biological foundation of mother-infant interaction that keeps them in close proximity to one another, and his theory proposed that one is born with certain "readily identifiable patterns already present at birth, or shortly thereafter" that constitute subcortically controlled "fixed action patterns" (1969). Building on this, Basch has found that these in turn differentiate themselves as to "density of neural firing, i.e.,...the frequency, intensity, and rate of increase or decrease of stimulation" (Basch, 1983, p. 107). Basch describes the affective precursors to empathy in the following way:

> Affects, so-called, are in the first instance somatic responses to the quality or intensity of stimulation of the nervous system, and not to the content, quality, or symbolic significance of the stimulus. This initially purely biological response quickly becomes linked to encoded memory traces, so that familiar perceptual patterns mobilize the appropriate affective autonomic responses in anticipation of what the infant has come to expect by association. (Basch, 1977, cited in Basch, 1983, p. 107)

"For example, an infant's distress when hungry is frequently allayed as soon as the mother is perceived" (Basch, 1983, p. 107).

Another promising direction in the study of empathy is perhaps contained within the psychoanalytic "integrational relational model" (Mitchell, 1988). Mitchell maintains that this relational direction in psychoanalysis has been developed in slightly different ways within the various subspecialties of psychoanalysis, specifically, self psychology, object relations, and interpersonal psychiatry. Yet despite differences, each of these three agree that "the basic relational configurations have, by definition, three dimensions—the self, the other, and the space between the two" (1988, p. 33).

Adopting this relational perspective has implications for the way that one views empathy. Ekstein, another relationally oriented psychoanalyst, has described empathy as "a kind of in between stage, a sort of temporary identification" in which the analyst/psychotherapist does not lose sight of his or her own identity and yet is able to project the patient's experience back in a way that helps create meaning for the patient (Ekstein, 1978, cited in Myers, 1992). This approach to empathy appears to focus neither on the separate self of the analyst nor of the patient, but rather on the relationship itself as it unfolds between them.

This "in-between" stage is reminiscent of Winnicott when he talks about the importance of a "transitional object" in development as infants creatively learn to use their first "not-me possession," such as a teddy bear (1971). Winnicott, who was a pediatrician before becoming a child analyst, draws attention to the fact that part of the infant's relationship with the transitional object is expressed by the place of the object "outside, inside, at the border" (1971, p. 2). As he explains:

> I have introduced the terms 'transitional objects' and 'transitional phenomena' for designation of the intermediate area of experience between the thumb and the teddy bear, between the oral eroticism and the true object relationship, between primary creative activity and projection of what has already been introjected.... [These transitional objects] come within the intermediate area as transitional phenomena along with the use made of objects that are not part of the infant's body yet are not fully recognized as belonging to external reality. (Winnicott, 1971, p. 2)

The Relational Perspective of Female Psychological Development

Another important aspect of the critical thinking concerning the nature of empathy, based in part on the developments in mother-infant research, comes from recent research into the psychological development of women and girls. An important aspect of this is its exploration of the idea that a paradigm shift is in progress. Jordan, and colleagues of the Stone Center at Wellesley College (1991) have alluded to the inappropriateness of empathy models that are based on Newtonian physics, in which matter is characterized by separate, discrete building blocks. This idea of separateness, transferring itself into our views of the self and of the self in relation to others, leads us to presuppose two separate, individuated selves (p. 67) who nonetheless are able to feel some sense of connection with another separate self, as espoused by Rogers (1975). Jordan points out that these models juxtapose the separate, individuated self—which is assumed to be healthy—with a merged, embedded self, the self that has not learned to be separate—which is considered to be pathological (Jordan et al., 1991). In contrast, a newer view of empathy is based on a "relational" model in which "movement-in-relationship" is the focus, with emphasis in psychotherapy being on the experience of mutually enhancing human interactions. This new model parallels advances in subparticle physics, with its emphasis on the interconnectedness of all things (Jordan et al., 1991). Thus the core construct in this view of empathy is relationship itself, with emphasis placed on the flow of connection between people rather than on the individuals as separate selves. This view also brings to mind the definition of healing in education as transformation, which emphasizes the movement of "transitioning" toward and away from the healing power as: "healing...[is] a process of transitioning toward meaning, balance, wholeness, and connectedness both within individuals, and between individuals, and their environments" (Katz, 1982b, p. 3).

This relational perspective "involves an important shift in emphasis from separation to relationship as the basis for self-experience and development. Further, relationship is seen as the basic goal of development; that is, the deepening capacity for relationship and relational competence" (Surrey, 1991, p. 53). The self is thus "a construct useful in describing the organization of a person's experience and construction of reality that illuminates the purpose and directionality of her or his behavior" (p. 52). This relational perspective "assumes a developmental pathway" for empathy—beginning in infancy with the mother-infant relationship and continuing to develop in relational contexts in differing ways for men and for women (p. 54). This perspective stresses that women carry certain essential values of human relating for the culture and that it consequently behooves us to study the ways that women develop this relational capacity—especially as our society has become increasingly "phallocentric," depersonalized, technocratically oriented, and disconnected from the myriad "selves" that make up its citizenry (Miller, 1986; Surrey 1991). The model emphasizes an interactional approach and an "oscillating self-structure"

such that "mutual empathy" ideally develops between two selves in the process of the movement present in the relationship toward and away from connection (Surrey, 1991, p. 58). According to this view, the development of empathy goes hand in hand with the development of a "self" as it learns how to relate to others: "the assumption is that the self is organized and developed through practice in relationships where the goal is the increasing development of mutually empathic relationships"; moreover, this view "stresses the growth of this [empathic] capacity as primary in women's development" (p. 54).

The mother-daughter relationship is viewed as "the model of relationships," and observations suggest that within this dyad there ideally is a movement from "mutual empathy" to "mutual empowerment" whereby both mother and daughter learn to "care for and take care of the relationship" between them, resulting in a "sense of mutual empowerment [that] leaves both mother and daughter feeling effective and motivated to respond to the other.... This sense of competence [then] begins to be transferred to other relationships" (Surrey, 1991, pp. 56-57).

This view emphasizes that the capacity for empathy is the foundation of human relating. Women, whose psychological development often fosters an orientation toward connection, tend to score higher on empathy measures (Hoffman, 1977, cited in Jordan et al., 1991), especially on the emotional or affective components, and, as a result, have become caretakers or guardians of certain values of human relating for the culture. As we will see, this often includes a different conception of the power relationship (Miller, 1991).

A key element in this view of empathy is that it is affective as well as cognitive. Thus we experience the other and feel our own affective response in listening to what moves us in the other's experience. At the same time, however, this model holds that a healthy self retains the "as if" quality in that it remains cognitively aware that it is a separate self even as it is affectively in connection with another (Jordan et al., 1991). Such views of the empathic process thus emphasize the qualities of "connection," "connectedness," and "permeability," and speak of a certain movement, "flow," or "zest" in relationship (Jordan et al., 1991).

Concerning the quality of permeability specifically, the writer suggests that empathizing with another person involves a certain permeability of boundaries whereby one neither fully merges nor is completely separate from the other, but there is an oscillatory movement in relation, back and forth, between self and other. We will see with the thematic analysis of Lynn's interview in Chapter Four how permeability is one of the subthemes grouped under the voice of "connection," and in Chapters Six and Seven, we will be able to compare and contrast the other psychiatrists in the subsample who manifested "permeability" under the theme of "connection" with their scores from utilizing the Mehrabian and Epstein questionnaire measure of emotional empathy (1972). Hartmann (1991), a psychiatrist/analyst has conducted sleep research, and using several measures, including projective data, has found varying degrees of "permeability" versus "impermeability" among his subjects on several dimensions of personality such as relating to states of consciousness, and interpersonal boundaries, among others. Hartmann cites the research of Landis (1970) concerning the "permeability" or "impermeability" of an individual's ego boundaries, and his own research further develops this concept of boundaries. He points out that although "these boundaries do not occur in nature as physical entities...[they] really exist only in our minds, and they are very real in influencing our interactions (Hartmann, 1991, p. 3). Returning to our cross-cultural context, the reader may remember from Chapter Two how Katz found that Ju/'hoan healers were also characterized by a kind of permeability of psychological and physical boundaries—thus, he found through utilizing adapted DAP and TAT projective instruments, that "healers emphasize the central importance of fluid psychological processes and transitions that break out of the body's ordinary anatomical boundaries" (Katz, 1982b, p. 235). Thus, as we continue to examine whether indeed we can compare psychiatrists to healers educated according to the principles of education as transformation, we will particularly note this tendency toward permeability versus impermeability among those psychiatrists that are also found to be empathic when we analyze the data in Chapters Six and Seven.

The Interactive, Relational Perspective of Empathy: Client-centered, Psychoanalytic, and Self Psychological Viewpoints

A recent review of the literature within psychotherapy itself also lends support to this idea of empathy as an interpersonal orientation rather than as an individual personality skill (Myers, 1992). Myers's review of how three different approaches to psychotherapy—client-centered, psychoanalytic, and self psychological—view empathy indicates that they differentiate themselves around the degree to which empathy is considered as a relational or interactional concept (Myers, 1992). In the opinion of the writer, Myers's (1992) review lends support to Jordan's criticism of empathy models in illustrating how the client-centered therapy model, with its focus on the subjective experience of the counselor/therapist, is based on this Newtonian separate, individuated self. For instance, within the therapeutic context, Rogers, a client-centered therapist, proposed that empathy was one of six "necessary and sufficient" conditions that are needed for change to occur in psychotherapy (1957) and defined empathy as the therapist's experience of sensing "the client's private world as if it were [the therapist's] own, but without ever losing the 'as if' quality" (1957, p. 99). Rogers and his associates were one of the first clinicians to carry out research into the nature of the therapeutic relationship. He defined empathy thus:

> The state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy, and with the emotional components which pertain thereto, as if one were the other person, but without ever losing the "as if" condition. Thus, it means to sense the hurt or the pleasure of another, as he senses it, and to perceive the causes thereof as he perceives them, but without ever losing the recognition that is *as if* I were hurt or pleased, etc. If this 'as if quality is lost, then the state is one of identification. (Rogers, 1959, cited in Hart & Tomlinson, 1970, p. 116)

It is precisely this "as if" quality which ensures that the truly empathic therapist does not merge with the client, but oscillates back and forth continually between his or her own associations and those of the client. Thus, empathy entails a "movement-in-relationship" (Jordan, et al., 1991) where one is never completely separate from the other, nor is one completely merged. Ducey has pointed out that "suggestive elements...play their part as the backdrop of psychotherapy" (1986, pp. 46-47) whether therapist or client is aware of this or not. Thus, a "bad" therapist might be tempted to manipulate a client, or do so unwittingly. If one only identifies with one's client, then one is in danger of merging with him or her, as we will see in Chapter Six when Eleanor describes how she had to learn detachment as she was taking on the symptoms of her client. On the other hand, if one is too removed, the empathic process cannot unfold. It is precisely this oscillating movement in relationship that allows the therapist to retain the "as if" quality that sets empathy apart from identification (Morimoto, personal communication, 1994). In the writer's opinion, thus, empathy involves connection but not merger.

Although Rogers understood this, along with the somatic foundation of empathy, many of his followers did not, as Myers, a psychologist, points out. She notes that in client-centered approaches, the focus has come to be on the therapist, for empathy is considered "an aspect of the internal world of the counselor" (Myers, 1992, p. 5). Moreover, she notes that an objectification of empathy occurs when it is viewed as a communication skill or attribute that is present in the therapist and that this, according to some, implies that it is a "thing" that can be "given" to the client, as well as something which can and should be "given" to a counselor, or a counselor-in-training (Myers, 1992). Thus, Myers points out that one client-centered researcher calls for "the pursuit of a delineation of empathy and the development of training procedures for it...[for] if empathy is good, let us specify it and give it to all people as soon as we can" (Aspy, 1975, cited in Myers, 1992, p. 13). Empathy is thus viewed as a quantified "it," where the more one possesses of it, the better. It is a resource that one can "give" to someone else, whether a psychotherapy client or a counseling trainee.

It would appear, however, that this objectification of empathy grew out of these attempts to measure empathy but that this was not what Rogers had intended (Ginsburg, 1984; Myers, 1992). Thus, when people tried to measure empathy (e.g., the Accurate Empathy Scale, Truax, 1961, 1967, or the Carkhuff Training Model, 1969, 1979, cited in Myers, 1992, p. 8) "the client-centered view of empathy changed radically" from what Rogers had originally intended (Myers, 1992, p. 8). Myers cites Corcoran, writing from another perspective, who identified the problem of the need to differentiate between "accurate empathy," which is "by definition a communication process" and the "empathic experience"

for the one may not reflect the other (Corcoran, 1981, cited in Myers, 1992, p. 8). Or, as another researcher cautions, "skill approaches to communication training mistakenly place skillfulness, rather than meaning at the heart of personal communication" (Plum, 1981, cited in Myers, 1992, p. 8). Myers thus cautions that "we must see technique as something subordinate to the response itself [for]...one cannot use therapeutic techniques to simulate empathic feelings [as] empathy must be felt to be real" (Myers, 1992, p. 12).

Corcoran thus had pointed out in a 1981 article, "Experiential Empathy: A Theory of a Felt-Level Experience," that many studies had "failed to report significant correlations between empathy and therapy outcome (Beutler, Johnson, Nevill, & Workman, 1972, cited in Corcoran, 1981, p. 30). He attributed this to the inaccurate representation of empathy by Rogers's followers, especially insofar as the more receptive aspect, the felt level of experiencing empathy was concerned. He concluded:

> In summary, all the operational definitions provided by Truax, Carkhuff, and their associates are different from the concept which Rogers hypothesized as a necessary ingredient for effective therapy. The necessary condition of sensing the feelings of the client has been replaced with perception and reflection of affect, the meaning and content of the client's message. Thus, accurate empathy by definition is a communication process, which may not reflect the empathic experience.... [Thus], it is quite possible that the lack of evidence supporting a relationship between empathy and therapy outcome is a result of the current operational definition of accurate empathy. Before it can be scientifically determined if empathy has impact upon therapeutic personality change, an accurate conception of empathy and method of training must be developed. (Corcoran, 1981, p. 31)

In Chapter Seven, we will look more closely at a relationally oriented empathy instrument—"the Relationship Inventory"—developed by another researcher who attempts to follow in the direction that Rogers originally intended (Barrett-Lennard, 1973, 1993), when we analyze the results of our subsample of psychiatrists from our Mehrabian and Epstein instrument.

Myers contrasts with the client-centered approach the psychoanalytic perspective, which tends to view empathy as "prerequisite to therapy" (Myers, 1992, p. 15) that "sets in motion the process of transference, [when] the analyst is made open to the mental state of the patient" (p. 18). She points out that in earlier orthodox psychoanalytic views, as with the client-centered approach, "empathy is viewed as an attribute which resides within the analyst" (p. 20). However, she points out that Schafer's introduction of "generative empathy" into psychoanalysis reveals its "relational nature" (Myers, 1992, p. 21):

> Generative empathy is a sublimated creative act in personal relationships which combines the gratification of intimate union with the recognition and enhancement of separateness and personal development of both persons involved. (Schafer, 1959, cited in Myers, 1992, p. 21)

Malan, a psychiatrist/analyst at the Tavistock Clinic in England, has built on Freud's notion of "rapport," which he defines as "the degree of emotional contact between patient and therapist" (1979, p. 20) and considers to be a "fundamental concept to the practice of psychotherapy" (p. 19). Malan asserts that a well-developed rapport must be established with the patient before the analyst attempts to offer an interpretation. A "deepening of rapport" occurs after the therapist has made a correct interpretation and the patient "becomes in touch with a feeling of great significance to him, and [is] not only able to express it, but to express it directly to one of the people principally involved in the feeling itself" (p. 20). Malan believes that one of the most important aspects of the therapist's roles is that he or she "should be able to sense the degree of rapport existing at any given moment in a therapeutic session" (p. 20). Furthermore, he believes that rapport can function as a "kind of thermometer between him and patient, and [the psychiatrist] can use the moment-to-moment fluctuations in the level of rapport in order to judge the appropriateness of what he has just said" (p. 20). He describes a relational process of "leap-frogging" whereby both therapist and client continue to go "one move beyond what the other has just said" (p. 82), resulting in such a deepening of rapport. This view implies interactional empathic relating (Myers, 1992). Building on Malan, Myers considers rapport to be very close to empathy, stating that it "might be thought of as the operationalization of empathy, the evidence of empathy working in relationship" (p. 26). She emphasizes Malan's "leap-frogging" as an example of "interpersonal empathy in action" (p. 26) as each infers what the other is feeling and together they construct a reality.

Agosta has also differentiated between "emotional contagion" and empathy, and in so doing points toward a particular movement in relationship occurring with empathy whereby the analyst and the analysand mutually influence one another (Agosta, 1984). He explains the difference in this way:

> In emotional contagion a representation of the other's feeling is aroused in the subject. That is all that happens. In the case of empathy, in addition to this first representation of the other's feeling, a second representation is mobilized. The subject becomes aware that the other's feeling is the source of his own. Thus, this second representation—which is indeed a representation of the other—is conjoined with the first. (Agosta, 1984, p. 55)

He goes on to emphasize that it is precisely this "double representation" that sets empathy apart from emotional contagion:

> This, then, is the crucial and irreducible difference between empathy and emotional contagion. Empathy involves a double representation. First, it involves a representation of another's feeling. (This is what empathy shares with emotional contagion.) Second, it entails a representation of the other as the source of the first representation. (This is what is lacking in emotional contagion.) Thus, what differentiates empathy from contagion is the emergence, the distinguishing of, a representation of the other as the object as well as the cause of what is being felt. (Agosta, 1984, p. 55)

And, seeking the reason for the fact "that many accounts of empathy incorporate a circular or spiraling movement" (p. 44), he turns to the idea of meaning-making:

> One possible answer is that as a form of human understanding empathy has the form of the "hermeneutic circle." The circularity—which is arguably not of a vicious but rather of a productive kind—occurs because the expressions of human life in question are composites consisting of many aspects that take their meaning from the whole of which they are a part and, in turn, lend meaning to that whole. (Agosta, 1984, p. 45)

It is necessary thus to take into account the context or world view of the person with whom one is empathizing in relation to a particular "expressive action" in order to truly feel into his or her experience:

> Thus, the expressive actions and behavior of an individual become fully meaningful only when located in the context of his life situation. But the individual's life is itself a composite of these expressive actions. The interrelation between the part and whole forms a circular network of mutually illuminating features. The oscillation between features that is so characteristic of many accounts of empathy may well turn out to be the shadow cast by the hermeneutic circle upon empathy. (Agosta, 1984, p. 45)

Here Agosta, alluding to Freud's famous phrase in "Mourning and Melancholia" (1917)—"Thus the shadow of the object fell upon the ego" (Freud, 1917/1925, p. 159)—reminds his psychoanalytically oriented reader that meaning-making is also

involved with empathy, which is a particular kind of "expressive" meaning-making that adds another important dimension—connection—to human experience:

> We find that it is necessary to posit some capacity or competence—let us call it "empathy"—upon pain of contradiction if we refuse to so posit it. A world with expressed and receptively experienced emotions, but without empathy, would be an absurdity in the strict sense. It would be a world of musicians without hearing—the frantic movement of bows across violin strings and fingers on ivory keys would be in vain for neither the musicians nor the listeners would in principle be capable of hearing the music. Similarly without the capacity to empathize with the feelings of another, we would just be bodies located physically in space alongside one another—no interhuman connection would exist at all. (Agosta, 1984, p. 49)

Somatic Empathy-in-Action in FUNCTIONAL INTEGRATION®

Empathy takes place in situations other than psychotherapy. Having viewed the mind-body relationship in reference to the self-in-relation via the paradoxical image of the Möbius strip, we turn now to a more concrete example of what happens when two people interact in a particular way. Listening to a somatic educator describing "FUNCTIONAL INTEGRATION®," a form of somatic education where the practitioner gently guides the student into new patterns of movement (Alon, 1990; Feldenkrais, 1972, 1985; Rywerant, 1983; Shelhav-Silberbush, 1987), we see an example of circularity and dialectical

interaction. At the same time, we encounter an example of two selves in interaction involving a kind of "felt sense" of empathy (Corcoran, 1981). This will serve as a springboard to consider empathy in psychotherapy in the vignette that follows this one. The writer has chosen the example of the FELDENKRAIS METHOD® of somatic education in part because in Chapter Four, Lynn, one of the psychiatrists in the pilot study, describes the empathic interaction between her and her GUILD CERTIFIED FELDENKRAIS PRACTITIONER℠ as an important factor in facilitating her healing process.

In describing FUNCTIONAL INTEGRATION®, Feldenkrais conveys a notion of recursive circularity akin to Maturana and Varela's view of circularity being present in autopoetic systems (1980). As mentioned in Chapter One, Maturana and Varela, two systems biologists, describe two ways of understanding reality in The Tree of Knowledge (1987). In the first, reality is viewed as a collection of independent parts, the whole is equal to the sum of the parts and such a perspective involves cause and effect, with the basic assumption being that finding the cause leads to the solution. The organism is thought to carry some representation internally of what is out there, so behavior corresponds to the needs of the environment. This is the perspective represented by cognitive science. Maturana and Varela offer us an alternative view, whereby organisms are thought to have autonomy and to act within their own environmental niches according to their own internal structures. According to these researchers, this process involves "coherence" and emphasizes the interconnectedness within the internal consistency of a living system. Every living organism thus has some innate coherent organization that remains until death (p. 37), for in order for something to be alive, it must be organized. "Organization signifies those relations that must be present in order for something to exist" (p. 42). "Living beings are characterized by their autopoetic organization. They differ from each other in their structure, but they are alike in their organization" (p. 47). Maturana and Varela point out that autopoesis "explicitly proposes that such data be interpreted from a specific point of view which stresses that living beings are *autonomous* unities" (p. 47). By autonomous, Varela means that there is no division between their being and doing—thus reminding us of what Kegan said in referring to his book The Evolving Self in Chapter One: "It is not about the doing which a human does; it is about the doing which a human is" (1982, p. 8):

> That living beings have an organization, of course, is proper not only to them but also to everything we can analyze as a system. What is distinctive about them, however, is that their organization is such that their only product is themselves, with no separation between producer and product. The being and doing of an autopoetic unity are inseparable, and this is their specific mode of organization. (Maturana & Varela, 1987, p. 48)

As Feldenkrais has described what he does:

> Through touch, two persons, the toucher and the touched, can become a new ensemble: two bodies when connected by two arms and hands are a new entity. These hands sense at the same time as they direct. Both the touched and the toucher feel what they sense through the connecting hands, even if they do not understand and do not know what is being done. The touched person becomes aware of what the touching person feels and, without understanding, alters his configuration to conform to what he senses is wanted from him. When touching I seek nothing from the person I touch; I only feel what the touched person needs, whether he knows it or not, and what I can do at that moment to make the person feel better. (Feldenkrais, 1981, pp. 3-4)

Thus, touching and being touched involve circularity both within each system or self and between two different systems or selves. We first encounter this with the mother-infant relationship. We interact with one another from infancy onwards through the modality of touch, developing our kinesthetic awareness. Touching someone involves the felt experience of being touched as well. Although in FUNCTIONAL INTEGRATION® we are talking about a modality which involves actual physical touch, unlike psychodynamic psychotherapy, nonetheless, in the writer's opinion,

the *quality* of interaction in FUNCTIONAL INTEGRATION® is indicative of a certain kind of teaching and learning that occurs in other sorts of empathic interaction as well. Feldenkrais, in his book The Elusive Obvious (1981), when asked to explain what he is doing when he teaches someone in this way, likens it to that of a woman who loves to dance and who is trying to teach an awkward partner. The woman does not, in actuality, teach the man how to dance, just as Feldenkrais does not, in actuality, transmit information in teaching a student to be aware of his or her movement. Rather, the woman creates the conditions for that person to learn, which occurs because of changes in the organization of his structure in interaction with her. Feldenkrais describes his own interaction with people thus: "In saying

that I work with people I mean that I am 'dancing' with them. I bring about a state in which they learn to do something without my teaching them, any more than the woman taught the dancer" (1981, p. 9). Thus, from this perspective, the degree to which the person learns the dance is limited by his or her structure as a closed biological unity, and no information is exchanged between the teacher and the student. Nevertheless, through interaction, the two overcome their separateness, thus bringing about connection.

Again, FUNCTIONAL INTEGRATION® is *not* the same as psychotherapy, although it has been found to have psychological aspects (Rinfret, 1989; Steisel, 1992). Nonetheless, in the writer's opinion, this example is in some way analogous to the kind of unobtrusive learning and teaching that may take place between a therapist and client who are empathically interacting, as we shall see in the vignette that follows.

Maturana and Varela maintain that living systems are in fact closed unities (Maturana and Varela, 1987; Varela, 1979) which are characterized by structure, which "denotes the components and relations that actually constitute a particular unity and make its organization real" (1987, p. 47). By organization, in turn, they mean "those relations that must be present in order for something to exist (p. 42). The organization of such unities is limited by their structure and as such is "structurally determined" (p. 99). Thus, "it is the structure of the living being that determines what change occurs in it" (resulting in a new organization), rather than environmental perturbations (pp. 95-96). In other words, how a living biological system [such as a self] interacts and changes its organization will depend on its own inherent structure. Maturana and Varela have termed this process of interaction between two closed biological unities "structural coupling." In addition to the structural coupling that takes place at a purely biological level, Maturana and Varela (1980) suggest that humans, specifically, overcome their separateness as closed biological unities through a different form of structural coupling: language or linguistic "structural coupling" (Maturana & Varela, 1980). They emphasize that human linguistic interaction does not mean that an independent objective reality is being described, but rather that language allows us to create a "consensual domain":

> Linguistic interactions orient the listener within his cognitive domain, but do not specify the course of his ensuing conduct. The basic function of language as a system of orienting behavior is not the transmission of information or the description of an independent universe about which we can talk, but the creation of a consensual domain of behavior between linguistically interacting systems through the development of a cooperative domain of interactions. (Maturana & Varela, 1980, p. 50)

We will look at empathy as such "a cooperative domain of interactions" in the vignette that follows. Having considered Feldenkrais's view of what happens when two people interact in a particular way which includes touch, we will now look more closely at what happens when two people connect empathically, without making physical contact, in the special relationship of psychodynamic psychotherapy, through a vignette that describes one therapist's understanding of the mutual meaning-making that was involved in her relationship with a client. While we might note that most client-therapist relationships do not include the level of relatedness portrayed in this vignette, it is nonetheless indicative of what can occur in that relationship when the therapist is attuned to the mutual reality that is being created. Here we will see empathy in action as both the psychotherapist and her client are actively inferring meaning from the other, both consciously and unconsciously. In a chapter entitled "Two Part Inventions: Knowing what We Know" (M. Turner, 1991), Turner describes below a session with a young woman who is a student at the musical conservatory where Turner is a psychotherapist. This young woman is seeking help around separating from her mother.

Vignette

Writing about where she and her client are in the process of relating, Turner marvels to herself at how parallel their lives are, noting that they are "both...struggling to translate an inner life into words and music" (M. Turner, 1991, p. 149) and that some of Marina's defenses "resembl[e] my own resistance to claiming what I know" (p. 152). Turner shares how she realized that what is key for both her and her client is "a basis for relatedness not only to oneself but also to others" (p. 154), yet she points out that, according to the traditional psychoanalytic structural view, this relatedness comes out of separation and differentiation both internally and externally; in other words, "the development of the self depends on a separation or differentiation from the other as well as on a differentiation of one internal structure from

the other" (p. 154). Thus, Turner's 23-year-old client, Marina, studying to be a concert pianist because, as she puts it, "it gives me a more complete version of myself" (p. 150), struggles to know what she knows as an individual separate from her mother and is caught in the dilemma of wanting neither to merge with her mother nor to isolate herself through complete separation. Turner describes how Marina moved in relation to her mother:

> At times it was if Marina felt "condemned to choice" (Valle & King, 1978, p. 8) as she alternated between poles, going from one to the other, doing and undoing. But more often she resided in "the between" (Prescott & Valle, 1978, p. 159), caught in the dialectical tension between the two, fighting for more air, while feeling at once bound to her mother and alien, even repugnant. (Turner, p. 155)

Turner notes that Marina was suffering on a somatic level from allergies, and that this made piano playing difficult. " 'It's hard to play the piano if you can't breathe,' she would tell me, 'and playing the piano is as much about breathing as it is about fingers' " (p. 155). Turner, a pianist herself, resonates in her own experience with Marina's difficulties, remembering how playing the piano makes her feel and her own unrealized wish to become a concert pianist, as well as her similar struggle to begin to write in her own voice. At the same time, however, she is beginning to realize how much Marina resonates with *her* and, in addition, that she, Turner, is experiencing some resistance to this fact:

> Ironically, I had seen myself as joining in her efforts to know what she knew, as she was ready to know it. But now I wonder if I was simultaneously neglecting my own reluctance to know what I knew: both something about myself and something essential about her, namely the extent to which she could discern things about me, the extent to which she needed to know who I was, what I knew. (Turner, 1991, p. 161)

Some of this discernment occurs in Marina's dreams. Turner recalls a dream that Marina recounted to her, one that both was and was not about Turner: " 'I had a dream about therapy. It was about you and not you. I had an appointment with a therapist. She was supposed to be you. She was dressed like you, but she was my age, my contemporary' " (p. 160). This therapist seemed about to tell Marina something important about herself, but although she never did, Marina had felt trusted in the dream. In retrospect, Turner asks herself why she had neglected to ask Marina "what the therapist in her dream might have revealed," wondering "How was it that I could have avoided this question? Was there something she knew about me which I was afraid to acknowledge about myself?" (p. 160). Then, in empathizing with Marina's struggle for authenticity, Turner suddenly makes a connection: "Why was I afraid to hear what she could discern about me, the kernel of truth in her projections or in her accurate perceptions? Did I fear becoming too real, not only to her but to myself? Could it be that I was avoiding the ways in which aspects of her struggle mirrored my own?" (p. 161). As a result of this questioning Turner arrives at an understanding of how Marina's struggle has evoked a similar struggle within herself:

> While Marina was working to orchestrate her internalized voices, I too was working to construct a different, more fully textured and embodied voice, and a name that is more fully my own. Simply put, I wanted to be able to speak and write in the first person, and to sign the work with a name that felt more like my own. (Turner, 1991, p. 161)

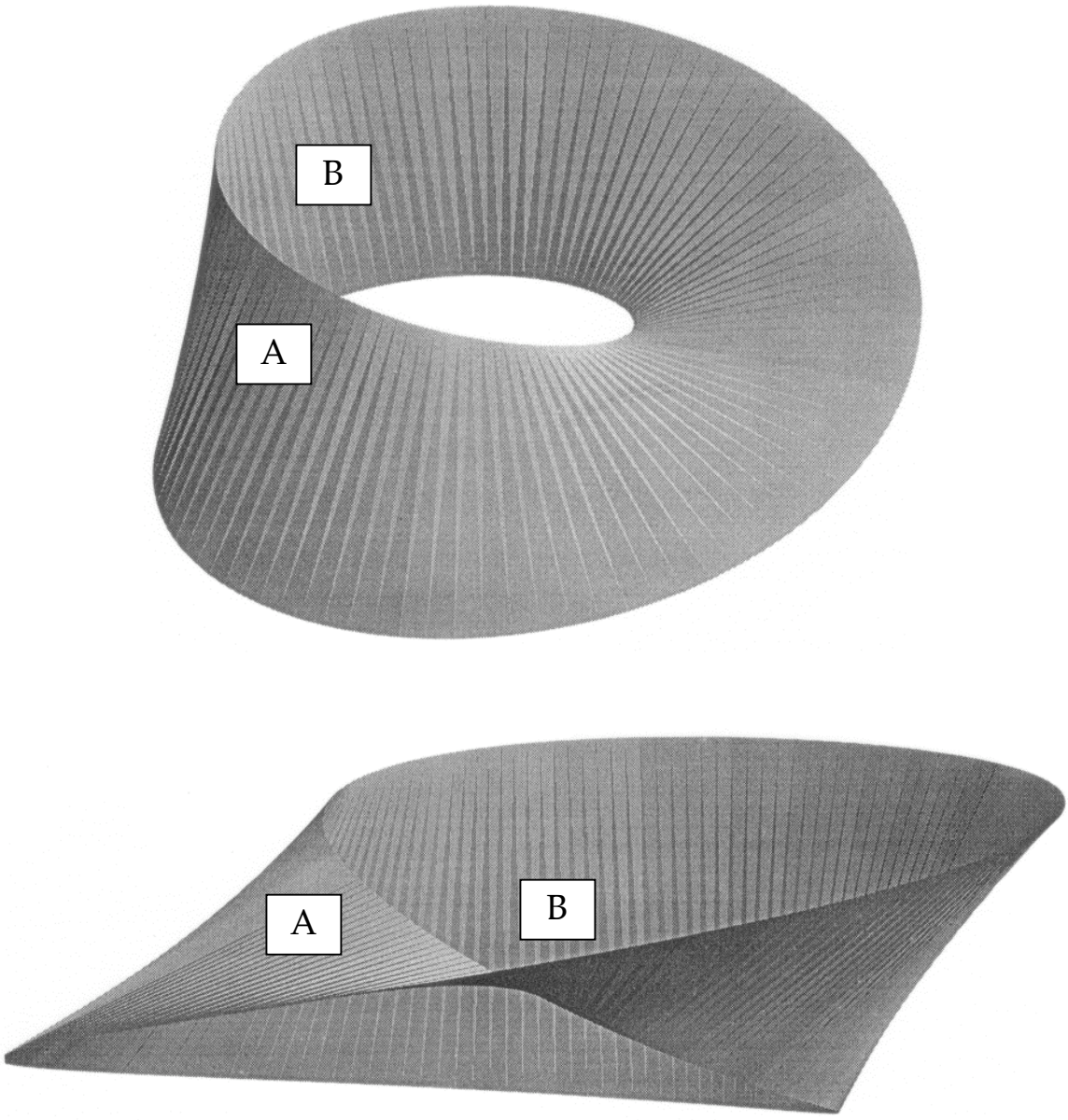
Turner recognizes that her own resonance with Marina's struggles for authenticity has evoked this awareness of her own desire to write. But beyond this, she discovered, once she had started writing "that for at least a year Marina had this implicit knowledge about my desire to write, a desire that I was only now allowing myself to know" and she found herself "marveling at how it was that she could know more about me than I could let myself know about myself" (p. 166). She recounts a dream Marina had had in which Turner had "dedicated two books to her [Marina], one on music, and the other on psychology" (p. 165). Thus, whether on a conscious or an unconscious level, therapist and client appear to be *mutually* empathizing with each other and growing in relation to each other, although within the therapy sessions Turner appropriately did not disclose to Marina her insights about her own process. But Turner can also appreciate the ways in which she and her client are separate and that this tendency to split or divide both the internal object world and the external world is the basis for relationship: "I wanted to italicize the idea that this division or this alienation or this splitting then serves as a basis for relatedness not only to oneself but also to others" (p. 154). Turner cites Kierkegaard (1954, p. 146): "The self is a relation which relates itself to its own self," and she reminds us that Cole indicated that "both Kierkegaard and Freud implied that for the potential self to grow and become a self, it must first relate itself to something outside of itself" (Cole, 1971, cited in M. Turner, 1991, p. 154).

The Empathic Self in Relation: A Möbius Strip

Perhaps this is where empathy steps in, as the connective experience that allows one person to grow from the experience of relating to another and even, potentially, to facilitate that growth in the other. Thus, when a therapist empathizes with a client, helping him or her to be and feel understood, the therapist ideally deepens his or her own self-understanding and through this deepening becomes more highly attuned to how to facilitate a continuous movement between self and other, a transitioning back and forth, in a reflexive oscillating movement, where growth can occur.

To illustrate the paradoxical nature of one self empathizing with another self, we might want to return to Schiller's use of the image of the Möbius strip, which appears to have two separate sides and yet is simultaneously one-sided. While Schiller offered this image to illustrate the paradoxical nature of the mind-body relationship within a single biological unity, it can serve as well to illustrate the interaction between two separate biological unities. In both cases separation and connection are simultaneously present, and cause-and-effect are difficult to discern. We might also contrast the Möbius strip with a strip of paper that has instead been joined like a ring. In the latter, the body could be represented by one plane—the outside of the ring—and the mind by the other plane or side—the inside. Likewise, one self could be represented by one plane, and the other self by the other plane. In the figure of a Möbius strip that follows, if one wants to move from Location B on the inside of the ring to Location A on the outside, one must cross a boundary; a line, started on the outside of the ring, will never touch the inside of the ring. But what if mind and body exist always in interaction with each other, and what if the self, while arising within and out of a biologically autonomous unity, is not a truly separate entity in that it is always viewed in relation to other selves and to the environment? In this case, the image of the Möbius strip might serve us better. As we have noted, the Möbius strip has a curious paradoxical property in that while it seems to be two-sided, it is simultaneously one-sided. Tracing with a pencil from any given point along the strip's surface, we find that we finally come back to that same point, leaving a line on both "sides" of the strip, and yet we have never been aware of crossing a boundary to that other side.

A Möbius Strip—Two Views



(Graphics by David Picariello)

Chapter Four:
Considerations about Method

Perspectives on Meaning-Making

Our purpose in this study is to determine whether we could make a comparison that would be beneficial and illuminating between the education of community psychiatrists in the West and that of traditional healers in the Kalahari and Fiji, as Katz (1981) has suggested. We have already noted that we will utilize a systems approach in this study, which will allow us to focus on the interrelationship of various factors in a healer's life as we examine how a certain group of psychiatrists views their education. The methodology for the present study was also derived from a synthesis of existential-phenomenological, constructivist, and hermeneutic perspectives. From an existential-phenomenological perspective, the researcher attempts to develop an empirical method, which includes hermeneutics—a psychological method "for the study of the meanings of human experiences in situations as they 'naturally occur' in the course of daily life" (von Eckartsberg, 1984, p. 1). The "human experiences" in this case are psychiatrists' stories about how they became psychiatrists. The writer begins with the basic assumption that humans are, first of all, human *beings,* which in itself entails activity. Thus, the question of studying human meaning-making "is not about the doing which a human does; it is about the doing which a human is" (Kegan, 1982, p. 8). Humans are meaning-makers, and as such, they are constantly co-creating the world around them in an interactive process. Thus, the world "out there" is subjectively known, and there is no such entity as one objective, absolute reality. Phenomenology entails "analysis of life-world experience," such that that which a person experiences depends on how he or she makes meaning out of it (von Eckartsberg, 1984).

Evidence from biological research concerning the nature of perception confirms that reality is constructed, and that all living is a form of knowing (Maturana & Varela, 1987). The brain puts together a complete image from the different ways that each kind of cell involved in the act of perception perceives its bit of constructed reality. It is capable of filling in reality such that we do not, for example, continually experience a blind spot where the optic nerve joins the retina. Thus, as Maturana and Varela point out, *"we do not see that we do not see"* (1987, p. 17), and they go so far as to say:

> This circularity, this connection between action and experience, this inseparability between a particular way of being and how the world appears to us, tells us that *every act of knowing brings forth a world.... All doing is knowing, and all knowing is doing.* (1987, p. 26).

Using this approach is an attempt by the writer to address to some degree the fact that we exist in a world of multiple realities, and that these must be clearly differentiated in carrying out research or in choosing an appropriate methodology. The chosen approach also follows in the footsteps of existential psychologists and their views of narratives occurring in psychotherapy sessions as outlined in Existence: A New Dimension in Psychiatry and Psychology, edited by Rollo May et al. (1958). Here May acknowledges this then-new movement's debt to Kierkegaard, Nietzsche, Dostoyevsky, and even Heisenberg, among others. All of these thinkers were able to see, before their time, the consequences of collectivization and fragmentation to man- and womankind. Nineteenth-century rationalism and materialism were based on the Copernican view "that nature...could be separated from man" (May et al., 1958, p. 26). In other words, there was such a thing as the "objective truth." The modern scientific method was a testimony to this detached observer-without-bias paradigm. Kierkegaard, according to May, was one of the first to question this assumption. One of Kierkegaard's most important contributions is the idea of the validity of "truth-as-relationship," or the original statement of "relational truth." Thus, May tells us,

> here is the fountainhead of the emphasis in existential thought on truth as 'inwardness' or as Heidegger puts it, truth as freedom...the forerunner of relativity and the other viewpoints which affirm that the human being who is engaged in studying the natural phenomena is in a particular and significant relationship to the objects studied, and he must make himself a part of his equation. That is to say, the subject, man, can never be separated from the object which

> he observes. (Kierkegaard's analysis in "On the Essence of Truth" in Existence and Being, cited in May et al., 1958, pp. 25-26)

The existential-constructivist methodological approach for this study also builds on Kantian models of knowledge, in that knowledge is viewed "as the invention of an active organism interacting with an environment" and "mental images are wholly creations of the organism, produced as a by-product of its navigation through life" (Efran, Lukens, & Lukens, 1988, p. 136). However, such a perspective does not deny that "an invented social reality—once it has been invented—is as real and solid as any other" (1988, p. 141), and that that reality changes in relation to context and the tradition that one is using to explicate one's data (p. 136). One's tradition thus includes one's own bias. Thus, the writer, when examining the data in the Chapters Six and Seven, will attempt to shed light on her own biases as they influence that analysis, for, while "the object of knowledge is already preinterpreted, situated in a schema, part of a text, outside which there are only other texts," "the subject of knowledge belongs to the very world it wishes to interpret" (Baynes, Bohman, & McCarthy, Eds., 1991, p. 5).

Thus, as a researcher using this approach,

> [o]ne embeds oneself in the process of getting involved in the text, one begins to discern configurations of meaning, of parts and whole and their interrelatedness, one receives certain messages and glimpses of an unfolding development that beckons to be articulated and related to the total fabric of meaning.... The hermeneutic approach seems to palpate its object and it makes room for it to reveal itself to our gaze and ears, to speak its own story into our understanding. (von Eckartsberg, 1984, p. 138)

Von Eckartsberg thus emphasizes how this research method involves a different kind of interconnectivity with one's subject for analysis than traditional methods of research based on the approach of the natural sciences. Hermeneutics is thus a relational approach. It involves an extremely personal kind of meaning-making that of necessity involves the meaning-maker in context with other meaning-makers, and thus brings him or her continually up against the relativity of his or her own meaning-making:

> In hermeneutic work we grope for the single expression that will do justice to the integrity and complexity and essential being of the phenomenon. We become spokespersons and messengers for the meanings that demand to be articulated. We become intrigued and entangled in the webs and voices of language and its expressive demands. In hermeneutic work we become engaged in an expanding network of meaning-enrichment contributing new meanings to the ongoing dialogue. It is a process of contextualization and amplification rather than of structural essentialization. Hermeneutic work is open-ended and suggestive, concerned with relational fertility. (von Eckartsberg, 1984, p. 138)

Von Eckartsberg goes on to point out that this approach follows Ricoeur's hermeneutical approach, which "utilizes the notion of the text as the basic paradigm" (p. 138). Thus, "human action and all other products of human activities as expressions—art works, rituals, institutions, etc.—can be understood as 'text analogues' in need of interpretation" (p. 138). By extension, the writer attempts to apply this methodology to the texts of community psychiatrists and healers talking about their formal and informal educational experiences in Chapter Six and Seven.

In analyzing the interviews, it is helpful to view them in the context of the stated purpose of the interview, which in this case is their education as psychiatrists. In so doing, the writer has drawn on another perspective while reading the interviews in order to clarify the relation of the knower to that which is known, or to knowledge in general. By one definition, it can be said that education involves access to and the imparting of "procedural knowledge," or "the business of acquiring and applying procedures for obtaining and communicating knowledge" (Belenky et al., 1986, p. 95). Perry, a psychologist, had given illustrations of "separate" knowing among college undergraduates who used "this new mode of thinking [i.e., critical reasoning]...to construct arguments powerful enough to meet the standards of an impersonal authority" (Perry, 1970, cited in Belenky et al., 1986, p. 101). In addition, the research of Gilligan (1982) and Lyons (1983) had identified two different modes of knowing—"connected" and "separate"—in their interviews with women. Belenky et al., in their research with a sample of over 300 women, further developed the research of both W. G. Perry (1970) and Gilligan with their exploration of "procedural knowledge" (Belenky et al., 1986, p. 95). Belenky et al. differentiated between two kinds of procedural knowers—"separate knowers" and "connected knowers"—Belenky et al. suggested that there were likewise two forms of "procedural knowing"—"connected [procedural]

knowing" on the one hand as differentiated from "separate [procedural] knowing" (Belenky et al., 1986). Connected knowing involves "understanding" as opposed to "knowledge" (Belenky et al., 1986, p. 101). As they point out from analyzing interviews of women in their sample,

> [u]nderstanding involves intimacy and equality between self and object, while knowledge (wissen, savoir, saber) implies separation from the object and mastery over it. Understanding...entails acceptance. It precludes evaluation, because evaluation puts the object at a distance, places the self above it, and quantifies a response to the object that should remain qualitative. (Belenky et al., 1986, p. 101)

Thus the methodology for this study would ideally provide some idea as to the psychiatrist's voice as indicative of his or her stance toward the environment/world—human or otherwise. Does he or she experience him- or herself in relation to others, or does he or she hold him- or herself apart from others?

Another earlier theorist, Bakan (1966) (whom we encountered in Chapter One when considering his notion of the role of the "mystery/mastery complex" in maintaining an unequal power differential) offered a related juxtaposition, pointing out the existence of "two fundamental modalities in the existence of living forms, 'agency' for the existence of an organism as an individual, and 'communion' for the participation of the individual in some larger organism of which the individual is a part" (1966, pp. 14-15). He went on to juxtapose opposite stances toward the environment/world under each of the two poles. Thus,

> [a]gency manifests itself in self-protection, self-assertion, and self-expansion; communion manifest itself in the sense of being at one with other organisms. Agency manifests in the formation of separations; communion in the lack of separations. Agency manifests itself in isolation, alienation, and aloneness; communion in contact, openness, and union. Agency manifests itself in the urge to master; communion in noncontractual cooperation. Agency manifests itself in the repression of thought, feeling, and impulse; communion in the lack and removal of repression. (Bakan, 1966, p. 15)

Following this line of thinking, we would group such concepts as "the embedded self" (Katz & Kilner, 1987), the relational self (Jordan et al., 1991), "the connected self" (Brown & Gilligan, 1990, 1992; Gilligan, 1982; Gilligan & Pollak, 1988; Katz & Kilner, 1987), or "understanding" in Belenky et al.'s sense (1986) under "communion." We would group the "separated self," "separate knowing," wissen, savoir, and saber under "agency." We will come back to this idea of two different stances toward the environment/world that are similar to "agency" and "communion" as we flesh out what we mean by "control" and "connection" in the course of analyzing our psychiatrists' themes.

The writer has chosen to invite the psychiatrists to talk about more than simply the didactic content of their formal education; they were questioned about their informal education as well. Thus, in a broader sense they were invited to tell their individual stories as to how they became psychiatrists, a process that yields what has been called "narrative truth" (Spence, 1982). We have seen in Chapter Two how certain researchers have viewed narratives as a major means by which human beings construct their reality and, thus, as being worthy of a closer look (Spence, 1982). While reality, narrative or otherwise, is thus a relative term, it is also constructed differently depending on the "sphere" in which it falls, for, as Bruner has pointed out, the "'reality' of most of us is constructed and constituted roughly into two spheres: that of nature and that of human affairs, the former more likely to be structured in the paradigmatic mode of logic and science, the latter in the mode of story and narrative" (Bruner, 1986, p. 88). The narratives of community psychiatrists and other healers speaking about their education fall within the sphere of human affairs, although, in the course of their conversation, they may also utilize "the paradigmatic mode"—especially when discussing the theories which inform their work with patients.

Bruner, building on William James' belief that "all human thinking is essentially of two kinds—reasoning on the one hand, and narrative, descriptive, contemplative thinking on the other" (William James, quoted in Bruner, 1986, frontispiece)—has pointed out that

> there are two modes of cognitive functioning, two modes of thought, each providing distinctive ways of ordering experience, of constructing reality. The two, though complementary, are irreducible to one another. Efforts to reduce one mode to the other or to ignore one at the expense of the other inevitably fail to capture the rich diversity of thought. (Bruner, 1986, p. 11)

He goes on to clarify the nature of, first, the "paradigmatic mode," about which "we know a very great deal":

> One mode, the paradigmatic or logico-scientific one, attempts to fulfill the ideal of a formal, mathematical system of description and explanation. It employs categorization or conceptualization and the operations by which categories are established, instantiated, idealized, and related one to the other to form a system.... There is a heartlessness to logic: one goes where one's premises and conclusions and observations take one, give or take some of the blindnesses that even logicians are prone to. (Bruner, 1986, pp. 12-13)

Against this he juxtaposes the "narrative mode":

> The imaginative application of the narrative mode leads instead to good stories, gripping drama, believable (though not necessarily "true") historical accounts. It deals in human or human-like intention and action and the vicissitudes and consequences that mark their course. (Bruner, 1986, p. 13)

It is the writer's opinion, however, that narratives are more than merely "good stories, gripping drama, believable (though not necessarily 'true') historical accounts" Bruner, 1986, p. 13). Rather, since we are concerned with meaning-making, they are perhaps the most valid data available.

Spence, a psychoanalyst, in talking about the relativity of "narrative truth" revealed in psychoanalysts' transcripts of clinical cases, reminds his colleagues of the necessity of "unpacking" or "naturalizing" the transcript, for each text is "packed" with multiple layers of meaning (Spence, 1982, p. 30), even in a single interview with a single psychiatrist. It goes without saying that "just as the analyst must listen constructively and actively much of the time, supplying his own meaning to a large part of the analytic 'conversation,' so the outside reader must supply many of his own assumptions when he tries to understand the transcribed text of an hour or read a published report of a case" (p. 30). Thus, Spence suggests that the analyst include "the background assumptions" utilized in writing up the case in the manner in which it appears and reminds us that "narrative truth" is constructed truth (p. 30). He asserts

> that the model of the patient as unbiased reporter and the analyst as unbiased listener suggests a kind of naive realism that is hard to imagine, harder to practice, and runs counter to everything we have learned about the way we come to understand the world. (Spence, 1982, p. 25)

It follows that the writer, in order to listen for the narrative truth inherent in each psychiatrist's text, needs to become aware of her own interpretation, or "conception," of what she is hearing. Bruner has described this process as reading a text while taking "psychological genre" into account:

> If we then ask about the nature and role of psychological genre—the reader's conception of what kind of story or text he is encountering or "recreating"—we are in fact asking not only a morphological question about the actual text, but also a question about the interpretive processes that are loosed by the text in the reader's mind. (Bruner, 1986, p. 7)

Another researcher, a psychologist, in arguing for an integration of psychoanalytic object relational and social psychological approaches, has pointed out how researching human affairs involves also taking into account what is "unconscious"—as well as "conscious"—in one's view of reality in order to offset distortions on the part of the researcher (Westen, 1991) in addition to looking at what may be unconscious to the subjects being researched. At the same time, as the writer listened to how each psychiatrist told his or her story, the way that story was told also influenced the writer's interpretive frame, in a recursive, circular, dialectical process.

In Search of a Voice: The Revelation of Voices that Differ

To return to Belenky's study, she and her colleagues noted how frequently women of all backgrounds in their sample alluded to the idea of how important it was for them to realize they actually had a "voice," after feeling "voiceless" for most of their lives (Belenky et al., 1986). Brown and Gilligan, from their experience interviewing adolescent girls, have developed a methodology that allows for this variation, called "Listening for Self and Relational Voices," in an attempt "to recast psychology as a

practice of relationship (rather than a profession of the truth)" (Brown & Gilligan, 1990, p. 1) and in order for the reader to be

> responsive to the layered nature, the harmonics of psychic life, the nonlinear, nontransparent orchestration of feelings and thoughts, the polyphonic nature of any utterance, the symbolic nature not only of what is said but what is not said...[a]nd as a relational approach, attentive to body, relationship, societal context, and cultural framework. (Brown & Gilligan, 1990, p. 3)

Following the lead of Belenky et al. and Gilligan et al., the writer developed questions with which to analyze the data for voice, not only to understand the content expressed by the voice of each psychiatrist, but also in an attempt to understand through the themes what was explicit and what was implicit in each voice manifested in the interviews. We will see that one of the voices that revealed itself among psychiatrists at one end of the continuum was similar to Belenky et al.'s (1986) "separate knower," or Bruner's (1986) "paradigmatic mode," while the voice at the other end of the continuum was analogous or closer to the "connected knower" and the "narrative mode." We may ask whether there are advantages to each voice, in that each voice also represents a certain stance or relationship toward the environment/world, human or otherwise. We will examine whether the voices divide themselves along gender lines, as in the research cited above. We will also look more closely in the analysis of the data at how different psychiatrists may use different voices indicative of different kinds of knowing for different situations. As we will explore further when presenting the "voices" of the community psychiatrists in the sample, we must not make the mistake of thinking even that individuals within the same discipline necessarily speak with the same voice all the time. For the research into the psychological development of women and girls has pointed out that the same individual may speak with various voices even within the same text (Brown, 1988). We may ask whether in conducting psychotherapy, it is important for psychiatrists to be both separate and connected knowers, and to manifest different kinds of voices at different times during the psychotherapeutic process?

In preadolescent and adolescent girls, Brown and Gilligan (1990, 1992) decided to study a population where the relational voice was first present and was then conspicuous in its absence as the respondents matured and disavowed their own opinions or voices. These researchers attributed it to messages received by young women from a patriarchially based value laden culture. They show how these girls' voices change from age 12 or 13 to age 16 in their relative degree of authenticity. They appear to move from a position of knowing and expressing clearly what they feel to increasingly not knowing the older they get, increasingly given to "disavowal" (L. Stern, 1990). Thus we can contrast the early surety of these voices in terms of knowing who they are in relation to society with what they feel at a slightly later age. We build on this thinking in exploring the role of the relational voice among our psychiatrists, which we will elucidate in Chapters Six and Seven. As we saw in Chapter Two, there has been a tendency for community psychiatrists to be looked down on, considered "lowbrow" in the profession's hierarchy by their medical colleagues in private practice (Rogow, 1980, cited in Light, 1980), and there have there been no qualitative studies concerning community psychiatrists. Thus, we might wonder whether the voices of our subsample will reflect their feelings towards this disdain on the part of their colleagues, or whether, indeed, they feel like "lowbrows" (Rogow, 1980, cited in Light, 1980). We will look for this in Chapter Six as we listen to how these psychiatrists speak of how they relate to self, family, community, colleagues, and patients, as well as what they consider most challenging about being a psychiatrist. We will pay attention to the way that the psychiatrists position the self vis-à-vis others they relate to in their lives, and how much space they allow for the other to influence the interaction.

In the pilot interviews with Max and Lynn, the former appears to take a less vulnerable stance, or one that is less open to adapting its views vis-à-vis the client. He appears to have a way of categorizing the client and then operating accordingly from his point of view, or his truth. Thus, his view of reality appears to dominate. The latter allows the relationship to unfold in its uniqueness and appears to be more unobtrusive in terms of setting the parameters of relating (once the initial boundaries of the scheduled time and fee have been stated), and one has more of a sense of one person moving in relation to the other, reaching to understand the other, and avoiding premature closure or categorization. We will explore this difference further in Chapter Seven when we analyze the themes.

In analyzing the interviews for themes in order to flesh out psychiatrists' voices, another useful concept was the "relational model" of the Stone Center researchers which has also emerged in the study of female psychological development (Jordan et al., 1991). In this view, "the primary experience of the self is relational, that is, the self is organized and developed in the context of important relationships" (Surrey, 1991, p. 52). Surrey (1991) has summarized findings of several researchers, which indicate that women's development takes place in relation to others and that this affects their world view in several

areas, including moral choice. She points out that Miller (whose research concerning a "power with" orientation among women was discussed in Chapter One) was one of the first to call for a different model to describe women's psychological development in contrast to the prevailing model, which emphasized the importance of separation and individuation and had been based on research with males (Miller, 1976, cited in Surrey, 1991). Likewise, Surrey cited Gilligan's (1982) research, which revealed the "importance of women finding their own voice in order to describe 'ourselves to ourselves' " (Surrey, 1991, p. 52) and has indicated that women's experiences of connectedness to others leads to enlarged conceptions of *self*, morality, and visions of relationship" (Gilligan, 1982, cited in Surrey, 1991, p. 52). Gilligan and her colleagues had also identified a care orientation among women as a counterpoint to a justice orientation among men (Gilligan et al., 1988, p. 77). They maintain that "a care perspective highlights attachment in relationship, and that a justice perspective highlights issues of inequality" (p. 77).

Nodding (1984), a philosopher conducting research into moral development, amplifies on the concept of caring, noting that caring involves a kind of feeling with the other, for caring involves "feelings and affective engrossment" (p. 35) and is "rooted in receptivity, relatedness, and responsiveness" (p. 4). Where "both parties contribute to the relation; my caring must be somehow completed in the other if the relation is to be described as caring" (p. 4). Thus, caring involves reciprocity, and "our motivation in caring is directed toward the welfare, protection, or enhancement of the cared-for" (p. 24). Caring involves being attentive to the needs of the other and accepting responsibility—"the one-caring desires the well-being of the cared for and acts (or abstains from acting—makes an internal act of commitment) to promote that well-being" (p. 24). Furthermore, once one cares, one becomes vulnerable to the person one is caring about: "vulnerability is potentially increased when I care, for I can be hurt through the other as well as through myself" (p. 33).

A caring voice comes from the heart and allows us to counteract the "heartlessness" (Bruner, 1986) of a purely logical approach. To do justice to the psychiatrists' narrative mode as they tell their stories, the writer has chosen thematic analysis, which is then followed by a modified coding system to delineate themes and subthemes that will encompass a caring vs. a distanced stance (cf. charts in Chapter Seven). The writer's task has been, in part, to develop her own methodology that will allow for a lens wide enough to encompass a transcultural perspective while at the same time also allowing for focusing down to reveal the variations within even a single phrase spoken by a particular psychiatrist at a given moment in an interview. Such a methodological perspective again brings to mind the image of the eagle and the mouse. In addition to such a transcultural perspective, the methodology has had to allow for different stances toward the environment/world similar to Bakan's (1966) notions of "agency" and "communion."

Psychiatrists' Voices in the Pilot Interviews

Having examined these background methodological considerations, we turn now to the pilot interviews that the writer conducted with two psychiatrists, Max and Lynn, in order to test out the proposed interview schedule. Following the interviews, she read through the transcription of each interview several times in an attempt to discern patterns. This analysis was further informed by the idea that taking a transcultural perspective in relation to our culture's system of healing and healer education might be beneficial and illuminating for the reasons cited above. She therefore went back to the seven principles of education as transformation and applied this framework to the psychiatrists as she read through the transcriptions, asking some of the same questions that Katz did about healers in the Kalahari Desert and in Fiji, as well as her own question as to how healers might handle their own wounds in relation to their healing work: How does the healer relate to the healing power? How does the healer see him- or herself in relation to that power and where is that power situated—in the healer, the patient, or a power bigger than the self? What is the healer's relationship with the person who has come to receive healing? What is the healer's relationship to his or her family and community? What is the community's role in the healing process? How do healers and the community handle the abuse of the healing power, as well as rewarding proper use of that power? How does the healer deal with the notion of his or her "character" as it is understood in the education as transformation model—involving qualities such as "honesty," "judgment," "kindness," and "purity" (Hahn, 1982, p. 5). How does he or she deal with his or her own "vulnerability" in the process of learning and practicing healing? Are healers in touch with their own woundedness? And, if so, are they able to transcend and use it for the benefit of others in their healing work? Obviously, not all of these questions are addressed directly by each psychiatrist.

Nevertheless, these questions add some important elements to our attempt to listen to and learn from these interviews given the questions we have raised in Chapters One and Two.

Reading through the transcripts of the two pilot interviews for the first time with this transcultural perspective yielded much information but required multiple readings before the patterns that emerged coalesced into a control-connection continuum. After reading through the transcripts several times, the writer soon began to discern a basic structure—similar to the role that a skeleton plays when mapping the human body. Another, richer level of inferred meaning was added when listening to the tapes along with the transcripts several times. Many hours of listening to the transcripts while reading along allowed the writer to flesh out the skeleton more and more fully so that a sense of the individual self of each psychiatrist in the pilot interviews gradually emerged. Most important in the writer's own meaning-making was hearing the voices on tape, as it allowed for the richness of the words, tones, rhythms, and textures to unfold.

Following are some excerpts from the two pilot interviews. Through these, the writer will attempt to delineate, first with Max and then with Lynn, how she began to arrive at the notion of two very different "voices" through thematic analysis. As appropriate, the writer offers her understanding of the psychiatrist's meaning on the basis of context—for example, the fact that psychiatric professionalization entails learning a particular body of knowledge, such as psychodiagnostics and psychoanalytic theory. It is hoped that in so doing, any biases on the part of the writer, as well as the nature of her own context for interpretation, may be readily examined by the reader. Note that the writer's voice is included when it was felt that to do so would further clarify either the content or the way that the exchange unfolded. Wherever the writer's voice is introduced, it is given in italics with *"OLC"* preceding it; all other quotes are the psychiatrist.

In response to the first question of the pilot interview, "What do you do during a typical day?", Max states:

> During my professional life, my typical day has involved working with individual patients, couples, some groups, families, being at rounds,...having a case presented in front of fifteen people, being in administrative meetings.... So my typical day over the last twenty-plus years of professional life has been that of a clinical teacher, administrator, therapist.

Max thus begins by listing the varied aspects of the professional role of a community psychiatrist who serves as the director of a community mental health center and who thus has administrative, supervisory, and teaching duties in relation to staff members in addition to seeing patients in individual psychotherapy. Then, continuing with his answer to the next question, "What do you do as a helper?", he notes the multifaceted aspect of his role as a helper, from the pain of individual patients to the complexity of managing a 200-person mental health clinic. He also lays out the principles and values that he uses in carrying out his work:

> My helper role has had various facets, and it has been from one individual person struggling with their individual life history and...pain,...to being in charge of 200 people in a clinic,...which is different, and yet I try always to be in all of these situations, using the same principles. It's all the same—community psychiatry, administration, organizational dynamics. It's individual psychotherapy, not all the same but they <u>are</u> all the same in the sense that you want to be honest and forthright and decent and available.... The first thing, I suppose, remains the key—although whether you're talking about whether you should, you know, change the laundry for the patients, to how somebody felt about their mother when they were three—that's content, and I think the real teaching as a helper is in process.

Thus, for Max, who often refers to himself in the third person as "the helper" or as a more inclusive second person, "you," "the key" appears to be not only the content—which in this context might include such elements as the body of knowledge of psychiatry, psychodiagnostics, and psychoanalytic theory—of what one is teaching, but also "process"—the experience of relating interpersonally both consciously and unconsciously within and outside of the context of psychotherapy. Max continues:

> I think we are in every sense agents of anxiety reduction, and I believe Freud's classical second theory of anxiety, which is that [anxiety] is a signal of danger and that this is true of societies as well as for systems.... But the point is to make the organism move successfully towards adapting and mastering the passages.

Here, Max draws from specifics in psychoanalytic theory, illustrating that he not only knows basic Freudian theory but also is acquainted with what the writer would consider is a sophisticated level of knowledge of Freudian theory—the "second theory of anxiety" (Freud, 1926/1959b) was a later development of Freudian thought and indicates a certain depth of theoretical psychoanalytic knowledge on the part of the speaker.

Max also talks about teaching when describing what he does as a psychiatrist. He mentions several times in the interview that teaching psychiatric residents, social workers, and psychologists-in-training is part of his role as a psychiatrist, for he has taught psychoanalytic theory to psychiatric residents in medical school, lectured to social workers in a school of social work, and taught community mental health professionals of all kinds as a part of his role in the community mental health center. At one point he says half jokingly, reflecting the growing interest of psychiatrists in the neurochemical factors of mental illness:

> When I get silly or flip about it, I say my job is to open up the corpus collosum and the corticothalamic mid-brain gyrations, as is said these days, to help people get it all together, never mind function, whether it's a social organism, a family organism, an individual.

The writer, thus, was struck by the way that Max initially seems to convey an exactitude and level of certainty as he emphasizes his professional roles as a psychiatrist, administrator, and teacher of other community mental health professionals. This tone is one where the speaker appears sure both of his role in individual and group contexts and of the relevant body of knowledge in his profession. It is the tone of the expert. From the above excerpts, it would appear that Max values highly the theoretical knowledge of his field, such as interpretations of psychoanalytic theory, and keeping abreast of the latest developments. He uses terminology familiar to psychoanalysts. He seems to have confidence in his competence as a psychiatrist, especially in working with difficult patients: "I don't know anybody that does better work than me...with people who have been given up on by internationally illustrious leading lights in therapy."

On the other hand, Max is also able to convey a more caring aspect. For instance, he equates the kind of teaching he does with that of a parent:

> The helper is always a catalyst and he in one sense creates nothing, he's always a medium. The helper's job is...like parenting. I mean, what does Kahlil Gibran say about being a parent? What did whats-his-name, the guy who did the rhesus monkey—Harry Harlow—show about good mothering? For a while they play and then you push them off. Growing people up, being an educator, educate means to lead out...to lead out of darkness.

He feels very strongly that "helpers have to want to help, and have to be strongly motivated to help" even though "sometimes this is very tedious and painful and frightening work," and he deplores the attitude of "so-called classical analysts [who] talk about 'I don't care whether my patients do well or not, I'm here to do an analysis.' " Of these he says indignantly:

> I wouldn't send anybody to them, just to spend infinite amounts of money and expose themselves to suffering and humiliation and pain and hard work for an intellectual exercise, which is interesting for the therapist, [or] for the analyst, I don't think that's right.
>
> OLC: They have to care.
>
> It matters, yeah, it has to matter.

When the writer asks Max what the role of the helper is, he responds that "one of the most nonspecific things that every helper does, regardless of their orientation or their school of thought, is that they confirm the person's worthwhileness, and they do this, and I think that one of the skills involved in that is to do this in a way that is authentically convincing to the person...whom you are confirming." Continuing, he says:

> I mean, to confirm somebody when you don't know all of the unpleasant and nasty components of their personality makes them simply feel that you're soft-soaping them, and either you don't know who they are, or you're bulls___g them, or you're a fool. So it's very important for the person, the helpee, to have the experience of revealing themselves and revealing aspects of themselves that they consider unsavory and shameful to show....
>
> *OLC: To show all of the sides to somebody and still be accepted, still be cared for, still be understood?*

Yes.

Max also feels that "people are absolutely fascinating and interesting and lovable and complicated and heroic, and I really think that we are divine, and I find that in everyone—including myself when I'm okay," although he says that he is also "subject to losses of self-esteem." Thus, as the interview progresses, Max also shares about parts of his education and career where he has felt less sure, and there seem to be glimpses of another voice that seems more vulnerable: "I've also gotten burned, but fools rush in and I'm a fool and I accept that." He considers himself an "edge walker," or someone who does not always take the safest route; thus, "edge walkers and I recognize each other and I respect that. I believe in divine discontent." Elsewhere, Max speaks of that fact that "the assaults from the negative have been very strong" and shares that he has been "suicidally depressed and I've given up, but I'm here, so obviously I have not given up." Later, he says that he'd "like to come in from the cold," and as the writer is about to ask him what he would wish for in so doing, he interrupts, saying, "Love, I want love, I want support and I want...to be known, and I want a community."

This willingness to speak of his own failures and shortcomings is also evident as he speaks of his divorce. Max tells the writer that he had been married for fifteen years to his childhood sweetheart, with whom he had had three children. In speaking of his divorce, which he describes as "the most traumatic event of my life," he admits that "I didn't know—yes, I did know but not in the same way, not as dramatically, not as obtrusively—how angry I could be, how vengeful, how malevolent, vindictive,...that combination of intimacy and malevolence. It's very shocking for anyone who goes through it. I think it is really quite horrible."

When the writer then asks him how he has coped with this experience, he replies "that is a test. What happens with that test, I think, I mean, eventually it becomes a source of strength and awareness and humanity and breadth...that you may take humility along with your grandiosity" (p. 44). He then ties this in with one of the "occupational hazards" of becoming a healer—becoming "arrogant [about] the specialness" of that role.

In terms of his practice of psychotherapy, he notes that "it is a help to be present when somebody is feeling tough feelings. It really makes a difference, and in that sense I have always been helpful." At the same time, however, he can acknowledge that he has not always succeeded in being present in the sense of being there with his patients and empathizing as they experience "tough feelings": "I don't mean that I haven't been unkind to patients or been absent or screwed up with my own preoccupations and made countertransference errors, so there have been times when I have not been helpful. There have been times when I've been unhelpful."

Later on in the interview, when the writer asks him what he would tell psychiatrists-in-training was the most important thing to learn in order to be an effective healer, he replies:

> I would want you to have an experience of your own in discovering yourself.... I'm not saying it has to be an analysis, it can be any form of learning experience where you do attempt among other things to articulate in words somewhere along the lines what you are learning...insightfully, and to come to grips with the resistance of that, the pain.

Max, who was fifty-seven at the time of the interview, was the middle child of three in a Jewish family and spent his earliest years in Germany in the 1930s, until his family emigrated to the United States prior to World War II. He describes his father, who had been a socialist, as a "freedom fighter" who initially underestimated Hitler and thought that the forces of democracy would never let him remain in power. Max remembers at the age of seven vehemently disagreeing with his father's benign assessment of the political situation. Nonetheless, he felt that his family were bonded together against a common enemy "outside the gates": "I was not brutalized by an alcoholic father who was violent unexpectedly. The enemy was outside the gates." Given his background, it is not surprising that the world view he describes even at the time of the interview is a dangerous one where one must always be on guard in order to survive, where one lives in "the consciousness of danger, the consciousness that it's a dangerous world, that things can blow up." Thus the writer noticed that Max mentions several times the need to be on guard against the CIA and fascism and a fear of being "controlled" or "brainwashed by a fascist state," especially in the United States.

Max describes himself as having been "shy and moody," yet "people always spoke with me and shared their hearts with me, and I was always good at helping them and I always enjoyed it." Both parents, who were deceased at the time of the interview, had been psychiatrist/analysts, and he was the only child to follow in their footsteps and become a psychiatrist. However, he makes a point of saying

that he became a Freudian psychoanalyst to rebel against his parents, who were followers of one of Freud's original analytic circle who had broken away from the founder.

After emigrating from Germany, his family had settled in an eastern state, where he had enjoyed going to a progressive private high school where everyone called the teachers by their first names and where his biology teacher, in particular, had impressed him with the creative way in which he had "wiggled like a paramecium" to teach the class about this microscopic creature and had sparked Max's interest in medicine. He had then gone on to a private New England college with a reputation for excellence where he studied literature, and then had gone on to one of the best medical schools in the eastern United States, where he had found himself "surrounded by people who had been chemistry majors from Dartmouth and stuff like that." He felt that "they took a chance on me, but I wouldn't have been able to take that chance if I hadn't remembered that I loved biology."

Max had decided to become a doctor because he "wasn't a good enough writer," nor was he quite good enough in other creative areas that he enjoyed, such as singing, painting, dancing, and acting. Yet he feels that he "could have been a contender in all these areas" and expresses some "sadness" at the fact that there was "a whole creative, hysteric side to me which in another world, in another life" he might have been able to express, had he not become a psychiatrist. He also chose to become a doctor "in part because I felt that if there was going to be another war, they'll always need doctors," and he wanted a way "to earn a living and have a work role which would survive disaster." As to his choice of psychiatry specifically, Max states that "I wanted to know myself more, I wanted to understand the world more,...and I needed to understand the dark side of life." Part of this involved "my own awareness of my own black side, my anger, all of that," and part was the desire to understand that of others. For instance, he describes how he went back to Germany after the war and sought out a German veteran in a beer hall to hear the latter's point of view about the war, for "it was more important to me to understand and to listen than to argue with him at that moment."

After completing his training in psychiatry, he also trained as an analyst at an analytic institute. After conducting a private practice in New England for several years, he had moved to another New England state and had served as director of a community mental health center for five years because he was "trying...to use my skills in a place where they could make a real difference, not just a teaching hospital [where] there's so many bright people and you really feel like you're not making that much of a difference." He had resigned this position a few months prior to the interview and resumed his private practice.

Max speaks of the need to compete in psychiatry and recalls having been disappointed once when he had been turned down for a department chairmanship. He is "always scrutinizing [his] work...[while gauging] whether I have been accepted by my colleagues, whether I'm getting referrals...[and] all of the realistic things." He also notes that he has experimented with less orthodox forms of therapy and because of this has "felt more like an outsider in the Establishment world which I have been both barking at and they're very ambivalent about me and I'm ambivalent about them."

Max feels that "helpers are always reflecting their culture" and that this "will be reflected in their actions, so to have somebody lying on a couch quietly, not in visual contact, and [where] the means of communication [is] only auditory is very different than [when] the means of communication [is] visual, kinesthetic, somasthetic, gustatory, tactile and intuitive." He prides himself on the fact that he has begun to explore other holistic models of healing, thus widening his horizons beyond the allopathic model.

He sees psychiatrists as "advocates of free speech" in the most profound sense in that "nothing human in you should be alien to you." Thus, "if you were an administrator and a teacher, your eyes should be open enough to see it all and to deal with the dynamics of the group or whatever it is." He feels that the role a psychiatrist plays concerning the "social responsibility issue...is very heavy and I think we are dangerous people in that sense [in that] that's a very important part of the helper thing, that can be used for power and stuff and rationalized." He thus emphasizes the power of the psychiatrist over others, in being able to decide another's fate, although he points out that the actual body of knowledge in psychiatry is "morally neutral," comparing it with the discovery of nuclear energy. He believes that "the means and the ends are related—one does not justify the other." Yet he shares how he once had an argument with his psychiatrist/analyst mother because he told her he would never turn a patient in, even if he knew that person was a murderer.

During the course of the interview, Max spoke quickly, gave very long answers, and jumped from subject to subject in an associative manner in a way that was sometimes difficult to follow. It also was difficult to stick to the order of the questions on the education as transformation pilot interview. The writer recorded in her notes at the time of the interview that she felt overwhelmed by the voice of the

expert and the amount of didactic information and terminology at times, and that she felt challenged to keep up with him and to try to follow his psychoanalytic allusions. She thus found herself listening attentively for content as well as process, to be sure that she could follow his meaning. At the same time that it was interesting to match wits, the writer felt breathless at the end of the interview, as if she has been running in order to keep up with Max's highly associative train of thought. Later, however, each time that she reread the transcript or listened to the tape, she experienced more and more how there was a vulnerable side to Max, which moved her, after she had initially been put off by his more distanced, didactic style.

In the second pilot interview, with Lynn, the writer found herself feeling more comfortable and relaxed in response to Lynn's style, listening and understanding and associating to her own experiences as Lynn spoke. The writer could easily identify with Lynn, utilizing her own experience with patients to determine what questions to ask or how to understand what Lynn was saying. She found herself waiting intently as Lynn searched for words to convey the process of relating, rather than merely focusing on the goal of treatment. Although the writer asked the same questions as she had of Max, she was struck by the different way in which Lynn responded.

In answer to the first question, "Tell me what you do and how you do it on a typical day?", Lynn answers,

> Well, that's an interesting question, what I do. A lot of thoughts come to mind. Initially, I was going to say that I take care of people in a certain way. I help them to do a number of things: to learn about themselves, to get better, to recover from illnesses...for which they've come to see me.

Lynn thus immediately introduces the notion of being in relation to the other. In addition, hers is also very obviously a caring voice. The writer was struck by how Lynn immediately introduced the notion of taking care of her patients, whom she calls "people" rather than "patients," and that she also mentions how she helps people "to learn about themselves." She goes on to introduce the notion of relating:

> I help people to learn how to have relationship with themselves and other people, how to first know what it is they want in life, and then perhaps how to find out how to get it, but I think probably the focus is mostly on relating—self-relating and other-relating.

Thus, in answer to the first question, Lynn immediately brings up the subjects of helping and care, of learning about the self, and of relating. But unlike Max, it should also be noted that Lynn had not had administrative responsibilities for some time, having been forced to give up her work as a director of a public health center in the public sector fifteen years earlier due to health problems. Thus, it is not surprising that she would focus on different aspects of her role than Max, who had only recently ended his tenure as director of a community mental health center a few months prior to the interview.

Lynn continues:

> I've never been one who's gotten terribly interested in diagnoses; I don't spend a lot of time figuring out what the diagnosis is. I probably wouldn't do it a whole lot except for insurance forms, and in certain situations where one needs to know what the diagnosis is because of a specific problem, something of that sort.

Thus, still in answer to the first question, Lynn downplays the importance of arriving at the proper diagnosis or in utilizing psychodiagnostic terminology except when receiving insurance reimbursal for her patient or when prescribing medications. She then introduces the idea of helping the patient to "have meaning" and again mentions helping the patient to "have relationships":

> But in [the] situation [of a specific illness], it's helping people to get better from an illness, but almost always, as part and parcel of that, there's what they want in their lives… is to have meaning and to have relationships. That's really, as I think about it, very much what goes on.
>
> *OLC: How would you say you do that?*
>
> That's such a hard, hard question. I do it on so many levels. I guess the initial kinds of levels are both cognitive and emotional, and they go together. Cognitive learning and taking in and gathering information and sorting it out and understanding it from a psychoanalytic point of view, a theory point of view, and from a diagnostic point of view in terms of illness.

She thus points out that what she does with her patients involves both cognitive and emotional levels and that "they go together." Thus, it would appear that it is difficult for her to separate the two levels, in that she is continually making use of both. She makes use of her knowledge of psychodiagnostics and psychoanalytic theory as a background for helping people to get better from illness, but she finishes her answer in emphasizing the importance of relating:

> What I do, I think, that really helps is to make a relationship with people. I think you can do most anything if you have a relationship, and a lot of work goes into making a relationship. Once you make it and when it's there,...in the process of making it that a lot is learned, but when it's made then you can teach people.

Lynn goes on to talk about the importance that teaching has for her, but it is interesting to note that it is teaching about relating and relationships that she emphasizes rather than teaching in the more usual, academic sense:

> I teach all day long. I teach people about how to look at themselves and then I teach them how they're relating to me and how I'm relating to them and what it's like.

Thus, what she teaches is how to "make a relationship," and this is a two-way process involving self-awareness and awareness of the other on the part of both participants.

Lynn remembers how she had struggled to remain "human" while in medical school: "when I was in medical school...it was a very competitive place, and I said I want to come out of this a decent human being. I don't want what I see around me to happen to me." When the writer asks her to explain, Lynn replies, "It felt to me awesome that there was a disregard for the patient in the service of learning," especially at Grand Rounds:

> They would wheel this poor patient down in his bed with all his damned IV's going and tubes in every orifice and they would pack this poor person down in the elevator and wheel them in so we could see that there actually was a patient. I never understood why we had to see this poor soul, and then the person to whom the case had been presented would go over, you know, and lay his stethoscope and listen and that was it. I mean, I never understood why this person had to go through this.

Lynn thus feels that an important ingredient in helping someone is "being able to be human—being able to be who you really are is very important."

Lynn was forty-eight years old at the time of the interview and had been living in a committed relationship with another woman for several years. She was conducting a private psychiatry practice and a majority of her patients were women. She had grown up as an only child of working class parents in the Midwest, but as she was part of a large and close extended family, she did not experience herself as an only child. She spent a great deal of time with and had sibling-like relationships with her younger female cousins, and she described having had close relationships as well with her maternal grandmother and three aunts, who all taught her different things, although her relationship with her own mother was more strained. When one of her mother's sisters became ill with cancer and had come home from the hospital to die, the entire extended family had returned to participate in the family event, even those relatives who had moved out of state. Lynn described this event as "an incredible experience for all of us and an incredible experience for me to see how families can come together like that."

Lynn had decided in high school that she wanted to be a doctor but had been told by the guidance counselor that she would not be smart enough and that she should try research in physical education or physical therapy instead. Fortunately, he had sent her to talk with her biology teacher, who contradicted the counselor and told her she should go into medicine immediately when he saw her heart was not in PT. In reflecting on her decision, Lynn "come[s] back to something inside of myself that seems like it was always there.... It really is something inside of me that I really always wanted to do and I wanted to do it in a way that I could combine all the things that I really liked and I really enjoy doing." This stands in contrast to Max's more pragmatic reasons for becoming a doctor.

At the time she had received little encouragement from her mother, who responded to the news by saying "Pass the potatoes," while her father had responded with "Great!" However, she described her parents as given to "reach[ing] out and tak[ing] care of people," especially those who were "less fortunate." She thus remembers both parents serving as models for her because they were "always aware of people who could be helped one way or the other."

Lynn was one of three women in her medical school class and excelled such that she became the first female pediatric resident to head a certain community health center. She chose to become a pediatrician, initially, and enjoyed her work immensely. She developed skill in determining what was wrong with babies, and she attributed this in part to the fact she was a woman. She also had the positive experience of having her male colleagues respect this intuitive knowledge. She used her position of authority to modify the waiting room hours so that her patients and their families might not have to wait needlessly for the doctor. She also required that all staff be dressed appropriately and recalled with amusement how she had enjoyed making the men wear ties in order to boost patient morale.

Lynn would have happily continued as a pediatrician, but she had fallen ill fifteen years earlier of a debilitating disease that had prompted her to go into psychiatry when it became too physically demanding for her to continue in pediatrics. This illness, however difficult, nonetheless allowed Lynn to gradually let go of some of her preconceived notions about what she needed in order to heal herself and to try a new approach to healing her debilitating illness, one that did not "make sense" within an orthodox allopathic framework. Her words remind us that we are perhaps most vulnerable when we fear for our survival, and illness causes us to confront these fears. In the interchange below, we see how Lynn recognizes that allowing herself to be vulnerable in relation to her illness has not only helped her to accept alternative ways of helping herself, it has also given her deeper insight into the suffering of her patients and how to help them. Not only is she vulnerable in learning how to ask others for help, she is also vulnerable in being able to allow her allopathic conception of disease to be supplemented by another more holistic approach that comprises another world view:

> *OLC: Would you say that there are any particular life experiences that have affected your ability to help others?*
>
> My own illness has really had a profound effect on my being able to help others, because I had to learn how to heal myself, with help, which wasn't easy for me to do. If I could have done it alone, it would have been great in terms of my style, but I had to learn how to do it with help. And that has had a real profound impact on my seeing how other people want/do not want, need/do not need to be helped and are ambivalent about it.

She describes how she healed herself with the help of a somatic educator, Andrea, utilizing the FELDENKRAIS METHOD®, who taught her how to regain her ability to move without pain. In this process, she had to overcome her own self-doubt, especially about using a different model based on assumptions she could not rationally explain: "I felt really dumb because I couldn't explain it. I had no rational reason why I was doing it. I was doing it on pure, unadulterated faith." But the proof was the fact that it worked, and she describes how this became clear to her when, one morning, she could once again reach up and turn off the alarm without pain. She also remarks that a friend had to point out to her that she was now walking and standing with better balance. She marvels at how she was able to let go of control of the process of regaining her balance, in a way that was uncharacteristic for her, but indicates that this was a necessary part of the process:

> *OLC: So all of a sudden you were healing yourself?*
>
> Yeah, it was just happening.
>
> *OLC: Even though you felt dumb.*
>
> Yes [laughing]. And I couldn't direct it and it wasn't under my "control" and it was just happening! It was the most incredible [thing] [she continues to describe the small "infinitesimal" movements Andrea had taught her to do].... I'm telling you, it was just a little bit of movement.

What she believes brought about her healing was, in large part, her own self-disciplined "style," such that she followed her teacher's advice and did certain movement repatterning exercises "faithfully" and consistently. But Lynn also emphasizes the important role that the relationship with Andrea played in her healing:

> And much again comes to relationship, [for] it was the relationship with Andrea and this sense of being able to feel like I could trust her...[as well as] a willingness to do it [according]...to my own style, which is to be disciplined.

> *OLC: And her patience and empathy, it sounds like, or her ability to know what you were feeling and know not to take you too far. Is that also part of it in terms of her being a helper for you, you know, in knowing when to stop?*
>
> Oh yeah, she's been an incredible role model for me. Yeah, her ability to be tuned, to know, she fed me just the right amount as we went along. And not too much, and sometimes even when she fed me enough, I would spit it out. But she knew what to give both in terms of the movements and everything else, and to allow me at the beginning and for some time to feel as much in control as I could, because I was so much into that. Because the more I lost, the more I sort of clamped down and tried to be in control and tried to figure out some way to make it better, and of course, the worse it got. It was just the whole wrong approach to what I was doing.

But while this one relationship was of central importance, she also learned more clearly during this time that her relationship with her therapist—"a senior kind of person," a psychiatrist/analyst whom she was seeing "intensive[ly]" twice a week—was not helping her. In fact, being in therapy with this person "was making it worse. It wasn't helping. It was making it much, much worse."

Lynn feels that her illness has improved her ability to help others help themselves in their own unique way:

> It's helped me to be aware, as I have healed, it's certainly helped me to be more patient, but more than that it's helped me to be aware that people don't necessarily do things themselves on purpose, they do it because they're not aware, and they need help to become aware. And I guess...I've learned a number of things, many, many things. One of the things I've learned is that you just never know where things are going to go with people.

Thus, she explains how "sometimes the people that you think are just going to move ahead and do all kinds of things just don't seem to do that, and other people you think, no, this person's just not going to do that well in therapy, and they do. They just take off and do all kinds of things." Thus, she "has learned to respect whatever it is in a person that's there that they bring to the situation to be able to heal themselves."

She goes on to describe a certain kind of shared responsibility or power that occurs when therapy is working. Here she uses the example of a woman patient suffering from panic attacks who learned to take responsibility for her own healing when Lynn did not offer the advice that led to the patient's improvement. Lynn describes how her patient, after discovering a chiropractor on her own who had helped her to relieve "the pressured feeling in her head," was "a little annoyed [with Lynn] because I hadn't known that this might help and sent her [myself]." Lynn had told the patient, "My job was to help you to get to the point where you could do this yourself." Thus, Lynn concludes that "what I do is I try to find or I try to help the person, [or, rather] both of us find (because I think we both have to find it instead of just her or just me) that place in themselves where they can find strength, their own power, their own authority to do what it is they need to do."

Lynn tells how she experiences herself teaching in a particular way where again "we have to do it together" when she gives the example of a woman with a "very narcissistic personality" who "has learned how to relate," although she remains narcissistic "because people really didn't relate to her" in her early development. Lynn feels that her patient is "entitled, but it's more from [the fact that] people didn't really teach her how to relate and so she's at the point where she's aware now [that] she wants things from me, so what she does is that she says, 'Well, I need this. Do it.' She says to me, 'Do it,' and I sa[y], 'Look I'm not a soft brain machine...I can't just do, we have to do it together.' " She concludes, "What I learned from the whole process is that she thought that I was withholding and that I was deliberately withholding—I wasn't giving her what she wanted, and what she learned was that it is a two-way proposition, that we had to work it out together." In teaching this woman, Lynn also finds that "bring[ing] a little bit of humor into it, because she's got a good sense of humor,...lightens it a little bit. It's a way to teach, and by teaching her in that way then she can take it in, she doesn't have to spit it out at me."

Lynn believes that she has come to rely more and more on a noncognitive, nontraditional, nonacademic kind of knowing, in addition to "a body of information that I know, that I can call upon," which is "emotional awareness, emotional intuitive, I think there is an intuitive kind of awareness that I go on." This kind of knowing sometimes surprises her as well as her patient:

> It's hard to find words for this...feeling, there's a quality to what's going on and a feeling of what I'm feeling in response to what they're doing, to what I'm picking up from them, what goes back and forth between us as to what's happening, and sensing that and knowing that and working with that is very important. And it's attending, being tuned, being there...being tuned in, if you will. Being there, being aware, knowing this person over time or coming to know this person, coming to sense what the movement means, what the affect is I'm picking up, how they're saying whatever they're saying—it's more than theory.

This particular kind of knowing thus comes from a kind of attunement, or "being tuned," and involves a kind of movement in relationship that changes depending on the affect generated between them. As Lynn continues trying to describe this unique kind of knowing, she is at a loss to discover exactly where it begins and ends, conveying a sense of circularity and recursiveness in the dialectical movement between them:

> There's a way of being focused, being very much there.... Where's it coming from? Is it coming from me, is it coming from them, what is it? I don't know that I get into an altered state per se, although it's different, I guess. It's certainly not what I do when I pick up the phone. It's a different state.
>
> *OLC: Maybe not altered, but a different state?*
>
> Yeah.
>
> *OLC: I mean when you say altered, what does that mean to you?*
>
> Actually what I think it means is not so present and I see myself as being more focused and trying or just being present, being tuned in, if you will.

Although she experiences this as a different state, she is not sure that she would call it an "altered state," and yet as she speaks, she conveys the sense of some power to know that grows out of the interaction when she is "intuitively attuned," and although it does not feel to her as though it comes from her "left brain," it also does not come completely "devoid of that," but, rather comes from some "mixture"; moreover, it is a "very important" kind of knowing:

> Sometimes I will say something and I could surprise us both. Like it comes, it comes out of being intuitively attuned or whatever to what the patient is feeling or saying or wherever the patient is, and it's not, I know it doesn't come from the thought process necessarily in my left brain. It doesn't come devoid of that but it comes from some mixture of what I've intuitively picked up, and that's an important ingredient.
>
> *OLC: So it's like, so as you say, it surprises you when you say something, when you come from this other region of your brain, whether it's right or left or whatever, but it's a different kind of knowing?*
>
> Yeah, it's a knowing that I've not trusted initially. It wasn't the usual kind of knowing that I know about. It's not cognitive, I can't always write it down or call it up when I want to and it's not something you can always validate, it's not traditional, academic kind of knowing, intellectual kind of knowing, but it's very important.

She realizes that she first became aware of using this kind of knowing as a pediatrician:

> And then there's this sense, this awareness that you get that is not that at all. As a pediatrician you look at a baby and you know because you know and it's partly because you've had experience, but it's because you have developed a part of yourself that you can look at that baby and say this is a really sick baby.

After the writer interviewed Lynn, she had written in her notes to watch for whether other psychiatrists she would interview would also refer to this special kind of knowing and characterize their interaction with their patients as a kind of movement.

Thematic Analysis of Max and Lynn

We turn now to an examination of the themes that emerged from the two pilot interviews, bearing in mind the literature that we have cited above. Of the two interviews, one voice, Lynn's, appears

to be manifesting a "relational" (Jordan, et al., 1991) stance to the world, first of all in relation to the self and then in relation to others, including community and, at some points in the interview a power greater than the self. Instead of striving to be separate, the psychiatrist is talking about connecting with the self, with another, or with a power that is greater than either the self or the other individually—the relationship itself. This is a Western translation of one of the education as transformation principles—appealing to a power greater than the self—but unlike education as transformation, it does not imply having to appeal to God, or a god. For instance, we will see this in the example of Harriet, who values highly what she thinks of as her egalitarian relationships with her patients, who are battered women (as she was), and makes a point of telling the writer that she does not "genuflect" to anybody.

The other voice, Max's, manifests a greater sense of expertise and of separateness, although with additional readings, the writer increasingly felt a sense of that psychiatrist's vulnerability and willingness to share as well. These were the most strikingly obvious differences noted, but as the interview process continued with the sample and all of the interviews were reviewed, additional juxtapositions began to emerge. Ultimately, the writer extrapolated a continuum, with the voice of "control" at one end (which in many ways is analogous to Bakan's "agency" orientation) and the voice of "connection" at the other (which might be seen as similar to his "communion" orientation [1966]). Additional juxtapositions fell into place as subthemes under these two main headings, and the writer argues that these can be compared to the principles of education as transformation and can be viewed in relation to the relevant literature that we have discussed in Chapters One through Three.

Thus, it is the writer's opinion that it is possible to compare Western psychiatrists with healers educated according to the principles of education as transformation healers, as Katz has suggested (1981) and arrive at similarities as well as the obvious differences between healers of such different cultures and cultural world views. Through the method of grounded theory (Glaser & Strauss, 1967) the writer extrapolated the following themes and subthemes based on a combination of the principles of education as transformation and the ideas and experiences related by the sample of community psychiatrists: connection/control; transitioning developmental path/hierarchical developmental path; connected self (self-in-relation, or relational self)/separated self; connected knowing/separate knowing; permeability of boundaries/impermeability of boundaries; movement in relation/movement to deflect; vulnerability/invulnerability; power with/power over; the teacher as healer/the healer as expert; the healer as moral explorer for/despite community; and synergy/scarcity

Following is an example of how the writer was able to compare a quality found among healers in the Kalahari and Fiji with a quality that Lynn manifests. We have seen how vulnerability in both the Kalahari and in Fiji is a part of the healer's power. To regulate and continue to dance with the boiling n/um is a risky, painful process, and finding and staying on one's straight path may place the Fijian healer in situations where his or her own community's very survival is at stake and where confidence in his or her ability to help, or even to have the right to help, hangs in the balance. Yet in these cultures, sharing one's vulnerability with the community one is serving is an essential part of the process of gaining and maintaining access to the healing power. As we begin to compare Western psychiatrists in our pilot study with our traditional Ju/'hoan and Fijian healers, we find a similar subtheme of vulnerability in the words of Lynn not only in terms of her humble stance vis-à-vis her own command of the healing knowledge, but also in her ability to adapt her healing model to encompass new approaches to healing for herself as well as her patients. As Lynn talks about her pain—in having to give up pediatrics and in having to come to grips with the fact that her relationship with her own psychiatrist was not helping, but was even making things worse—the writer feels included, as if looking together with Lynn and identifying with her pain. With Max, although we also hear something of a vulnerable tone, especially when he discusses his painful divorce and professional setbacks, it felt to the writer during the interview that he was holding himself apart as he talked about his pain, almost as if he were observing his own case, as with one of his patients. Thus, we see the concept of vulnerability—so much a part of the education as transformation model—with both of these Western psychiatrists, but while it is present in both, there are differences in the way in which it manifests itself.

Below are summary charts for Max and Lynn, with the writer's intuitive empathy ratings and analysis of the subthemes (noted above) that are present under the main themes of connection and control. Similar summaries, with additional information regarding the relative presence or absence of principles of education of transformation, will be found in Chapter Seven for each of the psychiatrists in the subsample.

Elements Present: Max

Connection	Control
(1a) Mind connected with body	
(2a) Developmental path/transitioning	
	(3b) Separated self
	(4b) Separate knowing
(5a) Permeability of boundaries	(5b) Impermeability of boundaries
	(6b) Movement to deflect
(7a) Vulnerability	
	(8b) Power over
	(9b) The healer as teacher
	(10b) The healer as moral explorer despite community, or does not view self as moral explorer
	(11b) Scarcity

OLC'S intuitive empathy rating (high/medium/low): Low to Medium
Mehrabian and Epstein emotional empathy score: None (Pilot)
Summary: Max was scored with a low intuitive empathy score by the writer. Her impression was that although his intentions to be empathic were clearly stated she felt that his preoccupation with his own concerns, and his tendency to verbalize them, as well as his tendency to talk a lot, might make it difficult for him to provide a silent empathic unobtrusive presence. She felt that he also might inundate his patients with theory. Max manifested seven subthemes of the voice of control. The writer had initially thought that he would be by far characterized by control predominantly, but as the interview continued, she experienced his expressing a more vulnerable tone especially when discussing the pain of his divorce, which still apparently lingered even though it had taken place several years earlier. Max also expressed vulnerability after suffering some professional setbacks, such as when he did not win a department chair. His propensity to be an "edge walker," where he would go against what the community dictated/expected in order to follow his own judgment, was exemplified when he argued with his mother over the fact that he would not betray a patient's confidentiality, even if he or she had confessed to murder. Also, Max did not ally himself with the government, which he experienced as "fascist." He was scored for permeability, as he mentioned trying different approaches to hypnosis and reported that he was able to influence patients, colleagues, etc. by pacing and modulating his voice, thus indicating an openness to others' world views, yet he was also scored for impermeability due to the consistent way throughout the interview in which he viewed the environment of the United States as fascist and his fear that the CIA was after him.

Elements Present: Lynn

CONNECTION	CONTROL
(1a) Mind connected with body	
(2a) Developmental path/transitioning	
(3a) Connected self (self-in-relation)	
(4a) Connected knowing	
(5a) Permeability of boundaries	(5b) Impermeability of boundaries
(6a) Movement in relation	
(7a) Vulnerability	
(8a) Power with	
(9a) The teacher as healer	
(10a) The healer as moral explorer for the benefit of community	
(11a) Synergy	

OLC'S intuitive empathy rating (high/medium/low): High
Mehrabian and Epstein emotional empathy score: None (Pilot)
Summary: The writer rated Lynn with a high intuitive empathy score. Lynn manifested all eleven subthemes of connection, and one of both control and connection—"impermeability vs. permeability." An impermeability score was also received because of her describing having had to learn to set firmer boundaries with her therapist after she experienced the relationship as making things worse. Lynn views herself as trying out new approaches to healing and acting as a bridge or liaison for her professional community to point them in the right alternative direction. Thus, she was scored as "the healer as moral explorer for the benefit of community". The writer felt that Lynn's having grown up in a large extended family with whom she still maintains contact might have contributed to her relational view even though she herself did not have any siblings. The writer experienced her as highly empathic, and felt that, most probably coming to grips with her own illness had probably made her more empathic with her patients. The writer resolved to add a more reliable empathy instrument in the subsample and sample, after her intuitive empathy ratings seemed to jibe with what she had expected (cf. background assumptions).

Vulnerability in Research

Although truth, "narrative" or otherwise, exists, it is relative, subjective, and contextual, despite, as we have seen, the earlier Newtonian "logico-positivistic" scientific bias to the contrary. This is true even of the "truth" in research. We know from the fieldwork of Katz and others, for instance, not only that the researcher must present the truth very carefully, but also that getting to know this truth involves the researcher's being "vulnerable" vis-à-vis that which is being researched (Katz, 1986, 1987). Katz recounts how it was only through acknowledging to one of the Fijian healers his own feelings of vulnerability—specifically, his uncertainty both as to what was "true" as well as to what was appropriate to share with another culture—that he himself gained access to more esoteric aspects of Fijian culture than he had already been entrusted with (1986). Katz's own experience could, in a sense, be described as the researcher as "moral explorer" (1993) in that he continually struggles in his attempt to share with the Western world, in an appropriate manner, one non-Western culture's view of the truth.

When Katz first arrived with his family to live for a period of two years to study community healing systems among the Fijian villagers, a senior healer in Suva, Ratu Noa, was approached by Katz to be interviewed. In the process of talking with Katz, Ratu Noa made the request of Katz to "tell [the Fijians'] story," stating that they wished him to "help in the revival of traditional Fijian culture because it will reveal what is missing today in our own lives" (Katz, 1993, p. 7). As a result of Ratu Noa's appeal, Katz chose to write about the Fijians, pledging to "recognize the value of their knowledge in our lives [and to] affirm the dignity and value of the land and people from which that knowledge grows" (p. 7). He hoped that his research would ultimately benefit the people whose ways he was studying, rather than simply intruding upon and perhaps even disrupting those ways, as has been the case with much anthropological research (1993).

Coming from the professional background of a Western psychologist and anthropologist, Katz at first looked to Ratu Noa, the healer, as an authority to give him permission and to tell him exactly what information he should share. In an earlier paper, "Hearing Healers: The Contribution of Vulnerability to Field Work" (1985), Katz writes of how, at the end of his two-year stay in Fiji, he explicitly raised the question with Ratu Noa that they had, less explicitly, "covered in many other ways":

> "When I get back to America," I ask, "how will I know what it is proper to talk about and what it is proper to remain silent about?" Ratu Noa replied:
>
> "Your responsibility is to tell the truth about our healing work and in that to help others to learn. Tell only what you know, and that will always be enough; tell more than you know, and that is too much, only exaggerating your own importance. You must also put what you know into practice. Now you have been here almost two years. We have stayed close to the yaqona. Trust yourself and be straight. If you follow the straight path, you will know what to say and what not to say. If after all this time you have not learned what to say and what not to say, just talk about whatever you please because your speech will have no value anyway." (Katz, 1985, p. 22).

(The reader is advised to refer to Appendix A, "Respect and vulnerability in research," in The Straight Path [Katz, 1993], where much of the same material as the above and what follows is covered. The writer chose to elucidate the concept of vulnerability in research with this earlier paper due to the quantity and richness of dialogue given in the interaction between Katz and Ratu Noa.)

Six years later, he returned to the Fijian village, still anxious to be sure that he was not sharing wrong information with the outside world and wishing to be absolutely certain before releasing the information in the form of a book about "the straight path," the Fijian way of educating its healers (Katz, 1993). Reiterating his earlier advice, Ratu Noa also reminded Katz that he had, in fact, stayed on the straight path during the intervening years by following the principle of dauvakanida—telling and living the truth—and he received the healer's permission, or blessing, to tell the Fijians' story as he saw fit: Ratu Noa stated:

> "I've established the truth of what you are writing about, including our conversations and the events you describe. All that remains is your own truthfulness in the writing—and I know that you are being truthful as you are struggling to follow the straight path." (1993, p. 7)

Opening oneself to meaningful interaction with one's research subjects, as Katz was doing with Ratu Noa, can lead to moments of extreme vulnerability, of which there are several kinds. One sort is that of confronting the relativity of one's own conception of reality, a process that entails truly entering into the world view of the people under study. For instance, Katz's concept of reality was shaken to its foundations numerous times as his own cultural world view appeared to clash with that of the people among whom he was living (Katz, 1986). At these moments, such as when participating in the Ju/'hoan healing dance or being ostensibly in the presence of a Vu, or Fijian God, Katz found himself encountering what Welwood has described as

> moments of world collapse...when the meanings on which we've been building our lives unexpectedly collapse. When an old structure falls away and we don't have a new one to replace it, we usually feel a certain inner rawness. That kind of tenderness and nakedness is one of the most essential qualities of our humanness, one which we are usually masking. (Welwood, 1983, pp. 148-149, cited in Katz, 1986, p. 2)

Katz describes one such experience that occurred during his two years of fieldwork in Fiji (Katz, 1986). Upon asking a healer whether he and his Fijian research associate could speak with her about her work as a healer, she responded, in what Katz experienced as "a matter of fact tone," that "it all depends on what the Vu (traditional God) who is the source of my power says." Katz recalls his reaction as the healer then entered a state of possession:

> And immediately the signs of her possession began, with the twitching, the sweating, the grimmacing *[sic]*, and the exaggerated angularity of her movements. Soon she began chain-smoking, and her face assumed a terrible expression, overpowering in its anguish. She began in a new voice, low and grunting, punctuated by gasps for breath, and in a different, somewhat unintelligible dialect. The Vu began to address us: "What is it you want to learn from me?" (Katz, 1985, p. 4)

Continuing, Katz tries to put what he experienced into words:

> Totally inside our fear, we stopped thinking. We could not answer.
>
> The Vu spoke again, now more urgently: "I am waiting here for your answer!" I looked at my friend; he was already looking at me. I saw in him what I felt: I did not know what to say because I did not know where I was. I whispered to him: "What do we do now? Who are we talking to?" The Vu? The healer? The Vu through the healer? Is this real?" "I too am lost," he replied, "I have seen many healers at work, but this has never happened before," and then with a pleading tone he added, "You're on your own here. Just do what you think you should." (Katz, 1985, p. 5)

Katz continued to grapple with what was happening in order to determine the proper course of action within the context of this new and unsettling reality. As he began to return to "a sense of place and time," his "sense of what to do became clearer":

> I realized I was possibly in the presence of a Fijian God and felt the deep respect and privilege such a visit traditionally meant for Fijians. I would attempt to talk to the Vu because that was possibly who was talking to me. A conversation began, my fear transmuting into respect. The Vu spoke of many fascinating things. Eventually the Vu said he must go, and formally took leave of us. The healer returned to her ordinary state, going through the same changes in tone and body expression, now in the reverse order. With a sudden last wrench of her entire frame, she slumped over, fatigue pervading her. (Katz, 1985, p. 5)

Upon returning to a normal state, the healer "said, with an unquestioned finality: 'I don't remember what went on then because the Vu took over, so there is nothing I can say, nor will I add anything to what he said. You heard it all'" (1985, p. 5).

As they left the healer's home, Katz and his friend struggled to understand what they had just experienced:

> As my Fijian friend and I walked away from the healer's home, we asked each other almost simultaneously the same question: "What happened? What really happened?" We agreed we did not know. Would a Vu have conversed with us? Were we deserving of such a visit? It could have been the Vu we spoke with, but maybe it was just a dramatic performance by the healer, meant to impress prospective clients. Or maybe the Vu was speaking and the healer

> was exaggerating her own role as the vehicle. We had considered all these possibilities—and dismissed none. But we knew that whatever really happened, our attitude and behavior of respect was correct. If the Vu had come, that was the only way to be. (Katz, 1986, pp. 5-6)

Even in retrospect, Katz wondered how he should understand this experience. However, although uncertainty remained, it was clear that he felt that his relationship to his research had deepened:

> To this day, my understanding of that possession-conversation is no clearer. But it is clear that by accepting the loss of my own world-view, that particular conversation, and the understanding of Fijian healing and the Vu which it stimulated, became possible. It would have been more comfortable and comforting to dismiss the possession as only a dramatic act, thereby reducing the levels of reality present in the conversation. But believing as a Fijian that the Vu was there, while at the moments when my Western mind intruded believing it was not, not only kept me in a state of intense existential transitioning but also kept me open to unexpected learning. This was not a case of acting like I believed in order to get "good data", but of stretching my own beliefs beyond themselves to allow new beliefs to enter on their own terms and in their own reality. (Katz, 1985, p. 6)

In reflecting back on this experience he concluded that

> to tell a story we must experience it, to the best of our ability. Through its radical questioning of world-views, vulnerability allows us to live inside a story, itself a risk which can threaten our lives. Having lived inside a story we are better able to tell that story. (Katz, 1985, p. 6)

Because he was vulnerable, Katz was able to be taken into the confidence of a true traditional spiritual healer, who taught Katz how to become a healer by taking him on as one of his students. Thus, the only way to learn about healing was to do it, similar to his experience among the Ju/'hoansi, where the only way to learn about boiling energy was to participate in the healing dance at whatever stage in development one finds oneself. Katz shares his own human qualities, such as impatience to attain kia before leaving the Kalahari.

Katz clearly writes from his own experience as he shares his own attempts to learn healing and, as he does so, attain the altered states accompanying the healing process. In writing up his fieldwork about the process of learning to participate appropriately in healing rituals in both cultures, Katz was careful to be vulnerable in the other sense—of acknowledging to others times and ways in which he unwittingly erred or was in danger of overstepping a boundary to acquire the healing knowledge. For example, when his time in the Kalahari was drawing to a close, he was feeling disappointed that, despite concerted effort to participate in healing dances, he had not yet experienced the altered state in which healing power is activated, known as kia. Katz therefore approaches Kinachau, a wise healer, about the possibility of attaining kia by another means, which he has heard is possible with the help of a plant. Kinachau gently and with humor, yet firmly, lets Katz know that this is not wise.

Another example of vulnerability or letting go one's preconceived notions of reality occurred in the case of alleged witchcraft that we mentioned in Chapter Two, when a great fear gripped the village he was living in after there were two unexplained deaths at a time when relations between two factions within another village were strained. Katz describes how he too began to fear for his and his own family's survival as rumors flew about the deaths' being the result of witchcraft, or the misuse of the healing power. Thus, he found himself no longer able to maintain his Western detachment. He realized that in the face of his fears for his family's, his own, and his friends' survival, his belief system came to incorporate the world view of the straight path as he lived and studied among Fijians. His research into the nature of the use and abuse of the healing power in Fiji subsequently took on a whole new dimension of meaning as he grappled with this fear and opened to his vulnerability. As a result, he experienced greater access to the healing knowledge in Fiji. He calls this openness to another world view the researcher's vulnerability.

Another researcher, Reinharz, a sociologist, relates a similar type of experience, one that changed her very sense of self by putting her in touch with a very different world view (1979). In the course of her research into the lives of villagers in an Israeli border town, which was under constant threat of shelling, she found that her understanding and ability to conduct meaningful research was deepened by her acknowledgement of her own fears as she shared, if only temporarily, their life-threatening existence. Facing this, she found, allowed her to know far more clearly what questions to ask the villagers. At least for a time, she was joined with them in their meaning-making as they struggled for survival, and as she shared their experience, her understanding deepened.

The difference, of course, is that the researcher is only a temporary visitor who eventually returns to his or her home culture, wherever that may be, while those being researched remain, for the most part, in the field setting. Nevertheless, the researcher remains permanently changed by the experience of the shattering of his or her usual concept of reality. Another sociologist, Wax, who conducted research among Japanese-Americans, echoed this same type of experience:

> I also had changed, in the sense that by undergoing this gradual process of instruction and resocialization I had found out things about the Japanese Americans and their situation which made it impossible that I ever again approach or talk to them in the way I had approached and talked to them three or four months before. In this sense I had become a different person, a person who could never go back to being what she had been before. (Wax, 1971, p. 79)

Katz also introduces the idea of another kind of vulnerability in research as he addresses the idea of the importance of sharing one's process as a researcher, including one's "mistakes," with one's colleagues as well as the people one is studying and truly being open about what the research entails. He believes that frequently

> vulnerability is dismissed as merely the result of a mistake or a source of bias in method, rather than viewed as a way of accessing significant understanding. The interview process provides one example of how, through accepting one's vulnerability as a researcher, "mistakes" in method can lead to understanding. Reports of field-work rarely report these mistakes. In my own work, I purposely present interviews with their "mistakes" included—the naive and ethnocentric questions, the times when I push too hard for certain answers. These "mistakes" belong in the field report because they are an aspect of interviewing, certainly intrinsic to the trial and error which characterizes in-depth interviews. These mistakes can become "opportunities" to improve the interview. When they occur I can realize how I've lost contact with the person. At that moment, I can become vulnerable. Feeling vulnerable creates the possibility of reconnecting with the person more meaningfully and again interviewing with sensitivity. We cannot assume mistakes are <u>only</u> mistakes, <u>merely</u> evidence of misunderstanding. (Katz, 1985, p. 25)

A further example of this kind of vulnerability is shown by another anthropologist, Briggs, who was able to acknowledge such a "mistake" in the way she went about relating to the Eskimo community she was researching (Briggs, 1970). The mistake she made was due to some degree to her not being completely open with her hosts concerning her true feelings of discomfort. Instead, she tried to hold onto her own personality and did what she liked, and in so doing, she alienated herself from the community she was studying, whose members finally made it clear that they wished her to cut short her stay with them. In <u>Never in Anger</u> (1970), Briggs allows the reader to participate in her own realization of the way in which she unwittingly offended this community. Retrospectively, she was able to learn from her mistake and to transmute this into a service to help other researchers perhaps to avoid making the same mistake. She made herself vulnerable in writing this book, (1970) reporting not only her "successes" but also her "mistakes."

Katz points out that, unfortunately, vulnerability in fieldwork remains "a suspect and rarely used tool" due in part to the belief of Western social science "that accepting, not to speak of encouraging vulnerability destroys the objectivity, the 'real' validity, of the data." In fact, "nothing less than the debate between objectivity and subjectivity is at issue" (1985, p. 24). Instead of Western objective truth, he offers Polyani's view that "all knowledge, including science," insofar as it is "'existentially dependent,' is a fusion of subjectivity and objectivity" (Polyani, 1958, pp. vii-viii, cited in Katz, 1985, p. 24).

In <u>On Becoming a Sociologist</u> (1979), Reinharz's sharing of what others might consider her "mistakes" constitutes an example of utilizing one's vulnerability in fieldwork to improve one's research methodology. It allowed her to clarify for herself where the problem areas in the participant observation method lay, and this eventually led her to devise her own method of "experiential analysis" for a third research project in Israel at a later time (Reinharz, 1979). She shares other moments of vulnerability that allow her readers to get inside the research experience in a way that is very different from the traditional positivistic, distanced mode of "objective" "scientific" research. In so doing, Reinharz found that if one concentrates only on the world view of those being researched, one ends up by leaving out the other part of the equation—the world view of the researcher and the assumptions and/or "preconceptions" underlying the way he or she conducts research in a given setting (Bruyn, 1966).

Thus, for her next fieldwork experience, a study of "the impact on family life of intermittent shelling by terrorists' rockets in an [Israeli] town" (Reinharz, 1979, p. 265), she derived her own method of "experiential analysis" (p. 265). Building on the problems she had encountered in her previous study, she attempted in this new methodology to "integrat[e] person, problem, and method in the process of research" (p. 264) by including the world view of the researcher, by deriving the research question from the setting itself rather than beginning with a preconceived hypothesis, and by openly establishing to the villagers under study her primary role as researcher (p. 158). Thus, this project was in keeping with her desire to conduct research that was both "open" and that would provide a service to her research subjects, "a joining of needs that resulted in our temporarily affiliating with some groups in town, not as invited guests or invaders, but as short-term partners who would provide feedback" (p. 309). By presenting herself in such an open way, she was free to participate in the culture to a greater depth. By taking into account her own reactions to the danger of shelling, she was able to get at certain data that might otherwise have escaped her notice.

As Reinharz points out, however, "interviewing and being with people in their space gives them the controlling power—they can manipulate the space or manage the stage" (p. 314). Moreover, "a researcher can gain access to someone's space without gaining access to their heart" (p. 310). Thus, she notes with deep appreciation the truly deep feeling of connectedness that developed after eleven days of fieldwork from having shared the very real danger with her subjects—"I cannot convey adequately the positive regard with which I viewed and felt enveloped by these families," whom she came to "cherish,...even if our relations were superficial and brief" (p. 312). She realized that she was furnishing her subjects with a means to be heard, and, in so doing, she realized that "sociological fieldwork is thus potentially a form of *social activism"* (p. 314). She found herself participating in some of the shared reality, such as a superstition that had developed around those who had been wounded in the shelling. Also, she experienced very real fear, which influenced her interviewing style. Reinharz recounts how, while she was interviewing the father of one household, "I suddenly heard a boom and spontaneously reacted by throwing myself into his arms for protection. His initial impulse was to run to the nearest window to see what had happened. Gradually, simply seeing others in their daily tasks or looking them in the eye gave me courage and the feeling that together we would be able to cope" (p. 350).

A final example of vulnerability in fieldwork which the researchers involved felt led to increasing the depth and authenticity of the interview data collected is provided by Brown and Gilligan (1992) and associates in research conducted at the Laurel School for adolescent girls in grades nine to twelve. They abandoned their original method after being challenged by the resistant behavior of the girls they were interviewing, who had figured out how to prepare "canned" answers in keeping with what they felt the researchers expected. Instead of trying to force the girls to comply with their original research design, they took the time to step back before proceeding further in order to examine what had led the girls to this feeling of disconnection and subsequent decrease in authenticity. They realized that what was needed was to drop the "distanced stance of the objective" researcher and engage in dialogue with the girls, thus finishing by co-creating a more authentic methodology.

Katz's charge, given him by both the Ju/'hoan and Fijian healers, was "to tell our story" (Katz, 1981, 1993). Likewise, the writer has, in a sense, for the purposes of study, requested of a group of community psychiatrists that they tell her the "story" of their own formal and informal education as psychiatrists so that she, in turn, may tell their stories in a way that she hopes is helpful. In analyzing what they say, it is thus advisable to arrive at a methodology that will allow these stories to emerge in the fullest way possible. As Katz points out, a story is complex, and it cannot be either told or heard in a way that is fully objective, in that it necessarily contains interpretive (i.e., subjective) elements introduced by both teller and listener. "By 'story,'" he explains, "I mean the description or 'text' of a phenomenon, which could include varying combinations of 'data' and 'interpretation' from various sources or perspectives" (Katz, 1985, p. 3). Although the writer interviewed each psychiatrist only one time (unlike Katz, who had multiple opportunities to interview each of the Ju/'hoan and Fijian healers while he was living among them), nevertheless, if the writer follows Gilligan and colleagues' advice about applying the lens of historical and literary interpretation, as well as of anthropology (Gilligan et al., 1988), then each text is "packed" with multiple layers of meaning (Spence, 1982), even in a single interview with a single psychiatrist. Furthermore, as the researcher conducts research, he or she is, in fact, also moving along his or her own developmental path, a process that encompasses far more than the research project itself, and, in so doing, is constantly in the process of meaning-making (Kegan, 1982). Thus, life experience affects the questions that the researcher asks, as well as the degree to which the researcher allows the research subjects to interact with him or her at a given moment during that life experience.

Like Reinharz (1979), Katz (1985), and Wax (1971), who write about moments of extreme vulnerability while carrying out their research, the writer was deeply affected by such a "moment of world collapse" (Welwood, 1983, cited in Katz, 1986, pp. 358-359) during the period in which she was conducting her research. While not directly part of the research project, this shattering event nonetheless was highly relevant to the issues being addressed by the research. As one result, the writer decided to include another question in her interview schedule, one that introduced a new dimension and, in the final analysis, may have deepened the material that was gathered. And perhaps more importantly, the experience led the writer to reconsider and, ultimately, to change her research methodology.

In spring of 1987, the writer experienced the loss of a patient from an apparent suicide. The circumstances around the death were ambiguous, making it all the more difficult for the writer to come to grips with this loss. It was after this experience, however, that the whole question of suicidality took on new meaning for her, and prompted her to add question #19 ("Have you ever had to deal with a suicidal patient? And/or a patient who actually committed suicide? If so, how did you cope with it? If not, how would you cope with it? And what would/did you advise a colleague to do in a similar situation?") in the interview schedule. At this point, the two pilot interviews with psychiatrists had been completed and other interviews with a Native American healer and a lama-physician from an Asian country had already been carried out without asking them the question about suicidality. The interviews of the sixteen psychiatrists began in the fall of 1987 at the Boston Institute for Hospital and Community Psychiatry, and continued at the winter meeting out West in March 1988. Although these interviews took place several months after the death of her patient, the writer was still struggling to come to grips with the shock of this loss. As a result, the writer decided to add the questions regarding patient suicidality in the interview schedule. Thus, the writer's life experience of losing a client directly affected her research questions and process. This experience also influenced the writer toward thematic analysis rather than only a coding system, for she wished to utilize a descriptive method that would allow the richness of each individual's felt level of experience to emerge in its fullest expression in talking about what they had learned in such life-and-death situations rather than reducing these experiences to a number for the purposes of coding. Likewise, it was the writer's hope that, in her own research process, the uniqueness of each individual's way of making meaning and each culture's world view would be honored.

In the section below, the writer is interviewing Harriet, the last of several interviews over a three-day period, and something in the moment of the interview, perhaps a sense of common trust, prompts the writer to begin to share her own unresolved questions about the loss of this patient. She tells Harriet about going to see the psychiatrist of her patient after the latter's death, at the psychiatrist's invitation. At that meeting, the psychiatrist had mentioned that he wanted to make sure that the writer was coping with the loss of her patient (even though the writer was in supervision with another psychologist at the time). While interviewing Harriet, in the course of asking a question the writer reveals that she has in some way been blaming herself for being "over-involved" with her client. Harriet picks up on this immediately:

> *OLC: I have one more question for you because I had a very disturbing thing happen to me last spring a year ago where a patient with whom I was overinvolved, a wonderful woman, twenty-seven years old...*
>
> Overinvolved by your definition or by somebody else's?
>
> *OLC: I think, I've almost come to..., I think other people would say that, yeah, other people's [definition]. Somebody I really cared for a lot, and I had a special bond with her. When she came in for treatment referred by another FELDENKRAIS® client, I had no idea how disturbed she was.*

The writer then explained to Harriet how she later found out her patient had been hospitalized for a couple of weeks in her early twenties due to a psychotic episode. At the time she had begun working with the writer, she had been suffering from whiplash and chronic low back pain, with a history of multiple motor vehicle accidents. The writer subsequently worked with this client for a year and a half to help her repattern her movement and learn pain-coping and relaxation techniques. The severity of the pain necessitated seeing the patient two or three times a week in order for the neuromuscular repatterning to take hold. During this time she had been seeing one psychiatrist one or two times a week, and then, after terminating with him, had interviewed a number of other psychiatrists before beginning to see another psychoanalytically oriented psychiatrist. The patient had not wished for the writer to confer with either psychiatrist, and the writer felt that she had no choice but to abide by the patient's wishes, although the writer discussed with her supervisor that it made her feel increasingly

uncomfortable to do so. It soon became apparent that her patient was quite disturbed, especially around relationships, had possibly suffered from abuse in a chaotic family situation, and had a tendency to view people in her life either as "all good" or "all bad," thus tending to utilize the psychological defense of splitting. The writer explained to Harriet that it was only after their mutual patient had died that the psychiatrist suggested that she come to see him to process any feelings around the loss of the patient. The writer shares with Harriet her misgivings about not being able to speak with her patient's psychiatrist until after the latter's death:

> *OLC: However, in retrospect, it has bothered me, that as I was not allowed to talk with [the patient's psychiatrist], and that perhaps we set up a situation which allowed her to engage in splitting, the way I see it...*
>
> Did she set it up or did he?
>
> *OLC: Well, I think it was both. I think they colluded. And I confronted him with this. I went to see him, he saw me...*
>
> Afterwards.
>
> *OLC: Afterwards. He said, "You did wonderful work, she never would have come to me without your therapy, you meant a great deal to her," and all this. And then he said, "But I think it was difficult for her to choose between two therapists.*
>
> Oh, s__t!
>
> *OLC: And I'm wondering because I have now an opportunity.... I have not worked with patients that I think are that disturbed, because I don't quite feel I'm ready yet.*
>
> Not unless you have a good collaborative relationship with the therapist.
>
> *OLC: Well, I think that what I, that's what I've come down to, and I value your experience, because what I've said to myself...is that I will not work with a patient unless I can have that collaborative relationship.*
>
> You have to have that support for yourself and for the patient. Otherwise, you are setting up the parental split that is causing the problem in the first place.
>
> *OLC: But what is so difficult is that I [had gone and written] [the psychiatrist] a letter before I saw him, and I had said to him [in the letter] you know, weren't we setting up splitting? I spelled it out.*
>
> Harriet then explained why in her opinion this had not worked:
>
> You can't expect a psychoanalyst who is traditional to acknowledge your sense of what happened over against his, because it's self-confrontation that he goofed.
>
> *OLC: Yeah, and he wouldn't do that.*
>
> No way. There's nothing in his background to prepare him for this.

The writer went on to discuss with Harriet how she had also been struggling in an impossible bind that the patient had put her in by not allowing the writer and the patient's psychiatrist to speak to one another about her case.

> *OLC: In my position, would you have said to him...I mean, I tried to insist that I talk to him, and she [the patient], said "I will leave." So I backed down.*
>
> Well, the only thing I can say is that you probably brought it up too late, and it should have been [the psychiatrist] that was willing, because he was in the position of power, and he should have insisted that if someone is working with his [patient], that the two of you work together from the beginning. But by the time you insisted on it, it was too late.

These words of Harriet also came to influence the direction of the research, as will be seen in the discussion of its implications for the education of future helping professionals in Chapter Eight. Later on in this same section of the interview, Harriet then clearly states how she would collaborate with other caregivers of the patient had she been the treating psychiatrist in such a situation. Just prior to Harriet's answer below, the writer has attempted to clarify for her the nature of her somatic education work with

patients such as the one who has just died. Harriet listens and then gives her view of what she would have done in a similar situation:

> See my thoughts of what, as much as I can understand of what you do, if I were in the situation where I had a client that you were working with, we would have some joint sessions so that we all know exactly what each is to do.
>
> *OLC: With the other therapist...*
>
> Yes, and we would all—the patient, the therapist, and myself—would all get together and set the rules, and we would say which things can be kept that you don't have to talk about if the patient doesn't want, and then you would set limits and say to the patient, "But if you do so-and-so, then we are going to have to talk."
>
> *OLC: Right, right.*

The writer again asks Harriet for support in her meaning-making arising out of the loss of her patient:

> *OLC: So it sounds like you would support my "policy," if I can use that word, for myself from now on that I have to insist on seeing [or talking to] the other therapist, or I don't take the patient.*
>
> I would for my own, yeah, because it turns out destructive if there is conflict.
>
> *OLC: Yes, I think I'm coming around to that.*

Then, Harriet begins to discuss suicide from her perspective as a psychiatrist and shares a new perspective, not yet manifested in the words of other psychiatrists in the sample:

> But I also think that suicide has become a sort of a criterion for the success of the therapist, and it shouldn't have anything to do with that. It should have to do with what did the patient really want, and just because somebody would commit suicide while they were under my care, except for all the legal ramifications, if my sense of myself and my success is dependent on whether or not a patient kills themselves, I'm in trouble.

When Harriet ends "...I'm in trouble," the writer is prompted to respond from her own position of continuing to blame herself in the way she dealt with the relationship with her client's psychiatrist—namely, in not somehow pushing for a means for them to work collaboratively:

> *OLC: That's what I blame myself [for]. I blame myself because I tried to make a compromise when it was really against my better judgment, and I was afraid of losing her.*
>
> Well, can you think of it differently than blaming yourself. Simply that this is a failure that didn't work, and you learn more from failures than from successes.

In listening to the writer blame herself, Harriet introduces another meaning of the word vulnerability besides that of acknowledging and learning from one's "failures." In her opinion, women share a particular kind of vulnerability in that they share the common experience of growing up oppressed in a patriarchal society and of always having to fight against this oppression. Notwithstanding this fact, however, she tells the writer how she ultimately listens to her "gut":

> *OLC: I think the thing that I am still having trouble not being angry at myself for is that I gave away my power, in the sense that I assumed that he was the doctor.*
>
> But you did that because you were an oppressed woman and you were taught to make his the authority. We as women are all in the same boat and we can get caught. That's our vulnerability, and so when I say I don't genuflect to anybody, that means that if my gut tells me something, I trust my gut.

Ultimately, the writer, also, in trying to make meaning out of the stories of the sixteen psychiatrists must rely on her "gut" to interpret them. However, as much as possible she will try to make her assumptions apparent at each step of the process. Also, the psychiatrists' own words are there in Chapters Six and Seven for the reader to interpret according to his or her own frame.

At the time of the first two pilot interviews, the writer had spent two years working in community mental health, as a psychology trainee in a chronic care hospital, while continuing her private practice as a licensed social worker, massage therapist and somatic educator. Within the training

situation, her initial experience had been to have been supervised simultaneously by a psychiatrist and a social worker within the department of psychiatry at the hospital. Thus, initially, the writer was aware of several biases. She tended to be overly critical of psychiatrists who had not been in therapy themselves. At the same time, the writer was beginning a second career, after transitioning out of public high school teaching into psychotherapy and massage, and was highly motivated to absorb a new body of knowledge as soon as possible. The writer respected both supervisors as teachers in their ability to impart knowledge relevant to gaining the skills necessary to function in community mental health in a variety of roles. Nevertheless, she had experienced some inconsistency in the way each related to her within the system. For example, she had been taught psychoanalytic psychotherapy by a psychiatrist who shared that he had never undergone his own analysis. Furthermore, before her research began, the writer had terminated with two male psychiatrists, before continuing with a female social worker for her own therapy, because she had not felt sufficiently seen, heard, or understood. Thus, initially, she was reactively more critical of psychiatry in general. However, by the time the gathering of the research data had ended, she had resumed her training in psychoanalytically based methods of psychotherapy and was less critical of psychiatry.

Further Considerations about Method

In this chapter, the writer has presented excerpts from the two pilot interviews, which led her to a methodology to explore both the differences and the similarities between these psychiatrists and traditional healers educated according to education as transformation. As she interviewed the two psychiatrists, the writer became increasingly aware of different tones, textures, levels of meaning—both latent and manifest—and perspectives in listening. Later, in analyzing transcripts, these subtle differences required further delineation both within the transcript of each psychiatrist and in relation to the other psychiatrist's transcript.

In analyzing the data, the writer viewed the psychiatrists' stories from a systems perspective emphasizing a relational approach, which will be developed further in the chapter on method, Chapter Five. Secondly, the writer analyzed the interview data from a perspective that attempted to take into account her own assumptions and "mistakes," and thus this methodology may be described as honoring the tradition of "vulnerability" in fieldwork or in other kinds of research in the social sciences, as has been advocated by Katz (1993) and Reinharz (1979). Thirdly, the writer analyzed the data for themes in an attempt to understand the "voice" of each psychiatrist. The writer has been informed by her reading of the Brown (1988) and the Brown and Gilligan (1990, 1992) method. While she thus wants to acknowledge her debt to these authors, she in no way wants to hold them responsible for any departures from their methodology. Any such departures are her own.

The criteria for selecting the sixteen psychiatrists was one which ensured that each had experience as a community psychiatrist in keeping with Katz's suggestion in his 1981 article that community psychiatrists could be more appropriately compared to traditional healers in the Kalahari and Fiji, as opposed to psychiatrists in private practice, given the fact that the former are also community healers working in community mental health centers, or community hospitals, thus serving many different kinds of populations, including those of different ethnicity. Thus, to participate in the study, each psychiatrist had to have worked in a community mental health center or department of psychiatry in a community hospital for at least three years.

The sample, thus, was self-selected, by means of the "snowball" method, with one respondent passing on the word to another or notifying the researcher of those who might be interested in being interviewed. It consisted of eleven men and five women ranging in age from thirty-nine and sixty-seven. All had worked at least three years in community environments. Of interest was the fact that three of them (two women, one man) had begun their medical career as family physicians and one (male) as a social worker before switching to psychiatry. In addition, two (both males) had considered a career as a minister or rabbi and one (a woman) had considered becoming a missionary.

In Chapter Seven, in conjunction with analyzing the interviews for themes, the writer will also consider empathy scores for each psychiatrist utilizing the Mehrabian and Epstein (1972) instrument. In addition to the fact that we have noted that empathy is an important component of the psychiatrist's role, empathy in the West includes, in the writer's opinion, some of the aspects of education as transformation. We will discuss these similarities, as well as differences, when we analyze the themes in relation to the

relative presence or absence of the principles of education as transformation and the empathy scores for our psychiatrists.

It should be noted that although education as transformation has seven principles, the writer, in the process of translating these into the Western notion of "voice," delineated eleven subthemes within a control-connection continuum. These subthemes were extrapolated from the voices of the psychiatrists themselves and, in the writer's opinion, encompass the seven principles but are tailored to the significant differences in Western culture, allowing us thus to do justice to the richness and complexity of psychiatrists' educational experience in the West.

Likewise, to do justice to the depth of a psychiatrist's particular voice, and to the way that each manifested with its own unique configuration along the control-connection continuum, the writer decided to choose a subsample of four men and four women from within the sample of sixteen psychiatrists. The subsample of eight was chosen on the basis of the fact that they gave a fuller account of their positions and their interviews were richer regarding responses to the questions asked. In the next chapter, the writer provides an overview of the actual method used.

Chapter Five:
Method

History of the Study

The present study examines the views of sixteen psychiatrists concerning their formal and informal education. A qualitative method of thematic analysis was utilized to analyze the transcripts of the interview data according to grounded theory (Glaser & Strauss, 1967) in an attempt to capture more of the internal felt experience of psychiatrists as they discussed their education and development than is often captured in past studies of physicians, or of healers in general. The writer had initially considered using a form of coding system only in order to determine the presence or absence of principles of education as transformation, but as she worked with this approach, she concluded that the richness of the psychiatrists' words could be better conveyed with a qualitative approach, where the seven principles of this model could be utilized in a less rigid manner in relation to the themes that began to emerge from the interviews. Thus, each respondent's particular way of making meaning could be appreciated within its own cultural context and with its own uniqueness, taking cultural differences into account as well as differences among speakers from the same culture regarding their individual understanding of such concepts as "healing" and "connection." In analyzing the data, however, the writer did note when a psychiatrist's life appeared to be characterized by one of the principles of education as transformation as manifested by both the Ju/'hoansi and Fijian healers following "the straight path." Those characteristics that the writer found to be clearly present as well as those that were open to interpretation are mentioned in the course of describing the psychiatrists and are summarized in Table 1 in Chapter Seven.

Grounded theory is different from logically deduced theories "based on ungrounded assumptions" (Glaser & Strauss, 1967, p. 4). It is a general method of comparative analysis whereby one develops theory from the data, and this theory is then further illuminated and refined by additional data until there is a better and better fit between data and theory. Thus, in principle, by allowing the relevant core categories to be established from the data itself, it tests theory rigorously and allows for a better-integrated theory (Glaser & Strauss, 1967):

> In discovering theory, one generates conceptual categories or their properties from evidence; then the evidence from which the category emerged is used to illustrate the concept. The evidence may not necessarily be accurate beyond a doubt (nor is it even in studies concerned only with accuracy), but the concept is undoubtedly a relevant theoretical abstraction about what is going on in the area studied. (Glaser & Strauss, 1967, p. 23)

A grounded theory thus allows the researcher to generate hypotheses by analyzing the data as it unfolds, organizing and reorganizing the data until finding the most suitable fit, rather than prematurely superimposing an outside framework devised in advance. The writer was also informed by the method of Miles and Huberman, Qualitative Data Analysis (1984).

In using such a grounded theory approach in this thesis, the writer discovered that themes covered similar content areas and could be grouped together such that the "voice" of each psychiatrist was revealed by drawing, in part, on the research methodology of Mishler (1984) and Kleinman (1988a). Mishler, as noted in Chapter Two, had introduced the notion of "voice" "to specify relationships between talk and speakers' underlying frameworks of meaning" when analyzing transcripts of medical discourse between physicians and patients (Mishler, 1984, p. 14). He had characterized the medical discourse of all physicians in his study as "the voice of medicine," whereas that of patients he termed "the voice of the lifeworld" (1984). While useful as a point of departure, the writer found that after thematically analyzing each of the two pilot interview transcripts, the voice of each psychiatrist increasingly took on its own distinct character rather than being limited to something that could be characterized as a single "voice of medicine" (1984).

The writer also followed the lead of Brown and Gilligan (1990), who, as noted in Chapter Four, had discovered a different manifestation of voice among adolescent girls, especially in relation to power. The methodology they developed in this study, "Listening for Self and Relational Voices," is an attempt

"to recast psychology as a practice of relationship (rather than a profession of the truth)" (1990, p. 1). They and their colleagues developed this methodology in order to be sensitive to what adolescent girls were both saying and not saying, in reaction to a tendency in the social sciences to leave female development out of the picture (1990). In their analysis of girls' differing voices, they discovered how the girls' views of self also revealed their sense of disempowerment in relation to their cultural context. They, as well as other researchers, have noted that during the course of interviews at three different ages, there were increasing instances of "disavowal" (L. Stern, 1990) as the girls matured that appeared to reflect messages conveyed implicitly by their culture regarding women's place in that culture and women's disempowerment by that culture (Steiner-Adair, 1986). Thus, Brown and Gilligan's methodology revealed the respondent's view of her relationship to power within a given cultural context.

Following the lead of Brown and Gilligan, the writer has developed an adaptation of their methodology that attempts to reveal how each psychiatrist views him- or herself in relation to self, patients, family, community, and society at large, both public and private. This involves, for instance, looking at how a given psychiatrist talks about relating to patients, to the vast body of medical and other knowledge, both formal and informal, that he or she is receiving and dispensing, and to the healing power. In the analysis of the subsample of eight psychiatrists in Chapters Six and Seven, we will see, among other things, to what degree the psychiatrist describes and gives the reader a full picture of the self, and how much vulnerability is revealed—or the degree to which each possesses a flexible world view and/or an ability to acknowledge and learn from their mistakes—and how each views his or her relationship to the healing power.

As with adolescent girls, one may discover what each psychiatrist's relationship to power is, the degree to which each feels empowered in his or her role as psychiatrist, and where, in his or her view, such power resides. Thus, although the concerns that adolescent girls voice are different from those of the adult male and female psychiatrists in our sample, the psychiatrists are, nevertheless, also concerned with issues of empowerment. In their role as healers, they listen to their patients' stories of their attempts to feel a sense of self-efficacy or empowerment, and ideally, in order to be sensitive to these struggles, the psychiatrists are, in turn, in touch with their own feelings of empowerment/disempowerment and vulnerability/invulnerability. Thus, the writer felt that it was appropriate to adapt Gilligan and Brown's methodology to psychiatrists as we consider their views of their formal and informal education from our larger transcultural perspective, which asks how one educates one's healers to provide service rather than to abuse their power, especially when the predominant Western power model, "power over," has been demonstrated to lend itself to abuse in several professions.

The Pilot Study with Psychiatrists Max and Lynn: Two Different Stances

As we have discussed already in Chapter Four, the writer received permission from the two psychiatrists, Max and Lynn, to include them in a study for her doctoral dissertation and conducted exploratory pilot interviews with them, utilizing the proposed education as transformation interview schedule (cf. Appendix B). Max had served as the head of a community mental health center for several years, while Lynn had initially been a pediatrician before switching to psychiatry and community mental health. As a pediatrician, she had been the first female resident to head a community health center in her state before she had had to switch to psychiatry in private practice after developing health problems.

As mentioned above, through the pilot interview analysis, two "voices"—the "voice of control" and the "voice of connection"—began to emerge, with characteristics, or subthemes, that became more distinct as the sixteen psychiatrists in the sample were interviewed. The writer uncovered these two different voices in the way in which the individual psychiatrists positioned themselves in relation to such things as the importance of mastering medical knowledge and medical technology, their particular stance toward conducting psychotherapy and, in particular how they positioned themselves in relation to the patient—i.e., as an all-knowing expert or as a supporting co-facilitator—and the degree to which each allowed him- or herself to be "vulnerable"—encompassing the ability to shift one's world view (Katz & Nunez-Molina, 1986) in order to better enter into that of the patient, or in relation to the self, as well as to acknowledge empathic failures, "mistakes," or areas requiring further learning, as opposed to always maintaining the stance of an all-knowing expert. Thus, the "voice of control" is more apt to maintain the stance of the expert and to operate using a "power over" model, whereas the "voice of connection" exemplifies a more "vulnerable" stance and utilizes a "power with" model. Detailed thematic analysis of

the interviews of the subsample of eight psychiatrists—four men and four women—is discussed in Chapters Six and Seven to provide the reader with examples of the research framework by which the existence of this continuum between the two voices—of "control" and "connection"—was further revealed and developed.

The Education as Transformation Interview

In interviewing the sample of sixteen community psychiatrists, the writer utilized an open-ended, semistructured interview schedule, based on the principles of education as transformation and designed to allow for as spontaneous a response as possible. The pilot interviews helped the writer to try out and further refine the questions on the interview schedule before asking the larger sample of community psychiatrists the same questions as part of her study.

Even before the pilot interviews, however, in order to test out the interview schedule within a cross-cultural and interdisciplinary context, the writer conducted interviews with several traditional healers—a Native American from North America, a curandera from Mexico, and an Eastern lama—as well as with several non-psychiatrist medical doctors from within the allopathic system—a dentist, a surgeon, a family physician who was also an obstetrician, and an obstetrician/gynecologist—as well as with other helping professionals—a social worker, a psychologist, and a pastoral counselor. Prior to that time she had also collaborated with a doctor in carrying out thirty interviews with charismatic priests and other healers affiliated with the Catholic Church, with an interest in discovering recurrent patterns and themes among healers. Each was initially asked to describe what he or she did as a "helper," before qualifying it by his or her particular profession, thus utilizing an umbrella term under which to group everyone. In order to determine what elements, principles, or the like of education as transformation might be present in each person's educational life history, questions were included about the respondents' formal and informal education that might in some way cover similar ground as the seven principles of education as transformation delineated by Katz (1981). The questions were also designed to be loosely structured in order to allow each helper/psychiatrist to speak for him- or herself and to weave his or her own narrative truth, and included a request for suggestions to improve the interview schedule. The interview attempted to elicit common themes but also explored what the different cultures might <u>not</u> have in common in the way that they educate their healers and the way that their healers describe their education.

The interview questions evolved in the course of this process. After the pilot interviews with the two psychiatrists, the first question, "Describe what you do in your professional life on a typical day" was dropped as it was decided that such information could be elicited better by another question, #2, "Describe what you do as a helper/psychiatrist?" Also after conducting the two pilot interviews, question #19, "Have you ever had a patient commit suicide. If so, how did you deal with it?", was added due to the circumstances occurring in the writer's life that were explained in Chapter Four. Question #24, "Was there anything that you would consider not to have been helpful, or which you consider to have been detrimental in preparing you to become a helper/psychiatrist?", was also added at the suggestion of three psychiatrists in the subsample.

The questions in the interview schedule, thus, were designed to elicit data that would be relevant to the issues raised by the education as transformation model, addressing how these psychiatrists described themselves as psychiatrists, what they considered they did as psychiatrists, what they considered important about their formal and informal educational experience, and how their becoming psychiatrists had affected their relationship with themselves, their families (both family of origin and family by marriage), and their communities. The questions also elicited information as to what they found most challenging about their profession and what they would suggest to improve the way that psychiatrists are educated.

After testing out the education as transformation interview with Max and Lynn, the next step was to construct a larger sample of community psychiatrists to interview utilizing the same interview schedule.

Gaining Access to the Sample

As mentioned in Chapter Four, the criteria for the sample was that each psychiatrist had to have worked in a community mental health center or community hospital for at least three years (whether they were currently still working in such a community context or not at the time of the interview). Likewise, although psychiatrists might have begun their training in another country, (as in the case of three among the sample), they all had to have undergone training and to have worked as a community psychiatrist in the United States, as well.

Following the pilot interviews, the writer began the process of meeting community psychiatrists who would meet this criteria and arranging to interview them. The writer's initial attempts at contacting such community psychiatrists, by means of a letter-writing attempt to chief administrators at local community mental health centers, met with little success. She had better success when she attended a lecture given in the fall of 1986 by a biomedical professional (not a psychiatrist) who was on the staff of an urban teaching hospital. After the lecture, the writer requested the help of the presenter in approaching community psychiatrists of her acquaintance to offer them an opportunity to participate in a cross-cultural study concerning the education of community healers. The presenter immediately introduced the writer to another member of the audience, a community psychiatrist who at the time had been working in a community mental health center for over three years. The latter not only agreed to be part of this study, but she informed the writer of the upcoming Institute for Hospital and Community Psychiatry, which was to be held in Boston later that fall (1987). The writer attended this conference and there was introduced to other community psychiatrists—three from the United States and one from Canada (although the latter had served in a state community mental health system in the eastern United States as second-in-command and thus met the criteria for the study). Three of the above psychiatrists consented to be interviewed immediately at the conference, and an interview was also conducted there with the first community psychiatrist to whom the writer had been introduced beforehand at the lecture and through whom the writer had been able to gain access to the others.

Among this group was an official of the American Association of Community Psychiatry (AACP), who invited the writer to attend the winter meeting of their association in order, first, to have a better idea of what issues concerning both practice and education were currently confronting community psychiatrists and, second, to have the chance to offer participants attending the conference an opportunity to be interviewed. At this conference, eight more psychiatrists were interviewed. Two of these, both male, were of foreign origin, one from Western Europe, the other from South America, but they also fulfilled the criteria for participation in the study.

The remaining interviews were conducted in the New England area. These names were obtained from colleagues, who would first gain permission from the community psychiatrist in question to be approached. As the sample was gradually constructed in this manner, it became clear how important it was to gain access by going through one of the targeted professional community members each time. Thus, the sample was constructed by what is sometimes called the "snowball" method.

The writer in this way interviewed a sample of sixteen psychiatrists, all of whom were currently working or had worked for at least three years in community mental health centers or in mental health departments in community hospitals in the United States, to see whether common themes would emerge or whether each psychiatrist, when asked the same questions, would be characterized by his or her own uniqueness. As in the pilot interviews, the writer found that what Mishler (1984) had termed the distancing "voice of medicine" was not always present. She then compared the voices of psychiatrists in the sample both with each other and with data collected from interviews with traditional healers from other cultures (Katz, 1982b, 1993) to see whether any consistent patterns might emerge within such a cross-cultural context.

In order to have a more workable number for the detailed thematic analysis presented in Chapter Six, a subsample of eight (four males and four females) was chosen, based on the fact that they gave fuller accounts of their positions and their interviews were richer regarding responses to the questions asked. All of the interviews were transcribed and analyzed thematically, however, and the results for the remaining eight are included in the tables at the end of Chapter Seven.

Data Analysis

To provide a background for the analysis of the data, detailed profiles of the subsample of eight psychiatrists are offered in Chapter Six; each of the sixteen psychiatrists is also briefly described in Appendix A. Descriptive data is drawn from various notes taken by the writer at different times. Initially, descriptive phrases of first impressions of each psychiatrist were jotted down as soon as possible after meeting the person, noting what kind of reactions each elicited while the impressions were still fresh. Then, for most, the interview was set up at another time, where further impressions and sensed reactions on the part of the interviewer were noted, thus allowing for the expansion or refinement of the original impressions. In the process, the writer also hoped to bring to the surface her own biases before further analyzing the data, in order to at least be aware of them to some degree. Afterwards, each interview was transcribed and analyzed thematically according to grounded theory (Glaser & Strauss, 1967). Later, when examining the interviews in both their transcribed and taped forms, further notes were made concerning themes, impressions, and reactions. In this way the writer analyzed each interview, both by reading the written transcriptions and by listening to the interview tapes for each of the sixteen psychiatrists in the sample. Throughout the interviewing process, and afterwards when listening and relistening to the tapes several times, an attempt was made to keep an open mind and to listen in such a way as to allow each person's story to unfold in its own way.

As has already been noted, the analysis of themes led to a cultural translation of the seven principles of education as transformation into the notion of a particular "voice" among certain Western psychiatrists, in such a way that the original seven principles were subdivided into eleven subthemes within a control-connection continuum. These categories were created on the basis of analysis of the data from a specific sample of psychiatrists, in keeping with grounded theory. Thus, just as education as transformation, found among two very different cultures, has been expanded into different subcategories to express the unique aspects of each culture's model of healer education, the same was found to be necessary in the West. For example, Katz subdivided the first principle, altered state of consciousness (A. S. C.) into three subprinciples—(a) linkage between the self, the community, and the healing power, (b) envisioning, and (c) transitioning; likewise, the writer arrived at two main themes and eleven subthemes that were appropriate to the experience of Western psychiatrists (cf. Chapter Seven for chart).

Although the writer does not use Katz's seven principles interchangeably with the components of voice, nevertheless qualitatively these seven principles provide the reader with a gestalt, or a world view, that has implications for the way psychiatrists are currently educated in the United States.

Why Choose an Empathy Measure?

As empathy is an important component of the psychiatrist's role, the writer decided to administer an empathy measure as part of her comparison with traditional healers. For, as discussed in the first chapter, a psychiatrist's ability to successfully conduct psychotherapy rests at least partly on his or her capacity for empathy. As empathy has figured in many types of studies to measure the effectiveness of Western psychotherapy and the competence of Western psychotherapists, it may be considered as a core underlying construct in the Western idea of the healer as well as a key element in the Western notion of the competence of a healer. Thus, an empathy measure was chosen to measure psychiatrists' competence in an area that is important for this study, since it is an important aspect in psychotherapy and has been associated with positive outcome (cf. Chapter Two). Although empathy remains a complex concept whose meaning, at the level of intellectual, theoretical discourse, is difficult to articulate with precision, it nonetheless has an operationalized aspect that is more accessible, and it is this more pragmatic approach that has been the main focus of the empathy research that has been conducted over the past forty years. Specifically, it has been noted that empathy is one of the primary ingredients that has repeatedly been associated with prosocial human relating or connecting (Kohn, 1990) and with successful outcome in psychotherapy (Basch, 1983; Campbell, 1982; Corcoran, 1981; Grunebaum, 1983; Gurman & Razin, 1977; Jordan et al., 1991; Luborsky et al., 1975, 1980, 1988; Meltzoff & Kornreich, 1970; Mintz, 1972; Pierce, 1974; Rogers, 1975; Smith & Glass, 1977; Sullivan, 1953; Truax & Carkhuff, 1967). A recent review of the literature has indicated that empathy is, fundamentally, a "relational concept" (Myers, 1992). Regarding the cognitive and affective bases for empathy, Celenza's (1990) research involving patients with borderline personality disorder, patients with narcissistic personality disorder, and normal subjects has found that patients falling in the first diagnostic category, borderline, retain the

affective aspects of empathy but tend to exhibit lower scores in the cognitive dimension than do normal subjects. The narcissistic personality, on the other hand, retains the cognitive but not the affective dimension. This is not surprising in that both narcissistic and borderline patients experience disturbances with both self- and other-relating. These findings confirmed Celenza's predictions that those with more disturbed boundaries would not score as high as normal subjects on the affective dimension (1990). Furthermore, Celenza found that the affective and cognitive components of empathy appear to interpenetrate one another in situations of actual human interrelating, instead of lending themselves to being separated into two distinct components, as a research study generally attempts to do (1990).

Thus, from recent research findings it appears that empathy is a complex, multilayered, global phenomenon that has both affective and cognitive components. Davis (1980, 1983) has developed a global measure comprising a seven-item individual difference measure of empathy (the Interpersonal Reactivity Index, or IRI), which is based on this multidimensional approach. Instead of treating empathy as a unidimensional or unipolar concept, as Mehrabian and Epstein (1982) have done, Davis has delineated four components of empathy that he has identified as separate from other psychological constructs (Davis, 1980, 1983). Barrett-Lennard has delineated different "phases" and a different "focus" in empathy, which he calls a "cyclic/phasic model of empathy" (1993, p. 3), and has constructed a Relationship Inventory (1973). We will compare and contrast our Mehrabian and Epstein questionnaire method of emotional empathy with these other instruments in our analysis of psychiatrists' Mehrabian and Epstein scores in Chapter Seven.

Most importantly, perhaps, the writer chose empathy because the capacity might be viewed as a Western equivalent of some aspects of education as transformation. For example, the voice of connection, an empathic voice that seeks to be in relation to others, might, despite obvious cultural differences, be said to be similar to principle 1(a), connectedness, found among the Ju/'hoansi and the Fijians, which denotes linkage between self, community, and the healing power. We will look more closely at the ways in which empathy and education as transformation are similar in the next section. This discussion will also serve to clarify why the writer chose the Mehrabian and Epstein instrument over others in an attempt to address some of the problems in the way psychiatrists are educated that we raised in Chapters One and Two.

Empathy and Education as Transformation

(1) Empathy has been positively linked to the acceptance of individual differences in others (Bryant, 1982). Education as transformation is a model of healer education which ensures that healing as a resource is equitably distributed to all regardless of differences. As we have seen, Western allopathic and psychiatric medical education have been criticized for their lack of accessibility to all populations and for neglecting to address sufficiently the problems of gender and ethnicity among both physicians-in-training and patients (cf. Chapter Two). Learning how to empathize might, in the writer's opinion, help to address these problems.

(2) Empathy has been related to moral reasoning in some cases. Inasmuch as an important part of the education as transformation healer's role is to be a moral explorer for his or her people, studies that define empathy on moral grounds are also of interest to us. For instance, Kalle and Suls's (1978) study of adults found a significant relationship between empathy and Kohlberg's Stage 4, or conventional morality, but no relationship to stages 2, 3, 5, or 6. However, Eisenberg, Pasternack, and Lennon (1984) found no relationship between empathy and Kohlberg's moral maturity scores with nine-and ten-year-olds. Bryant's (1982) review of the above findings noted that they "are consistent with Gilligan's (1982) evaluation [from a relational perspective] that Kohlberg's stages of moral development are not sensitive to developmental components of moral reasoning based on emotional connectedness and responsibility for others" (Bryant, 1987, p. 368).

(3) Empathy has been correlated in other studies with such broadly human qualities and actions as altruism and role-taking, as well as with helping behavior and emotional contagion. Thus, in our study, it behooves us to utilize an empathy instrument, such as Mehrabian and Epstein's Questionnaire Measure of Emotional Empathy (1972), which defines this human capacity in terms that correspond with a main principle in education as transformation—that of service.

A large amount of evidence from studies using the Mehrabian and Epstein instrument has shown that there is a positive relationship between empathy and helping in adults which has also been shown not to be confounded by liking or perceived similarity (Mehrabian & Epstein, 1972), but of

interest is the fact that Sturtevant (1985) found no relationship between empathy and helping in children. These findings point toward the need to take into account that empathy, although it is apparently related to helping behavior, is a complex concept that may differ in the way it is expressed or understood among those in different age groups.

(4) Empathy has also been positively associated with a "higher propensity for arousal by others' emotional experiences" (Mehrabian & Epstein, 1972, pp. 368-369), or emotional contagion (although, again, the evidence is not as clear-cut with children as with adults). When applying this to our psychiatrists, contagion implies a kind of permeability between healer and the one seeking healing. Again, this is reminiscent of education as transformation wherein as the healer gains access to the healing power through an altered state of consciousness, the boundaries between the healer, the healing power, the one seeking healing, the community, and the ancestor-gods become more permeable.

(5) We are interested in cross-cultural comparisons, and the Mehrabian and Epstein instrument has been utilized in other cultures as well as in the United States. Some examples: a Hungarian study where it was used to differentiate teachers' influence on children's behavior (Dobay, 1986); an Israeli study with undergraduates that indicated that adopting a more pronounced cognitive outlook facilitates a logical mode of relatedness characterized by task-oriented behavior, whereas adopting a more pronounced emotional mode of relatedness facilitates a self-involved orientation (Kipper & Uspiz, 1987); and a Canadian study to test the hypothesis that dogmatism, empathy, and nonverbal behavior of fathers are related to the cognitive development of preadolescent sons (Tremblay, Larivee, & Gregoire, 1984-85). Within the United States, a review of available measures pointed out that the Mehrabian and Epstein instrument was shown to have adequate validity and that it measures vicarious emotional arousal, rather than role-taking, and that it may tap a general tendency to be arousable in various situations (Chlopan, McCain, Carbonell, & Hagen, 1985); a study with undergraduates who scored at the extremes of the Mehrabian and Epstein scale showing that the highly empathic tended to volunteer to work with responsive children and thus for helping situations that offered the possibility of alleviating empathic distress, whereas low empathic subjects preferred impersonal helping encounters that demanded little emotionally (Barnett, Feighny, & Esper, 1983); and a study that showed a linkage between empathy and religiosity (Watson, Hood, Morris, & Hall, 1984).

Thus we suggest that these findings concerning empathy share something in common with some of the principles of education as transformation—such as the emphasis on service, the role of the healer as moral explorer, and the notions of permeability occurring between healer and healee, constituting a kind of emotional contagion. We will examine more closely in the next section how the instrument was constructed.

The Mehrabian and Epstein Questionnaire Measure of Emotional Empathy (1972)

The instrument chosen to determine the level of "emotional empathy" among the chosen sample of community psychiatrists was that of Mehrabian and Epstein (1972). This particular instrument was selected due to its apparent appropriateness in relating empathy to "helping behavior," which could then ostensibly be applied to a sample of prototypic helping professionals, such as community psychiatrists (Cheever, 1984) in comparing the latter with education as transformation healers. This instrument was also chosen for the fact that it is used cross-culturally, for the way it was constructed in breaking down related aspects of empathy and because of the relatively short time that it takes to administer.

In the early 1970s, Mehrabian and Epstein developed this questionnaire to measure "emotional empathy," using a sample of college students of both sexes. The questionnaire has thirty-three statements that respondents are asked to rate for their degree of agreement, on a scale from +4 (very strong agreement) to -4 (very strong disagreement). These statements were chosen for the questionnaire from a larger pool of intercorrelated subscales measuring related aspects of emotional empathy in an attempt to design a study that would determine the personality correlates in helping behavior. The subscales consisted of the following: "susceptibility to emotional contagion," "appreciation of the feelings of unfamiliar and distant others," "extreme emotional responsiveness," "tendency to be moved by others' positive emotional experiences," "tendency to be moved by others' negative emotional experiences,"

"sympathetic tendency," and "willingness to be in contact with others who have problems" (Mehrabian & Epstein, 1972, p. 527).

An earlier study by Krebs (1970) had seemed to show that one could not draw specific conclusions concerning personality traits of helpers (Mehrabian & Epstein, 1972, pp. 534-535). Mehrabian and Epstein ran two separate studies to test subjects' empathy level in relation to two sorts of personality correlates—aggression and helping behavior—in order to determine the replicability of their thirty-three-item subscale in two separate social situations. Their measure showed discriminant validity in that the empathy questionnaire did not correlate with the Crowne and Marlowe (1960) social desirability scale, indicating that subjects did not respond to the questionnaire items solely to make themselves look good [$\underline{v} = 8$] (Mehrabian & Epstein, 1972, p. 540). Thus, the writer initially chose this particular empathy instrument due in part to the thoroughness of its authors in fleshing out confounding variables, as well as to the fact that it had been utilized in a variety of different studies.

In the following chapter, the writer, following grounded theory (Glaser & Strauss, 1967) as previously delineated, will present the educational life histories of eight of the sixteen community psychiatrists of the sample, in order to allow themes to emerge. The interview data is organized in terms of (1) the psychiatrist's current situation (i.e., at the time of the interview), (2) the way that the psychiatrist became a psychiatrist, (3) the psychiatrist's relational history with family (family of birth and of marriage), friends, mentors, and colleagues, (4) the psychiatrist's relationship with patients, (5) what the psychiatrist does and does not value having learned in both his or her formal and informal education, and (6) what challenges, obstacles, and vulnerabilities the psychiatrist has faced.

Chapter Six:
Psychiatrists in Relation

In this chapter, first, we will organize the interview data in terms of ten organizational categories (which should not be confused with the eleven subthemes of the control-connection continuum), several of which have additional subdivisions. It should be noted that some of these categories correspond directly to questions in the interview schedule, while others—such as the category describing relationships—arose from the interview responses themselves. In both cases, however, the writer has arranged the information as she deemed most appropriate, regardless of which specific question was being answered at the time the information was given. An answer to interview question #9, for instance, where respondents were asked how they saw themselves in relation to their community before becoming a psychiatrist, might have contained information relevant to category #11, which asks about informal experiences (i.e., out of classroom, including before entering medical school) that might have influenced them to become a psychiatrist. Occasionally, the writer's voice is included, when it was felt that to do so would further clarify either the content or the way that the exchange unfolded. Wherever the writer's voice is introduced, it is given in italics with *"OLC"* preceding it; all other quotes are the psychiatrist.

These categories are as follows: (1) a brief overview of the psychiatrist's background (which includes some information from a brief written questionnaire that each psychiatrist was asked to fill out) and of the psychiatrist's initial contact with the writer; (2) the psychiatrist's current situation (i.e., at the time of the interview); (3) the way the psychiatrist describes him- or herself as a psychiatrist and the way the psychiatrist describes what he or she does as a psychiatrist; (4) the way the psychiatrist became a psychiatrist; (5) what has made him or her a better community psychiatrist; (6) what the psychiatrist considers to be the main ingredients in helping someone; (7) the psychiatrist's relational history with family of birth, friends, spouse/significant other and children, community, colleagues, mentors, patients, self, and a power greater than the self; (8) what the psychiatrist does and does not value having learned in both his or her formal and informal education; (9) what challenges/obstacles/vulnerabilities the psychiatrist has faced; and (10) a summary of the writer's initial impressions following the interview (cf. Appendix B for the Education as Transformation Interview Schedule.)

To protect their confidentiality, all psychiatrists have been given pseudonyms, and certain details that do not distort or change the context in a significant way have been altered.

Hassan

Hassan, fifty-seven years old, is a foreign-born Arab-American male whose wife died several years ago. He describes himself ethnically as "Mediterranean Christian," although he was "raised Congregational." He was pre-med as an undergraduate and attended medical school in a country in northern Africa. He then came to the United States several years later and did his clinical training in the Southwest, but he "does not remember" where he did his rotations. He does not specify any aspect of his formal and informal education as either particularly useful or not useful, marking "not relevant" on the questionnaire. As to his theoretical orientation, he describes it as "eclectic" and feels that this has been useful in that it has given him flexibility to meet the varying needs of his patients. During the interview, he also mentions his analytic training as useful. He did not complete the last two questions of the questionnaire ("What position do you currently hold and where?" and "How many years have you been working in a community mental health environment since completing residency or internship"?). However, he indicates that he has spent more than three years in a community mental health environment, the minimum required in order to participate in the sample.

Initial contact with writer

The writer first met Hassan at the 39th Annual Hospital and Community Psychiatry Conference, held in Boston in the fall of 1987. She was introduced to him and some of his colleagues by another

psychiatrist, who already had volunteered to be in the sample, at a social gathering for the members of the American Association of Community Psychiatry. These psychiatrists had been told by their colleague about the writer's research, and several, including Hassan, expressed an interest in being interviewed.

Present-day situation

At the time of the interview, this psychiatrist was working in a city in a central Atlantic state, in the psychiatric unit of a hospital that works with community mental health centers. He was also doing a lot of teaching about medical as well as psychiatric approaches at schools of social work as well as to hospital staff. His courses have included such varied areas as the use of occupational therapy as a treatment approach, abnormal psychology, sociology, the "rational" use of medication, treatment planning, and the role of the physician in treatment.

How Hassan describes himself and what he does as a psychiatrist

After the writer makes a few remarks to introduce the first question, Hassan's answer to this question is succinct and without elaboration, although the writer tries to elicit more information:

OLC: How would you describe yourself as a psychiatrist?

A good one.

OLC: What does that mean?

I do what I'm paid to do and do it effectively with little complaint, and that's a fact.

OLC: How would you describe what you do as a psychiatrist?

I have no idea what that means. Unless you tell me what that question means, I can't answer.

OLC: Well, for example, if you were explaining to me what a psychiatrist does, and I wasn't in a mental health profession, how would you describe to a lay person, in terms that are very simple, what you do?

I evaluate the person, decide what kind of treatment they need, and try to see to it that they get it.

Later on in the interview, he differentiates between a career in the public sector as opposed to private practice, stating that he feels that his work in the public sector "requir[es] imagination" in order to achieve his goal of getting "people back into their appointed roles," especially since there are always large numbers of patients whom he is attempting to provide treatment for. He also stresses the importance in his work environment, where resources are sometimes scarce, of knowing how to identify and/or create resources that can provide for the multi-leveled needs of patients, as well as continuing to communicate clearly with past sources of care to ensure proper continuity of care for his patients:

> First, you have to make use of the widest scope of resources. Sometimes you have to create resources because they aren't there. You're working with people usually who have social and personal disabilities as well as psychiatric disabilities, and so your planning is on a broader [scale], and then there's the pressure of numbers—you want to get people back into their appointed roles...and to be sure that when they [are released], the welfare offices, the visiting nurses association already know to drop in, that they link with the right center for their health problems, that protective services is aware of their leaving, that the physician in the mental health center knows what I have done and how I have done it so that what he or she does is a continuation of what I did.

Becoming a psychiatrist

Hassan feels that, in a sense, he became a psychiatrist "purely by accident," as he initially was planning to go into public health. In 1954, while still in his native country, he found a position in a psychiatric hospital that would fulfill a requirement of a year's hospital work for licensure as a

psychiatrist, which would in turn enable him to go into public health. He feels that "[it] was purely fortuitous that I got that position" and thus that he became a psychiatrist. On the other hand, however, he notes that he was drawn to his professors of psychiatry in medical school and states that "I probably would have gravitated anyway to a psychiatric specialty."

After training in his native country as both a community and a private-practice psychiatrist, he came to the United States in the '60s,where he opted to continue only in public-sector psychiatry, following his long-standing interest in public health. At the time of the interview, he was working with community mental health centers in planning after-care and "in avoiding admissions sometimes."

Becoming a better community psychiatrist

He states only that "getting older" has made him a better psychiatrist. But when questioned further as to whether this has made him feel wiser, he replies, "No, actually less wise. I know much less now than I said I knew thirty years ago, because I am more of a realist now. I realize how dumb I am." He emphasizes that "I changed as I grew older and my experiences changed when I started traveling."

When the writer asks him about what the most important things are for a psychiatrist-in-training to learn, he responds, "I think the basic qualities that make a good psychiatrist are not learned,...[nor are] you born with them...[nor do you] learn them in new psychiatric training." He does not answer the writer's question as to how one then would learn them. Instead, he describes the desired qualities of a psychiatrist, albeit with a sardonic twist at the end—"being as great as I am"—after first noting that a psychiatrist needs to learn "a certain amount of humility":

> [These] are basically keeping an open mind, considering alternatives to every stimulus you get, and learning a certain amount of humility—that you can't always be right, [that] sometimes...there are no answers. And being as great as I am, that's all.

When asked whether he means that he wishes trainees to understand that it is all right not to have the answers, he replies: "Sure, but it's not okay for them not to try and get them," and he emphasizes that "you learn by reading and by listening to others." He also repeats what one of his supervisors had told him: "Keep your ears open and your g_____n mouth closed!"

What Hassan considers are the important ingredients in helping someone

He states that what he considers most important is assessing the needs of the person he is helping, and then continues briefly, "You can't help anybody unless you know what their needs are. Once you know what their needs are, then you can decide how they need help."

Relationships

With family of birth: He mentions very briefly that his father was a banker and a teacher of economics, and his mother "had the hardest job a woman can have—raising a family." When asked about any major forces that have shaped his character, he indicates that his father and mother were such a force in his life, but he answers this question tersely: "Father and mother. They're both dead. What more do you want to know about them?" He is the youngest of four siblings, with a brother who is a professor of law at a university in his native country and two sisters, one a nurse and one a teacher. However, he does not elaborate on his relationship with any family member, either before or since moving to the United States.

With friends: He gives no information as to friendships as he was growing up or in his years of medical school, but he mentions the importance at the time of the interview of having friends who are outside of the field of psychiatry.

With spouse/significant other and children: He indicates only that his wife died several years ago and offers no other details about any kind of intimate relationship.

With community: As to the community he serves, he states that he prefers working in state-hospital psychiatry to working in private practice, as he had earlier in his career. Giving his reason for

this preference, he states that "if you have any imagination, you work in the public sector. If you're boring, dull, unimaginative, then you work as a private psychiatrist, which antagonizes everybody." It is interesting to note that when he talks about the population he is serving, he generally uses the term "the public sector" in preference to referring to a term such as the "community" he is serving. In fact, he does not use the word "community" frequently, but in one instance when he does he seems to indicate that by this he means the place where he grew up in his native country.

When asked whether by practicing community psychiatry he considers that he is helping individuals only, or whether he feels that he is affecting the quality of life in a particular community, he begins by saying: "I always used to say if you greet somebody kindly in the morning and you make one person feel better, you have changed the quality of life that day." But he then somewhat undercuts the goodheartedness of this sentiment by adding, jokingly, "[That] sounds like something horrible social workers would say." When the writer asks, in response, "Are all social workers horrible?", he replies with a takeoff of a well-known phrase: "Some of my best friends are social workers."

As to his relationship to his professional community, he mentions in general terms that this has changed over the years, and he attributes this to having acquired professional skills:

> I'm more community-involved because I have developed some skills.... Well, let's say I've been asked to teach courses I wouldn't have been asked to teach if I hadn't my skills. I've been a consultant to special programs [that] might have dunned me for money but they certainly wouldn't have asked me to be a consultant if it hadn't been for my skills. So, yes, my relation has changed.

Outside of work, he indicates that he enjoys performing with a chorale every Easter; this is an activity he has been involved in for the past fourteen years. He also performs in a church-affiliated community theatre and says wryly, "Anytime they want a middle-aged fellow with an accent, I get the part."

With colleagues: He mentions that he has a close relationship with one female psychiatrist who works with him and that he would ask any of the staff members in the hospital for assistance if he ever faced uncertainty. However, he indicates confidence in his own competence when he adds that "most of the time I know what I'm doing, and I know who to ask if I don't know." Again, on a sardonic note (in the writer's opinion), he jokes that "I am arrogant enough not to be burdened by admitting ignorance."

With mentors: He mentions only one person, a professor of psychiatry whom he met in medical school, who the writer judged might have performed the role of a mentor. He describes this man as "one of the greatest men," adding that he was "just generally good,...intelligent, knowledgeable,...[and] a good teacher." When asked, he says that he did not spend time alone with this professor "until years and years later," at which point they became and have remained friends. In contrast, he also mentions two other professors of psychiatry, one of whom he describes as "100% despicable" and the other as "95% despicable" because "their models were not my models.... They weren't worth the trouble of worrying about...[because] they were just not nice people."

With patients: Unlike most others in the sample, he gives no specific examples of different patients. Instead, he speaks in more general terms and in no detail, as when he says, "I evaluate the person, decide what kind of treatment they need, and see that they get it."

Of his patients in his private practice in his native country, he says, "Well, I would have liked to have the kind of patients I enjoy working with, [but] most were self-indulgent people that I wanted to slap." When questioned further by the writer, he explains that his patients were middle- to upper middle-class and that psychotherapy had been conducted in French, the language of the well-educated. He goes on to mention the effect of patients' physical appearance on how they are treated: "We know that better looking people usually get more attention. They're assessed as less disabled, [and] they get more attention."

With self: When asked whether there is anything he feels particularly confident about when he does it, or looks forward to doing because he does it well, he answers that he does not "have...time for wallowing in navel contemplation," thus avoiding sharing any level of self-reflection:

> I get [to work] in the morning, do what I have to do, and leave in the evening. I have no time for wallowing in navel contemplation....

In addition to not wanting to reflect on things, which he attributes to the time pressure he is always operating under, he equates such reflection as being analogous to being overly preoccupied with interpretation in psychoanalysis, and he repeats the feedback he received from his analyst:

> There's too much going on today and there's a hell of a lot happening tomorrow for me to spend too much time on what [has] happened [in the past].... If I have learned [something], who cares how I learned it? As my analyst used to say when I would get overinvolved in interpretation, he used to say a very profound psychoanalytic word: "B_____t!"

One prominent aspect of the tone of the interview is the fact that Hassan appears to relish bantering and matching wits with the writer, seeming not to wish to take himself so seriously but also blocking the writer's attempts to probe further on some questions. For instance, in the course of discussing what were valued learning experiences for him, he makes a short, somewhat wry, comment in passing about his life: "My life would make a very boring movie. There are no climaxes where I look like Greer Garson out of the window and say 'I just discovered radium.' There's none of that." Out of this grows what the writer interprets as a bantering exchange after she responds with a French expression often used in English: "[That would be] a little *de trop* [too much]!" As Hassan and the writer had spoken French together during an earlier social gathering, Hassan feels free to respond in French, and this prompts a short exchange in that language in which Hassan says that it would be fine for him to continue the interview in French. When the writer indicates that she does not wish to do so, saying that she wants to code the interviews in English, Hassan responds in mock surprise, laughing, "You mean I'm going to be coded, I'm going to be holes in a card?" and then adds "I'm pulling your leg."

Another instance of this banter, this time with a somewhat cynical edge, occurs during an exchange at the very end of the interview when the writer offers to answer any questions Hassan might have as to the nature of the writer's research and why she is doing it. Hassan cuts in, saying, "So you can get a Ph.D., so you can get a better paying job." Upon responding, "Well, you might say that, but that's not my only reason," he answers pointedly, "Yeah, but I hope that's a prominent reason." The writer then repeats, "It's <u>one</u> of the reasons...," and Hassan continues, "Good, because if it weren't one of the reasons, I wouldn't believe you." The interchange ends with the writer insisting on saying, "No, it's <u>one</u> of the reasons but I'm also very interested in cross-cultural healer education and looking at people in the way that their community affects them in their healing role."

<u>With a power greater than the self</u>: Hassan does not mention anything to do with a power greater than the self, and the writer does not ask him this question directly. Although he mentions that he enjoys singing a particular piece of church music with his chorale every Easter, it appears that it is due to his love of performing, rather than because he senses a connection with a higher power.

Valued and non-valued learning experiences

He values having learned "the skills,...the tools of the trade," which include being able to evaluate and assess the needs of individual patients and, on a systems level, the institutional environment:

> You need the kind of skills that ultimately help you find the way to understanding, maybe never understanding,...what the mind, the feeling, the non-physical part of the person...is and what kind of body it is and what kind of social setting it is.

Elaborating, he states that one has to take into account the degree of physical illness as well as mental illness: "It's useless understanding somebody's—quote—psyche—unquote—if you don't take into account that they might be quite ill." This involves "understanding what assets the body might serve, and what liabilities." In other words, it is important to rule out physical illness the symptoms of which might mimic mental illness.

He says that "I would like to think that when I learn something, it affects me. [But] if you want specifics...," and he does not elaborate further about his feelings concerning his education.

<u>Formal education</u>: In answer to the question about his formal education, he replies that "it would be absolutely awful if all the courses I have taken over the years have not had any effect on me." He states that he had had an analytically oriented training as a resident, where he was in analysis with the same analyst as three of his six fellow residents "because it was very stylish." Also, "because I was lucky with the analyst I had, I was inspired to do a fourth year of training...and go into the _____ Analytic

Institute." He then went on to another graduate school, where he enrolled in a master's degree program in experimental and behavioral psychology. When asked how he felt about this and whether his motivation had been to become a behavioral researcher, he replies,

> No, no, I [was] just learning, it was fun, it was something I didn't know much about. It was nice going to school at that time because I didn't need to. It's lovely that way.... I was working for a graduate degree, I took all the courses, I learned what I wanted to learn, thanked the faculty, and never bothered to get my degree. I already had all the degrees I needed.... I've never enjoyed going to school so much.

When asked how he had felt about medical school, he replies, "I [didn't] particularly hate it. I...was in fourth place [and during] the year I sang in three choirs and went to a dance once a week." When asked if he enjoyed himself while in medical school, he says, "I try to enjoy myself no matter what I am doing. I think it's a damn good idea."

As to non-valued learning experiences, he mentions that although the year at the Analytic Institute

> was supposed to make me feel my way and find how I'm going to do [analysis],...many of the training analysts were consultants at the hospital where I was working, and meeting them terrified me. I could just see myself becoming like them—opinionated, no assets, mostly obnoxious people. So I flushed analysis down the drain and that's when I went and took my graduate work in experimental and behavioral psychology.

Informal education: He does not mention anything directly about informal learning experiences and does not appear to feel that he has learned anything that relates to his effectiveness or self-definition as a psychiatrist from his outside interests or friends. However, he emphasizes the importance of having interests and friends outside of psychiatry and mentions that he does crossword puzzles, needlepoint, weaving, and mosaics, as well as acting in a community theatre and performing with a chorale, both of which he has done every year for a number of years.

Challenges and vulnerabilities

Hassan does not like "situations [that are] out of my control," such as when a patient suffered severe side-effects to medication, and adds that "it doesn't make me uncomfortable, it just makes me anxious." Likewise, he describes how he was uncomfortable when half the staff was out sick during a flu epidemic, leaving them short-staffed and, consequently, out of or less in control. However, regarding the issue of certainty, which involves the sense that one has adequate information to act appropriately, he states that he does not always have all the answers, even though it would be easier if he did:

> It's nice having answers, and my work would be much easier if I had all the answers, but sometimes I get the answers by listening to what other people say and sometimes by pure disagreement I find the answers.

One area of potential vulnerability to psychiatrists is dealing with suicidal patients, and especially with instances of a patient actually committing suicide. Hassan's immediate reaction to the suicide of a patient, in the one instance he describes, was to help other staff members cope with the loss rather than confronting his own feelings:

> *OLC: Just to get back to moments of uncertainty—you must have dealt with suicidal patients during the course of your career. Have you ever lost one?*
>
> Yeah.
>
> *OLC: How did you deal with that—when the person committed suicide?*
>
> I first lectured.
>
> *OLC: What did you do to help yourself?*
>
> Usually I was so busy taking care of the other members of the staff that somewhere along the way I hid my own feelings.
>
> *OLC: In helping others...it sounds like...to deal with it?*

Yeah, to deal with their own feelings, my own feelings got [lost].

He then continues by telling of another time when he had a series of more personal losses. Unlike the situation above, he appears to have reached out to a friend on this occasion:

> One time...I had three personal losses in about a couple of months, you know, a ten-month-old child of a friend of mine died, another friend who worked in a lab must have had some kind of infection and before it could be diagnosed he was dead, and then the son of a friend of mine who was fifteen committed suicide.

He continues, with no pause, beginning to explain what he did to cope with these losses:

> I had lunch with a woman who is probably one of the best suicide counselors in the country and she taught herself after her son committed suicide, and she and I had a nice lunch together and it was very...
>
> *OLC (interrupting): That's wonderful. Did you know her before?*
>
> Yeah, I had known her before. So seeing her and hugging her was not unusual. She's very huggable, but at least it was very spontaneous on both our parts.
>
> *OLC: It sounds like, though, that one of the ways that you take care of yourself or, at least in this situation, is in helping others?*
>
> It just so happened this way....

The writer's initial impression

Hassan was the first community psychiatrist whom the writer interviewed. She noted at the end of the interview that she had felt "unfinished" and quite breathless, with a sense of not having succeeded in conducting a "good" interview. She felt that she had elicited a minimum of information and that it had been difficult to stick to the order of the questions on the interview schedule, or not to get off onto another question, before she had fully taken in or understood Hassan's response to an earlier question. She also found it difficult to get a clear sense of him as a person, including his deeper feelings and self-reflections, and remarked in her notes that she had felt "nervous" and wished she could conduct the interview again. If one were to liken the interaction to a sports match, such as fencing or tennis, there was a playful sense of parrying, or of short, quick volleys at the net, where the writer felt she had to react quickly—and sometimes defensively—to Hassan's responses rather than having time to reflect on them or being invited to explore further with him what he meant by his responses. Furthermore, she was intrigued by the number of activities that he reported himself engaging in, in addition to his community psychiatric role. She jotted a question in her notes as to whether she would find a similar high extracurricular activity level among other community psychiatrists in the sample.

Dwayne

Dwayne is a black male, forty years old and married to a Hispanic woman, a lawyer who has one daughter from a previous marriage; together they have two sons. He describes his religion as "Zen Buddhist, I suppose." He went to a state university in the West, where he majored in biology as an undergraduate. He then went to medical school in the same part of the country, but he does not list any particular area of specialization. He describes his orientation as "eclectic, biological, psychological, social," which allows him "to use a model that fits the patient." He considers the most important part of his formal education to have been his "medical training and especially courses in human biology." He is "not sure" what were the least important academic courses. However, he repeats at different times during the interview that he feels that there should have been more courses in medical school about self-healing and more exposure to "real healers." At the time of the interview, he had worked in community mental health for fifteen years since completing medical school.

Initial contact with writer

The writer met Dwayne at the Hospital and Community Psychiatry Conference in Boston in the fall of 1987. One of his colleagues had suggested that he might be a good person to interview, given his unusual specialization in conducting psychotherapy with urban gang members. The writer contacted him by phone following the conference, after he had returned home, and it was agreed that she would interview him a few months later when he was to come to Boston again for another conference in March l988.

Present-day situation

At the time of the interview, Dwayne was working in a community mental health center and a community hospital in a Southern city, drawing his patients from a largely adolescent population, including gang members. He also held the position of executive director in this city's Community Mental Health Council.

How Dwayne describes himself and what he does as a psychiatrist

Dwayne states initially that "I'm a physician who tries to heal people," in that "I try to help people develop their innate ability to heal themselves and to reach their maximum daily potential for their self-healing." Stating a bit later than "I've always been a healer—that's very apparent to me," he elaborates on what he means by "healer" and "healing," and how he has developed his innate understanding of what true healing entails from being around those who use various methods of healing as well as from encountering others who are not true healers. He emphasizes that an important part of being a healer is knowing how to heal oneself. What leads up to this discussion is an earlier response to the interview question as to what he found least helpful in medical school and what he would eliminate from the curriculum. Instead, he says that he would include courses in self-healing:

> Well, if I would talk about eliminating something, I would eliminate an omission. See, people don't see absences, and the omission that I would eliminate is the lack of emphasis on self-healing, self-preservation.
>
> *OLC: So, in other words, that would be something that you would want to emphasize in that curriculum, self-healing and learning tools for your own healing? Do you include psychotherapy or your own self-analysis in that?*
>
> That's one way of doing it.
>
> *OLC: Was that the route...did you go that route at any time?*
>
> Yeah, I don't care how I do it.
>
> *OLC: Did you find the psychoanalytic approach helpful?*
>
> Me and my shrink were...—yes, it is useful, 'cause it's real and you don't...

Then, in order to illustrate the point that he is about to make about the necessity of "seeing" one's unconscious repression, not just talking about it, Dwayne shifts from talking about his own healing and, instead, gives an example of a black woman whom he was able to help get in touch with her unconscious repression of having been raped when she was eighteen. Initially, when this patient had sought his help, she had complained of suffering from panic attacks after she had been tied up and robbed in her home a few months earlier. In giving this vignette, Dwayne comments on a limitation of just verbally sharing in psychoanalysis:

> [T]he problem is that people [in psychoanalysis] sit around and they talk about "repression" and they talk about the "unconscious" but they never see it. I had a woman who came in who was anxious, her breathing was irregular, she was tremulous, she was upset and I learned that she had been at home and some people had broken in and tied her up and robbed her. [They] didn't hurt her, but she was freaked out.

Continuing, he mentions that he helped her to express her feelings about being robbed and gave her medication to help her sleep. Subsequently he did not see her for several months until she reappeared in his office complaining of being terrified, telling him of having feelings of a knife's being held to her throat for five minutes, while she seemed to hear someone laughing. Dwayne asks her, "Well, what was on your mind?" as the patient describes hearing this laughter, and at this same time Dwayne shares with the writer what was going through his own mind as he began to formulate a strategy:

> Again, I'm thinking she's had a terrifying experience, [and] I've got to get her to emote and cathart. [However] she did not [appear to] have anything on her [conscious] mind, which is impossible. So I kept badgering and harassing her until finally she told me that she was glad her daughter wasn't with her, and I thought to myself, and I don't know what intuition led me to say, "When were you raped?" And this woman literally fell on the floor...and started crawling around the floor, very upset.

Dwayne continues by saying that he believes that it takes courage in such a situation to keep on pushing or "badgering" or "harassing" such a patient, and that he doubted whether "most people would have continued." And yet, by following his intuition and forging ahead, he was able to uncover the original trauma of her being raped as a teenager, which she had repressed until the robbery had apparently retraumatized her. Her healing involved her actually reenacting her fearful reaction by spontaneously crawling on the floor. He continues to unfold what happened in their session:

> She regressed, and then she told me about how when she was eighteen, she had been raped by two men in the snow. She relived this experience for me. And then she picked herself up off the floor, sat in the chair, took a deep breath, and then she stopped her tremulousness, her breathing was more regular, she was no longer upset, she was calm, much better. And she said, "Oh yeah, I feel so much better. I haven't thought about that in years."

The writer then wishes to return to what Dwayne had been discussing just before this, the importance of the healer's own self healing, in order to be sure that she has understood him correctly:

> *OLC: So what you're saying, it sounds like...if you don't do your own analysis or whatever form it is of your self-exploration, self-understanding, you can't help somebody else? You can't recognize it? In other words, you can talk about repression and suppression and all that, but you don't know what the experience is?*
>
> Without the direct experiences, you don't know what it's about. And this woman then after she sat up, and I said, "What kept you from telling me?" Well, it was like there was a barrier, repression, it was like a wall.... People use those words.

He adds that, while working with this woman, he was observed by a resident in family practice, who appeared to be quite shocked by what was going on as the patient developed further insight into her present-day anxieties. Dwayne continues:

> And then this woman [the patient] said, "You know, I now understand something about why I'm so uncomfortable in the wintertime. Because I got raped in the snow, and everytime it snows I guess I would think about, even though it wasn't conscious, I would think about [the rape]."

He makes an added point that this woman was "a working class kind of poor black woman" who was nonetheless "able to hit upon that dynamic of human life." As Dwayne continues to talk about the nature of true healing, whether of the self or others, he talks about the importance of an attitude of respect, especially when one is trying to help someone of a different culture with a different belief system:

> I believe that one of the most respectful things that you can do for another person is leave them the f__k alone.
>
> *OLC: Right, and if they're seeing a "curandera" or "curandero" [a female or male healer from the Latino tradition] or something, you would let them?*
>
> It's not my problem.
>
> *OLC: Would you collaborate with a healer from another culture?*

> If they were...if they had some sense, 'cause there are lot of people out there that are b____g other people...and they try to crack on me because I'm a Western type of healer. So they think...
>
> *OLC: ...that they have something to show you?*

Dwayne then mimics another healer trying to convince Dwayne that his way is better, and Dwayne's answer to such a healer:

> "Yah, and my way's better than your way," and I, "No, it's not, and for you to even say that shows me that you're not a real healer."
>
> *OLC: Exactly. What is a real healer?*
>
> A real healer is a person who heals instead of b_____s people.
>
> *OLC: So that a healer doesn't say my way is better than your way, that's not healing?*
>
> Not if he is real. My way may be packaged differently than your way, but a real healer is a person who gets results.... I don't have a problem with that as long as they're real. If they're not real, I'm gonna kick their ass, because...there are a lot of real psychologists, social workers, psychiatrists, nurses, who are not real healers because they haven't healed themselves, and they sit around and they talk to people about their unconscious and they make interpretations, but they've never <u>seen</u> their own. And that's not real.

Thus, Dwayne describes what he does as a psychiatrist by emphasizing the importance of himself as the healer showing the way through his own behavior:

> I first of all practice what I preach.... I try to help people develop their innate ability to heal themselves and to reach their maximum daily potential for their self healing.

He also emphasizes the importance of teaching in his role:

> I think the better teachers are [those] who pay attention to their own learning process so that they know how they learned so that they can see other people's learning processes and help them learn.

However, he cautions that if one is successful as a "healer/teacher," then there is a danger of being distracted by "lost people" who follow the healer/teacher around, looking for answers from that person rather than from themselves.

Dwayne thus emphasizes the importance of helping the patient to develop his or her own "practice or philosophy." This is a process that he feels taps into the spiritual dimension of human experience, and it is an area that he has personally explored, especially through the practice of martial arts:

> You have to help [your patients] develop a practice or philosophy. One thing is the practice of getting there, tapping into their innate spirituality. Another is the philosophy of knowing that it's there, and that whole philosophical, cognitive [framework].... Another is the direct experience of it. So with those three things,...you try to get people there if you can. When you do that with them, there is some sharing of that, but I don't have to go there to get the person there. I have to have <u>been</u> there. I'm much more capable of getting people there, having practiced going there myself....

Continuing, Dwayne explains that this entails a kind of world view that he has always had where he sees himself "building" things and helping people and things to grow "synergistically." He describes a certain feeling of oneness accompanied by a form of inner "music," and he believes that in choosing psychiatry he has found a way to incorporate his innate abilities into a profession:

> This is nothing new for me. I've always built things. I've always seen a synergy. I've always had the music inside of me. I have always had an effect on people which has caused them to grow. So that's always been there. I've just taken advantage of it and make a living at it.

This inner sense of peace helps him to deal with stressful situations, and it is an experience that he hopes to pass on to his patients: "I try to get [my patients] to experience their own direct involvement

with that [mystical experience]. And that's when I know I've got 'em." He then goes on to try to explain this phenomenon:

> I don't know what they [patients] call it, but it tends to bridge gaps, it tends to make connections, it tends to produce more energy, more potential. But it's having the person get there and then go back and going back and going back to that place. Now some people don't get there, but they practice getting there, and to a great extent the practice of getting there is equally important as getting there. Because just because you get there doesn't mean you stay there.... Just because you see light once doesn't mean it's always there, because you forget it.

Becoming a psychiatrist

Dwayne states that in high school, he found himself fascinated by biology and decided that he could either teach biology or go into medicine. He therefore chose to enter medical school, with the intention of becoming a surgeon, feeling that he had a certain affinity for it, which he calls "the touch." However, while in medical school he found himself being drawn to psychiatry because he thought he might have emotional problems that could be helped by a knowledge of psychology and psychiatry:

> [For the] vast majority of my life people had referred to me as being crazy, [which was] painful. So initially my interest in psychiatry was...[to] go get some help for myself by going into this profession [where I could] sneak a little treatment for myself on the side.

He then recounts how one day, after he had corrected one of his psychiatry professors in class, a classmate had told him that he was "crazy" to do so. At that moment, however, another psychiatrist stepped into the argument and pointed out that he was not "crazy" in the sense of being psychotic but rather in terms of being "arrogant, bold, individualistic, [and] inner-directed." Thus, at age twenty-two, Dwayne realized that "all my life I've been thinking people are calling me crazy, saying that there is something wrong with the validity of my conceptualization, and really they were talking about the fact that I'm arrogant."

Following this realization, he decided that he did not need to continue with psychiatry since his sanity had been affirmed, and thus he at first decided to return to his interest in surgery. He later returned to psychiatry, but this time it was for a different reason: because he was intrigued by the "mystery":

> As I got along a little bit further in medical school, it became very clear to me that I could conquer medicine, I could conquer surgery, I could conquer OB [obstetrics].... It's easy. The only thing that I could not figure out was psychiatry. What the hell is this...black box?...That's what I'm going to do, because this is the mystery,...this stuff was just totally unknown.

Becoming a better community psychiatrist

Dwayne continually comes back to the need to go inward and to practice self-healing, to practice what he is preaching.

What Dwayne considers are the important ingredients in helping someone

As we have seen already, Dwayne has a strong sense that he helps people by getting them to find and utilize their own inner resources, stating that "You have to help [your patients] develop a practice or philosophy." His sense of his own right to find his own path is strong, as we will see in more detail, and he has a similarly strong respect for others' right to that same self-determination. As we have seen, he feels that "One of the most respectful things that you can do for another person is to leave them the f__k alone."

Relationships

With family of birth: Dwayne grew up in a ghetto area of a city in the Northeast. He lived with his mother, a brother and sister, and a stepfather who entered his life at age five. His father had left home for good when he was two years old, and Dwayne reports having no memories of him. His brother, seven years older than he, tested and teased his younger sibling "to make me tougher." As an adult this brother became a policeman and was tragically shot and killed by his white partner. Dwayne discusses how this event affected him and how he finally achieved some resolution when he was sent as a patient a black policeman who was suffering from having killed his white police partner. Dwayne also emphasizes that he owes a great deal to his mother, who brought up her sons and daughter "to be free, so I wasn't that tampered with" as he was growing up. He marvels at the fact that "she never directed me, which sounds weird, but I never got directed, I never got socialized," and, he laughs, "I'm still not socialized."

With friends: Dwayne has always seen himself as different, both in his sense of self-direction and in the fact that he often chose to put himself in the position of peacemaker while growing up in a cultural setting that was dominated by gangs. He feels that he "was very constructive in gang activities":

> For example, if somebody would knock somebody down and then kick them while they were down, I would sit there and think to myself, "He didn't have to do that." And then, if asked, I might tell the person, "You didn't have to do that." I tended to bring people together instead of split them up.

His childhood and adolescence were spent in trying out "a number of different sorts of...social organizations,...[which was his term also for] gangs." For instance, "I was in a club and we would give parties downtown, rent a hall, rent a band,...and I was in charge of the social register, and we had 500 people...mostly blacks, around the city coming, things like that." To an extent, then, he was a social leader, yet "wherever I would be, although I was much less sure of my leadership ability when I was younger, I didn't really want to be bothered. I was too busy trying to lead myself first."

Both before and during medical school, he derived a certain kind of satisfaction from his ability to move between different groups of all sorts:

> I used to float in and out of the intellectual group...which was a white group.... I remember I did some Jewish folk dancing, which was weird, but it seemed okay.... I think I had a buddy who was going out with a Jewish girl, and we wound up at the Jewish folk dance.... [Then] there were the "gang bangers" in high school, there were the "Ivy Leaguers," which were the middle-class bourgeoisie people, there were the black intellectuals that hung out with the white intellectuals, and there were the blue collar types. So I floated all around and would make connections between all the groups.

With spouse/significant other and children: Dwayne is married to a lawyer and has two sons who are approaching adolescence and a stepdaughter who is a bit older. He finds that he enjoys a relationship where he can talk with his children "person to person, but, I'm the boss." The whole family is involved in the martial arts, a long-standing interest of his own; he particularly admires his stepdaughter's proficiency in this discipline, saying that they always call her "the jock," and he considers that his wife "has more innate ability in martial arts than I have."

With community: He does not consider that his relationship to community has changed at all since becoming a psychiatrist, since he feels he has always played a "constructive" and peacemaking role and continues to do so.

With colleagues: Dwayne does not say very much about his relationship with his colleagues, other than to say that he feels that people in general do not really know him. He mentions as an exception to this a colleague whom he describes as a true "healer," even though the latter works as an administrator for a professional psychiatric organization. He goes into some detail about this colleague (and friend), stating that he had entered a Christian seminary as a young man but had not been able to remain in a purely intellectual environment that did not permit him to practice what was being taught. Dwayne's description of his colleague's experience is reminiscent of his own in the colleague's need to "check [his] own experience out" and his awareness of "synergy":

> And then he began to realize that he had to define and experience the concepts that they were talking about in school, like charity and faith and sin and all that stuff. It's real nice to be cerebral about it, but you've got to have some guts too. And so he said, "Well, let me leave

> this [seminary] alone for a while and go and check my own experience out," which he started doing and continues to do. And he decided, "Well I don't have to do this in a formal way, I can do this in an informal way by healing or ministering to an organization, helping society. And I feel that there's a general possibility for good, and you have to have all the pieces working towards that, which gives you synergy, and that's what I'm going to do."

With mentors: Dwayne emphasizes the degree to which his learning has always been self-directed, stating that "I never had a teacher, and have always taught myself for the most part, [although] I have had people along the way who have taught me things. But most of what I've gotten, I've gotten on my own." Nevertheless, he mentions one of the first people who "had some influence over me" as far as medicine was concerned. He recounts how when he was a child, he had had scarlet fever and almost died, except he had had "a wonderful pediatrician" who pursued him into his hiding place in the closet to give him a shot of penicillin: "Now he was a healer, and he was a good doctor, so he had some influence over me" although he adds, "I don't think about him, but, he...saved my life!" He also emphasizes his sense of equality with his teachers and professors: "I have never had a relationship with a teacher where I was [just] a student and they were a teacher, but also we were equal.... Even in high school, I had a geometry teacher who I had a great deal of respect for, but he and I could talk person to person, but we could also talk teacher to student." Thus, Dwayne appears to appreciate being able to learn from someone who knows more than he does but who does not talk down to him. In spite of his essential self-directedness, however, Dwayne considers that he was "in a healing universe" when, in medical school, he was being taught by a group of what he calls "crusty black physicians."

With patients: Dwayne's relationship to patients reflects a willingness to lead by example, especially as he has been working with many present and former gang members, and he has adapted a form of psychotherapeutic intervention with them to incorporate their learning martial arts as well. But while he teaches by example, he appears at the same time to be open to his patients' finding their own constructive ways of healing themselves:

> I try to help people develop their innate ability to heal themselves and to reach their maximum daily potential for their self-healing.... I have never met anyone who didn't want to go there, and that's generic. The manner in which they go there is not for me to say. Some people may want to do it through religion, some people may want to do it through martial arts, some people may want to do it through music, some people may want to do it through running, but the principles are all generically the same.

Dwayne feels that he can work with anyone, no matter what the seriousness of their mental illness, as long as he can continue to help them. Having grown up with violence and tragedy, including the accidental death of his brother, Dwayne does not limit himself to any one population, no matter how serious the disability:

> As long as I'm helping people, I don't have a problem with how bad off they are. You know, so what? I'm able to help them. So you're crazy, that's nice, so what? I can help you. You've been raped by fifteen people? That's nice, so what? I can help you. So long as I'm able to do that, what difference does it make what's happened to you? So that doesn't bother me.

Dwayne knows what works with each patient, and he treats each one differently. He feels that he has found a way to retain his professional integrity while adapting his approach to the individual needs of his patients, especially those who are members of gangs. Just as he feels he used an unorthodox approach to overcome repression with the woman described above, he describes another equally unorthodox approach that he used with an adolescent patient:

> [This patient] was such a jerk [that] one day I drove him home to the bus stop and before I did that I took him up to the [martial arts] gym and flipped him a couple of times, and had him flip me, because he was very interested in martial arts. And I figured that's kind of crossing the boundary a little bit, but I was still clean.

By "clean," Dwayne is referring to his integrity as a professional, which he has mentioned earlier in the interview when he refers to staying "clean like Teflon 3." Thus, he is aware that he sometimes takes certain liberties in the manner in which he practices psychiatry, but he feels he does so in order to effectively help his patients and so remains "clean." He also means by this that when people try to stereotype him they cannot pin him down. Thus, he says that when "people interpret and they try to apply things to me and I'm like Teflon 3,...it doesn't stick."

Just as Dwayne has come to value his own individualism and judgment, he respects it in others. Dwayne acknowledges the need to individualize his treatment approach and to recognize the fact that "there's a different timing as well for many people."

With self: Dwayne feels that he was, in certain ways, a "fairly normal kid." Yet most of what he says points to his sense of being different, as when he states, "There are a lot of different examples where I did not behave in a way which was conforming with my peer group or with the expectation of adults.... I would do what I was going to do, because it made sense to me." He perceives a large difference between himself and others in that

> I'm much less influenced by social pressure, social issues. I don't tend to go where other people go just because other people are going there. I'll go there if it makes sense, and if it doesn't, I won't. And if it does, I will regardless of whether or not I'm going alone. Now, sometimes that is lonely and people are always funny because they always say, "You like being different." And I always go, "No, I really don't," but I am [different]...despite the fact that I would like to be brain dead like I perceive most other people to be, because they need to fit in, you know,...not [be] eccentric.

He also feels that he has led a life that has caused him to develop a certain amount of detachment and independence: "I'm always doing something else, I'm always some place different than most people are." He does not seek to conform. Thus, he still considers himself to be peripheral or on the margin of his community. The advantage of this position is that it allows him to be like "Teflon 3":

> [When people] try to apply things to me...it doesn't stick, and they are always surprised, but I have people trust me and they know I'm going to tell them what I think.... Even though they may not like me because they make all kinds of assumptions about why I'm doing what I'm doing and what my motivations are, they know that if they ask me something, I'll tell them what I think...so that helps me to be more effective.

Dwayne mentions that the way to reduce or manage stress is to be effective in what one does. When the writer asks him what he does to reduce stress or to nourish himself, he responds in considerable detail and in a way that makes clear that he experiences himself as very attuned to his own inner needs and processes and always prepared to counter stress:

> I take care of myself.... I tend not to be under stress, and the reason [for this] is because I'm always prepared to be under stress. So since I'm always prepared, I'm always proactive, I'm always ready for it so it never quite gets there. If something happens to me in life that is more stressful, I increase the things that I do to strengthen myself: [I do] martial arts, I sleep, I...alter my states of consciousness quite consciously through whichever technique—sleep, meditation, internal scanning (which is physiologically figuring out where your body is), doing outside activities, meaning outside of myself. Another thing that leads me to cope with stress is to be effective. Being effective reduces a great deal of stress.

He also feels that it is because of this attunement that he is able to help others:

> I take care of my emotional, spiritual, and physical health, and through my own refinement of those aspects I am able to more clearly identify people who are lacking in their own aspects and I'm more able to lead them properly to where I think all people want to go, which is to that core of maximization of that potential.

Elaborating on the spiritual aspects of his life and work, Dwayne mentions "the music" or "the touch" that he feels:

> It's always been there even before I was a psychiatrist. I've always been a healer. That's very apparent to me.... This is nothing new for me. I've always felt things. I've always seen a synergy. I've always had the "music" inside of me. I have always had an effect on people which has caused them to grow. So that's always been there. I've just taken advantage of it and make a living at it.

When asked when he first realized this or first experienced it, Dwayne differentiates between the two:

> Well, if you experience something, you realize it, but that doesn't mean that you're fully aware of it, and then as I began to become more introspective, which occurred through my practice of martial arts and psychiatry, I became more aware of it.

In addition to developing introspection, Dwayne also mentions another sort of heightened awareness that he has been aware of since childhood, which he calls "the touch" and which he developed further in medical school, especially in surgery. As an example of knowing that he had "the touch," he recounts how, as a medical student, he disagreed openly with a medical superior when he stated, after palpating a pregnant patient, that he knew she would have twins, even though only one fetus could be seen on the X-ray. As Dwayne explains it, he was treating a "private patient of the chairman of the department of obstetrics and gynecology [who] called me into his office and...said, 'What the hell is wrong with you telling this woman she's going to have twins! She's my private patient! How dare you upset her!' " Dwayne then had said, "I don't care what the X-ray shows, I do not care what science and this wonderful instrument has said. The woman is going to have twins." Dwayne had ended up delivering her twins after having to "bet [my] medical education on it":

> So I learned from that that I was a better instrument for diagnosis than any scientific anything. Now the issue is can I develop my reliability, validity enough to compete with a machine, and the answer to that is that it's very, very hard, but in terms of..."depth," "holistic whole person," the answer is yes. Because a machine is piecemeal, all that stuff is piecemeal. And I'm a whole person, so I can see whole people. Figures won't lie, but they won't make the hen lay! So I had some awareness from that.

With a power greater than the self: Dwayne's belief in the "spiritual" and in "altered states" and "the touch" are apparent throughout his interview. In the following quote, he speaks particularly directly to these beliefs:

> All of the times in my life when I have ever felt overwhelmed there has come from deep within me a music which relieves me of that feeling of being overwhelmed. At this point in my life I am assured that that's there, so I've heard that [internal music].... It's an indescribable thing which comes from inside which changes my perspective.... It's an altered state. I've had expanded states of consciousness. Those are kind of nice. So it's related to that. It's a religious experience, it's a spiritual [experience]—I'll say spiritual, I won't use religious, although it doesn't matter to me because they are all the same thing. But it's that kind of thing, and I think most people want to get there, and some people get there easier than others. And, again, once you get there you're able to maximize that innate potential to self-heal, to heal other people, etc. etc., do all kinds of good stuff.

Dwayne continues to try and put into words this ineffable, inner state of being, which he equates with the mystical:

> When you tap into that inner spirituality, there is a sense of being connected with everything else, and you get then into this energy, you get into the sum being greater, the whole being greater than the sum of the parts. So it's more, but you're also a part of it. So since you're a part of it, you're also the more...and that's paradoxical.... There is no separation, although there is. That goes back [in]to the group but not of the group. You're still the group, or you can embody the group or represent the group...and still be an individual. So you can be two things at once in the same place, but that's that weird stuff, that's that mystical stuff which you can't explain to anybody.

Valued and non-valued learning experiences

In general: In his formal training, Dwayne values his background in biology and ecology, for which he feels a natural affinity.

Formal education: He found the most important course to be biology, for which he has "had a feel" since high school: "If you have that feel for it, I think you're more able to heal, because you've got the whole piece, you've got everything."

He deplores the fact that formal medical education does not require a physician to heal him- or herself. "The problem is that people sit around and they talk about repression and they talk about [the] unconscious but they never see it" in themselves. Thus, an aspiring psychiatrist has "got to have

something" besides what is gained in a cognitively oriented education; this "something" is, at least in part, the "courage...to go inside of yourself and to go inside of other people and be honest with yourself, be honest with other people." Without this ability, he believes, one cannot practice psychiatry effectively. But while psychotherapy is one way to accomplish this inner work, it is not the only way. He continues:

> I mean, you [have to] go down there to be able to know where it is, to be able to help other people to go down there. I've seen entirely too many people who have never been [there] themselves and [have] talked to somebody else about going [there] themselves. That's...not going to work. Because when the person goes [in]to themselves, there's a lot of fear, danger, opportunity, ugl[iness], beauty, it's all that stuff, and it's real intense because it's very direct and it's very personal. And if you can't tolerate your own, you certainly aren't going to be able to tolerate anybody else's. And if for whatever reason you have been put off from going to your own, you will probably in all likelihood be afraid of someone else's.

Informal education: Dwayne derives a great deal of satisfaction from his study of martial arts, which he began after graduating from medical school, although having "grown up black," he had already learned to box, fight, and wrestle. He has found that his proficiency in this area has given him a useful tool with which to reach gang members with whom he conducts psychotherapy. He also feels that he has learned a great deal from "seeing other healers...and how they go about it."

Challenges and vulnerabilities

Dwayne mentions several challenges, including three times where he nearly died, which he refers to as "near-death experiences": once when he was sick with scarlet fever, once when his older brother locked him in a trunk and he almost suffocated, and once in his teens when he narrowly escaped being in a serious motor accident and saw his life pass before his eyes.

He also shares his difficulty in accepting his brother's death and in forgiving his brother's police partner, a white officer who was responsible for the death, although it had been accidental. Dwayne's feelings were intensified by the fact that the partner has never spoken about the incident to Dwayne. It was only when fate brought him as a patient a black policeman who had shot his white partner that Dwayne was able to develop some compassion for his brother's partner:

> As I sat there talking to this guy and thinking, except he was black and his partner was white [it's the same as my brother's death]. And I'm sitting there and I'm going, hmmm, this is interesting, this must be some kind of karmic debt that I gotta pay or something, I don't know what's going on. But I'm talking to this guy and I'm saying, now is this going to get in the way of my treating him because my brother was killed by a policeman and he's a policeman and he's killed another policeman? But then I started getting some insight for the guy who shot my brother.

Dwayne also shares one experience, while in medical school, where he had felt ashamed of "chickening out" of going on a mountain climbing expedition, and how a good friend had helped him be more forgiving of himself. After he had admitted to this friend that he had been afraid, his friend joked with him, saying "Well, you know what this means." Dwayne, taking him seriously, had asked "What does it mean?", and his friend had answered, "This means you can't join the superhero squad!" Dwayne shares his reaction with the writer and how his friend's understanding of his vulnerability made him appreciate all the more the connection he felt with this friend:

> And I thought to myself, boy you hit it right on the head. He was so much with me that I just felt better, you know? So I've had that experience. He was funny.
>
> *OLC: He understood, though, he really understood where you were coming from?*
>
> We just connected.

Concerning patients who have committed suicide, Dwayne has experienced this with three patients although he was not their principal psychiatrist, and, as he expresses it, since he works with so many people, he does not remember them all. However, he says that "I always try to do a right and healthy thing for everybody I see, so that I know I did my best, what I was supposed to do, [and] I had a healing relationship with that person."

When questioned by the writer whether he ever sought help from other colleagues, he replies: "What's inside me is...and as long as I have direct experience with that, I can't.... If I were to go to someone else and say, "make me feel better," they could say things to make me feel better, and that's happened before and I've felt better. But I had to be capable of feeling better inside myself."

The writer's initial impression

The writer interviewed Dwayne after she had conducted several other interviews, so she found it easier to interview Dwayne, despite the fact that, again, she found that she varied the order of the questions depending on what Dwayne brought up in answering a question. For example, she asked him the question regarding how he handled stress earlier in the interview because he himself introduced the idea very early, in answering another question. The rhythm of this interview was slower-paced in comparison to Hassan's. Dwayne spoke slowly and chose his words carefully. To continue with our tennis analogy, it felt more as though the writer and he were engaging in long volleys, with plenty of time to position oneself to receive the ball and to return it.

Fiona

Fiona is a Caucasian, Protestant female, forty-six years old, married to a man who holds a responsible position in a social service agency; they have a son and a daughter in elementary school. As an undergraduate she majored in history and literature, followed by medical school in a southwestern state. She specialized in child psychiatry at the child guidance clinic in one of that state's main cities and interned at the university hospital of the state university. She describes her theoretical orientation as family systems, which she has chosen "because it seems most helpful to work with clients." In her opinion, the "blend of theoretical and clinical" is what was most important in her formal education. What was least important was the "competition." The most important courses were medicine, pediatrics, histology, and cellular biology. She does not specify any that were least important. She has been working in community mental health contexts for about fourteen years since completing her residency.

Initial contact with writer

The writer met Fiona at the Institute for Hospital and Community Psychiatry in October 1987 in Boston. The interview took place in the lobby of the hotel where the conference was held, just before Fiona was leaving the conference.

Present-day situation

At the time of the interview, she and her family had recently moved so that she might become the director of the Division of Child and Adolescent Psychiatry of a midwestern state's Department of Mental Health. She is also director of the Division of Child Psychiatry at the state university, where she teaches family therapy courses and workshops as well, and she holds a position as director at an institute for juvenile research. Prior to that, she had worked at a city in another state's guidance clinic which, although a private clinic, was funded by the county mental health system.

How Fiona describes herself and what she does as a psychiatrist

In response to the question about describing herself as a psychiatrist she immediately begins, instead, to speak about what she does as a psychiatrist, speaking about her patients and their feelings as she perceives them and asking which of her roles—e.g., teaching students in community mental health or working with patients—she should address first. She quickly chooses to focus on her general approach with patients, whom she finds are "real teachers" who "add to my experience," and likewise, "hopefully I add to theirs too." Often her patients have never seen a psychiatrist before, and are feeling "demoralized." Thus, her approach is "to see what they're doing in a very positive light":

> I guess I basically think that people are pretty interesting and...I also find that patients usually feel pretty downtrodden, especially psychiatric patients, not because they've been downtrodden by previous psychiatrists, because they often have not seen one before, but just that they feel really demoralized by whatever it is that has driven them to the psychiatrist's office. So my general approach is to see what they're telling me in a very positive light. [I] try to take them very seriously but also...to see what they're doing in a very positive light.

Fiona then offers an example of how she turned around one patient's negative presentation of herself into a more positive one merely by "reflect[ing]" the patient's description of herself back to the patient. As a result, the patient was able to see how she was presenting herself to others, and Fiona hopes that she "transferred" something to the patient that would help her in future situations:

> An example of taking people very seriously and also sort of transferring something was...a girl [who] came in and said she was dumb, she was dumb and unattractive. So I asked her how she got into college since she was so dumb, and she said, "What do you mean I'm dumb?" And I said, "Well that's what you told me, wasn't it?" And she was so shocked that I would use her words back [to her that] she had to revise her vocabulary in telling me about it.

Fiona makes a point of saying that she does not like to use the words "helper" or "healer" for psychiatrists, when these are offered as possibilities by the writer. Instead, she thinks of herself more as a "facilitator." Although she acknowledges that the concept of the healer is "an appealing idea," she says, "I have a feeling that people don't heal [others], [although] they may activate healing [in others]." To clarify this, Fiona suggests how she might seek to "activate" a family's healing resources:

> Well,...for instance in the family system one tries to activate the family's own abilities to perceive itself or to respond to its own problems...sometimes by stating the problems they have told you about in a way that they can perceive it differently, and therefore can respond to it differently, or by reminding them of the fact that there are people or ideas abroad in their family that they haven't been making use of.

Fiona is careful to say that, with both individuals and families, "I don't want to really label [them] as 'the client' or 'the patient.' " She finds that "they come and they've got something that's bothering them, [and] they don't need to be called any names about it." Rather, she emphasizes that "the idea is that they usually have within themselves the resources to solve the problem."

Fiona then goes on to point out that in her role as a psychiatrist, she also does a great deal of consultation work, which she considers her "favorite thing to do." Here she uses "a kind of hit-and-run approach"—presumably because she immerses herself in a case briefly but soon leaves it behind—which "involves assessing a fairly complex system...to clarify diagnostic issues":

> It involves assessing the child, reviewing all of the written material—which is really not so much information about the child [as it is] information about [other] people's <u>experience</u> of the child—talking to the staff, getting a sense of what the rules and regulations are that govern the institution itself, and then trying to understand whatever it is that people think the problem is in all those contacts and making recommendations accordingly. [This] may not be simply...coming up with a set of suggestions or something like that; it may be [that] the making of recommendations comes in the form of some kind of event like a staff meeting to which the child is invited. It's interesting how few staff meetings include the people they're talking about.

While she is sometimes required to make a diagnosis, Fiona does not consider this to be her main focus. Instead, she says that "what I usually do is to try to clarify,...to suggest ways of thinking about the kid developmentally in terms of their relationships," in what amounts to a "descriptive" rather than a "labeling" way. When she does have to use a diagnostic label, she explains it in terms that the child can understand. Likewise, she goes out of her way to explain the medications to child patients. They "feel very helpless about it, and I always ask them, 'How does it make you feel?' 'Do you think it helps?' 'Does it make you feel bad?' 'If it makes you feel bad, could you tell somebody?' 'Why don't you tell somebody?', etc., etc."

In addition to her role as therapist/consultant, she enjoys her work teaching residents, psychology interns, and social workers. Her approach with teaching is similar to her approach with clients. She feels that she "takes[s] what people say and get[s] them to look at it,...to take their ideas and,

if they're not exactly what I think would be most useful,...to get them to look at it and give them the opportunity to revise it, or to give them some alternatives or try to acknowledge what [they] offer." In so doing, she feels that she "really tr[ies] to get people to think,...so that they leave with the sort of ability to be able to invent new responses for new circumstances rather than ...going on rote." She sees herself, in the process, as "get[ting] very involved, [and] do[ing] a lot of talking,...tell[ing] a lot of clinical experiences to try to...inundate them with the richness of possibilities." But she is sometimes unsure whether she is not instead "just inundat[ing] them with myself," and she realizes that her manner of teaching will not appeal to everyone. Thus, she adds, "some of the students really like me and some don't."

In response to the question inquiring about when she feels most confident, she talks about the feeling she gets when she feels that she has made "a connection" with a student about an idea they are working on, stressing the importance of that connection but again indicating that she wonders if her enthusiasm is a problem for some students:

> I think there's a point at which...I feel that I've made a connection [with a student], that we're on the same wavelength, we've come up with a metaphor that is appealing or is being mutually confirmed. People are really running with the ball and then I feel very confident and sometimes I guess I may even run too far ahead with it at that particular point, get overconfident, and I leave them in the dust.

She gives an illustration of a time when she did not get ahead of her student, but instead supported and took pleasure in the original metaphor the student used to describe a particular family. Fiona identifies with how confident the student clinician must have felt when the family agreed with the metaphor the student had thought of to describe their situation:

> [One of my students] came up with an appealing [idea] She's dealing with a very confused and chaotic family, and at the end of it she says, "I see this as a family that has trouble getting their laundry sorted out." Like, it's terrific, they've been telling her "He's wearing my socks!..."
>
> *OLC: Right.... They feel confirmed...?*
>
> ...and then of course you feel great because they say "Oh yeah, that's exactly right" and that confirms you so that's when the confidence really goes around!

Although she works hard as a psychiatrist, she says that she never feels depleted or stressed out due to patients. Rather, she sometimes feels that she should learn to say no to giving so many workshops and lectures, which can be stressful when she conducts too many at once.

Becoming a psychiatrist

When she was young, Fiona initially wished to be a "lady baseball player," then an elementary school teacher. But, as she puts it, her independence and her desire to not have someone looking over her shoulder, as well as her wish to work with children, led her eventually to medicine, and initially to pediatrics:

> I didn't become an elementary school teacher because I understood that one had to submit one's lesson plans and I didn't want anybody overlooking what I did (that was my rebellious college senior position), and somebody said "Why don't you become a physician?" and I said "Well, that sounds like a good idea, but I'm not going to treat old people." So I decided I was going to become a pediatrician.

Then, because of an additional interest in prevention, coupled with the realization that there were few preventive programs in child mental health, she decided to switch from pediatrics, "where they didn't want me to come and invent prevention," to child psychiatry, where she felt she could "be on the forefront of prevention."

She comes from a non-medical family, saying, "Nobody in my family is in medicine, probably including me." As an undergraduate, she thought that the behavioral sciences "were a lot of bunko." In fact, she "had refused to take any courses in them...because I thought they were screwing everybody up." Elaborating, she recounts how she felt that

> Freud had pretty much screwed up the civilization by making everybody self-conscious and thinking about...not so much the discontent but they were all kind of planning their anxieties and stuff like that. [It seemed] really boring, and they should [just] get on with life. Then...I also grew up in the era when if you saw a psychiatrist, it meant that you were really disturbed, not everybody and his brother did, or else you were really rich to afford the luxury of psychoanalysis.

After entering medical school, however, she began to change her opinion after getting to know her lab partner, who was undergoing analysis despite the fact that "he seemed to be pretty normal," and she credits him with ultimately influencing her to enter psychiatry:

> He talked about it a lot [and had] a lot to say about it in its defense,...and I thought that was pretty interesting, so I decided to go into analysis too, partly because he was obviously getting something that I wasn't getting, and I thought maybe it would be interesting to find out what that was.... I think [that]...my lab partner was probably the person that really oriented me towards psychiatry [as an] interesting kind of area.

Becoming a better community psychiatrist

She does not feel that her own analysis was particularly helpful, stating that, "after seven years, he [her analyst] didn't change a bit, so I figured that he was a hopeless person." After she had "recovered from" this experience, however, she participated in another kind of therapy with a second therapist, someone "who taught things about healing," which she feels did help her. In addition to introducing her to the work of Carl Jung and Milton Erickson, this therapist engaged in "conversations" with her and "took my contributions seriously." These conversations, she believes, constituted "the therapeutic element of that therapy":

> It didn't matter what the content was. [What was important was] the fact that we had conversations in which I contributed and he took my contribution seriously.... It was that whole business of being valued as a person, or being valued for what I brought to the relationship and that sort of thing.

She believes that this experience continues to influence the way she conducts therapy with her own clients/patients. Thus, she says that this is what "I value so much about how, I think, I...treat [my patients]." In addition to her therapist's positive influence, she feels that she has become a better psychiatrist through the influence of a few teachers, most notably Salvador Menuchin.

As to what she would recommend to a psychiatrist-in-training to become a better one, she answers,

> To get out of the office. To go where the people are, especially the kids if he's a child psychiatrist. And to realize that no matter how much he may know about somebody,...there are more people who know more about that person, including the person himself,...the person's family, the person's teachers, the person's people that he works with. [They] all know more than the psychiatrist would [so]...he should know that.

And while she would "try to influence people towards a particular theoretical framework, like multi-person, interpersonal/systemic, medical system, that kind of framework," she also values an open-minded but independent attitude:

> I find that some people are converts and some people aren't, so I will always talk in those [the person's own] terms. I think that [psychiatry students] should listen to as many people who are good at what they do as possible regardless of what their framework is, because it will be stimulating for their thinking and that they should always think and never follow anybody else's prescriptions or recipes.

However, at the same time that she wishes her colleagues to give her credit for the training she has had, whether it is analytic or not, she also models for her students the therapist's need to be unobtrusive. Thus, she teaches her student-clinicians "that in the end of a successful therapy [especially with children], they [the therapist] should be forgotten":

> When you talk to anybody who had psychotherapy as a child, they usually don't even remember the name of their therapist. And, they may remember something about the therapy, but they usually don't remember the name of their therapist. So it just shows how unimportant therapists are even when they try to be, and that should be humbling.

What Fiona considers are the important ingredients in helping someone

In answer to this question, Fiona emphasizes her role in helping patients to think of new ways to view their problems:

> [Most important], I think, [is] somehow finding a way to describe what [the patients] experience as a problem in a way that they can think of solutions to it. One of the things that happens is that they experience the problem and they experience their efforts to solve the problem in very narrow terms usually and so they end up continuing to do things that are not productive.... Then they get discouraged and sometimes there's the old "more of the same kind" of routine or "the problem becomes the solution" routine. So, one of the things that's really useful is to think about the problem in a different way.

Another important ingredient is "basically confirming people's validity, reality, that their experiences are meaningful, that they themselves are meaningful, that they're not just sort of frivolous, stupid people." However, she immediately qualifies this statement, adding "unless, of course, [they] are [frivolous or stupid], in which case they need to be told that." She illustrates this with the following example:

> I remember one lady, [to whom] I finally said..."You know, you're not a very friendly person." She was really shocked. She'd never thought of herself that way and, you know, she got to be a little more friendly. I mean, it really meant something to her, so that was affirming in terms of a piece of her that was missing that has always mystified her, how come people didn't respond to her in a certain way. But I think [speaking to people in] more affirming than disconfirming [ways] is helpful to most people.

Another important ingredient, she believes, is

> really acknowledging people's relationships or...feelings for each other,...the attachment, and validating these kinds of things. And in order to do that, of course, you can't put those other people down because there are just many, many examples of how that really throws kids—particularly kids—into a very peculiar situation.

Likewise, when it is a question of treating patients from a different culture, it is up to the psychiatrist to find out as much as he or she can about the patient and his or her culture: "If there are people that are because of their customs and their experiences unlike you, then [you] have to learn more about them."

Relationships

With family of birth: Her parents divorced when she was young. Both married again and had other children. She grew up with her mother, her mother's second husband, and one older brother but from time to time she visited her father and his second wife and her stepsiblings. She considers herself to have developed a "pretty close" relationship with these stepsiblings, but she did not grow up with them, as they are about eighteen years younger than she. The family moved frequently, and Fiona consequently experienced loneliness as a child and was always having to develop new friendships. Perhaps as a result, she feels, she developed independence "both in terms of managing myself and also...in my thinking," as well as cultivating an enjoyment of controversy:

> I'm pretty good at taking any side of a subject if someone else is going to argue with me on the other side of a subject. I'm very frank,...I'm just a very definite sort of person.... I have an older brother who's quite the opposite and I expect that my sort of definiteness developed even more in the context of his phlegmatic nature.

She describes herself as having a "very interesting religious heritage" in that although originally she was brought up Episcopalian, her stepfather's father was a Buddhist and his mother was a Theosophist, and "there was all this kind of stuff around,...always books about and pictures of Buddhist temples". Her mother became and still is "an avid Jungian," and her older brother "ran away to Iran and became a Sufi mystic," although he later returned to the United States.

Speaking further of her brother, she notes that they are "not really close, but we do acknowledge each other's existence on a periodic basis.... We're very different people." What she finds interesting is that "I think we're both kind of revolutionaries."

With friends: Fiona mentions that she has enjoyed having lunch at the conference with colleagues who are also friends, but she does not mention friendships outside of psychiatry, beyond saying that it had been difficult for her to develop lasting friendships as a child due to her family's frequent moves. However, she mentions that, having recently moved to a new city, she finds it strange that when she and her husband go out to the theatre or a concert, they do not recognize anyone, and she misses not seeing familiar faces. Thus, in describing her present situation, she says, "I'm very much aware of the fact that I don't know people.... We lived so long in ___ that you couldn't go to a concert or a play and not know people there.... I'm always amazed that when we go to a concert or a play we don't know anybody there.... Where is everybody?, you know!"

With spouse/significant other and children: She is married to a professional man working for a social service agency and has one daughter and one son, whom she describes as "developmentally delayed," which has necessitated her playing an active role in parent meetings at the children's elementary school.

With community: She is not sure initially which community she should address, but then speaks of making participation in parent meetings at her son's school an important priority. In speaking of this, she alludes to a certain level of discomfort on the part of other parents because of her profession:

> The way people think about kids and being active as a parent has been something that I really find interesting, because people don't know exactly what to make of you [as a psychiatrist], you know, what you're going to do, are you analyzing them...and so on.... They've got funny ideas about psychiatrists, some of them probably well-earned but nevertheless...

She also speaks about the community of her patients and of her attempt to be sensitive to the fact that she is understandably viewed as an outsider when she is working in Spanish-speaking or black neighborhoods. One "very powerful" experience that she "really cherish[es]" occurred in medical school, when she participated in an anthropological study of a black neighborhood. There she "not only learned something about people, but I learned about my own insignificance—I mean, how to become insignificant—and how to stop being such a big sort of intrusive kind of character in the lives of these people." She explains that she "read Oscar Lewis and I went and I sat in these people's living rooms—God knows it was really an intrusive thing to do, but they didn't seem to mind too much."

With colleagues: She mentions that she enjoys having lunch with colleagues when she is attending conferences, such as this one. However, the subject of her relationship with colleagues also comes up when asked when she feels least confident. She replies:

> I actually feel least confident in the presence of other psychiatrists, mostly because...I just don't agree with most of them actually, and I feel that they're judging me in some kinds of ways. It doesn't feel bad enough for me to change the way I think,...to be more like [them], but I find that it's the most intimidating kind of circumstance.
>
> *OLC: But when they don't say anything, do you feel that they disagree with you or [do you feel this way only] when they actually disagree with you?*
>
> Well, when they don't say anything, it's not so great and when they take a kind of a patronizing stance. I mean, the perfect stance is, "Well, if you haven't been analytically trained, how can you say that it's not worthwhile?"
>
> *OLC: Do you find that happens a lot in this day and age?*
>
> Less and less, but it used to happen, ten years ago it happened a lot.
>
> *OLC: Because you didn't go into psychoanalysis as a specialty?*

> Right, and because I trained in a clinic which was clearly not analytic, and was being accused of not having child psychiatry training, which I thought was outrageous. I was a child psychiatry training director! I must have [had such training]!

With mentors: She speaks very positively of the importance of her relationship with Salvador Menuchin and even suggests that the writer might want to interview him as part of the study. She also states that Henry Grunebaum had been an important teacher and suggests the writer might want to interview him as well.

With patients: As previously noted, Fiona emphasizes that she has found "that patients are real teachers and they sort of add to my experience, and hopefully I add to theirs too." She describes how she interacts with patients:

> I tend to take them at their word and I reflect their words back to them, but I'm really mostly interested in them, sort of how they got to be there and what they're up to and what it does for them and that sort of thing.

She also emphasizes how she must first learn as much as she can about her clients or patients, especially when "their customs and their experiences are unlike you[rs]."

As she is also a family therapist, she talks about how she intervenes in the family system in an attempt "to activate the family's own abilities to perceive itself or to respond to its own problems." As an example of this approach she tells of the following situation:

> For instance, one patient [is] a sixteen-year-old boy who's just always up in his room and always depressed and so on, and his family comes in and he never talks to [them] and they never know whether to talk to him. And I say. "You know, you've got this whole resource system there and they're there and they want to be your friends, they want to be involved."...[But] he wasn't using them and they weren't putting themselves forward except to take him to doctors.

With self: She regards herself as independent and enjoying controversy. Yet she also knows how to play down her own importance, such as when she was involved in the anthropological study of a black neighborhood while in medical school and she "learned about my own insignificance—I mean how to become insignificant—and how to stop being such a big sort of intrusive kind of character in the lives of these people." She also appears to have worked at tempering the way she shares her opinions with her students, for instance, and is able to acknowledge that her approach may not be acceptable to all of them. Thus, she tries sometimes to see herself as she thinks others view her:

> I'm very opinionated and I wouldn't say I was a wishy-washy sort of person at all. On the other hand, I've learned through probably painful experience that people don't like to have my opinions jammed down their throats, so I think I don't do it any more, but they probably think that I still do, because I'm still very opinionated.... For instance [if] we're doing an exercise or something, [I] take [my students'] ideas and if they're not exactly what I think would be most useful, [I] get them to look at it and give them the opportunity to revise it, or to give them some alternatives or try to acknowledge what the student offers. I think mostly I really try to get people to think,...so that they leave with the...ability to...invent new responses for new circumstances rather than [just] going by rote. I get very involved. I do a lot of talking, I tell a lot of clinical experiences to try to...inundate them with the richness of possibilities. Sometimes I think I just inundate them with myself, but I'm not sure. Some of the students really like me and some don't.

Her independence also manifests in the fact that she likes learning in her own ways. For example, she chose not to pursue traditional analytic training, and she has taken an anthropological approach in working with people in the inner city.

When asked the question about what she does to "nourish" herself, Fiona appears to be somewhat nonplussed before she responds by indicating that she unwinds by watching "mindless TV," which includes baseball games as well as "a lot of really junky TV programs I totally love," although she is usually doing something else while she watches it. But when asked what she would suggest to a psychiatrist-in-training about nourishing him- or herself, she responds a bit more assertively, speaking of the importance of taking one's own needs into account:

> Oh, that's why you do family therapy. Family therapy is so much easier than individual therapy. Family takes care of itself and you go home and you can take care of your [own] family.... If you find yourself dancing too hard trying to save people's lives or things like that, then you have to reassess what the hell you're doing and say, "Now, my life is more important than that person's life to me." And sometimes telling the person is helpful because then they realize that you're going to take care of yourself and they're either going to have to take care of themselves or not, but it's up to them.

With a power greater than the self: When asked how she feels about the idea that in some cultures healers are known to appeal to a power greater than the self in healing, and whether the idea of a God was important to her in her work, she replies:

> Oh, absolutely. Sometimes it's God although it's become less and less since I decided not to remain an Episcopalian. I mean, God used to be the name and I would...sort of attribute to God certain acts that were unexplainable, [but] now it's more fate.

She goes on to define what she means by "fate," but without specifically relating either fate or God to her own ability to heal or to promote self-healing in others:

> Fate...to me has a very elaborate design, and that may be the meta-meta system that catches us all in it where we think we're making changes but we're actually just doing what the meta-meta system [determines]—our pattern, our dance in the meta-meta system, something of that sort.

However, when it comes to her patients' beliefs:

> If a family...looks to an explanation from God [for a child's illness]..., I certainly encourage them to do that. I suspect that that's just as valid and useful as anything else, and I'm usually interested in what they have to say about it.

Most fundamentally, however, what she tries to do is "to get people resonating in their proper place, so that it feels right and...it fits...into their pattern,...[although] sometimes their pattern is like Job, I guess, [and] they have to have plagues and boils." She continues by recounting an example where a patient's family had such a strong belief in what their pediatrician told them that they did not seek further treatment for their child, who was gravely ill with cancer. This example provides us with an opportunity to see how respectful Fiona is towards her patients, no matter who:

> I once...worked with a family briefly whose daughter had a terrible cancer at the age of two, and she was treated by [the former Surgeon General] Koop,...who is a brilliant pediatric surgeon but also a very charismatic guy, and he told them that she would be all right and then they went to the oncology service and they said...Dr. Koop said she would be all right and they didn't get her treated [with chemotherapy]. And [the child] was all right, and they came back for their follow-ups and they were wondering if she was all right, and I said "Go see Dr. Koop"...[because] clearly they had some kind of relationship with him...or he had some kind of perception or power or whatever it was that they needed.
>
> *OLC: So it isn't so much God as fate or would you say some power greater than yourself or...*
>
> Oh, absolutely. There's some kind of pattern and in a sense you know you can get real funny about it, but in a sense what maybe what I do or try to do anyway is to get people resonating in their proper place so that it feels right and that it fits, the whole idea of fit, I guess...and sometimes their pattern is like Job, I guess. They have to have plagues and boils, I don't know...

Valued and non-valued learning experiences

In general: She values the "unusual" training she received as a medical student when she participated in the anthropological study of a poor and predominantly black neighborhood that was described above. It was an experience that she "cherish[es]" and considers "very, very special."

She feels that her training in family systems has also been very helpful. In addition, she benefited from her second attempt at therapy ("after I recovered from psychoanalysis") "with somebody who worked more on different levels of healing that had to do with the more concept[ual] levels of healing....

We talked about the kinds of things I could experiment with myself if I wanted to, so it wasn't that he was so much doing healing." This therapist also introduced her to the work of the hypnotherapist Milton Erickson, which she has found helpful.

Formal education: She found her formal education to be a positive experience. On the other hand, she notes a difference in the way she was treated because she was planning to go into psychiatry:

> I've always been very enthusiastic about every aspect of my training.... I thought it was very exciting, [and] I wanted to...read electrocardiograms and understand cardiac physiology even though I knew I was going to be a psychiatrist.... [But] other people thought that was really dumb. I remember one of my attending physicians said, "I'm not going to ask you that question, you're going into psychiatry," and I said "I know the answer."...I enjoyed all of it, really.

Informal education: As noted above, she emphasizes the importance of being with clients in their own contexts as well as having the opportunity to see first-hand how skilled psychiatrists, such as Menuchin, conduct their work.

Challenges and vulnerabilities

Fiona takes very seriously her role in "improving services and systems for children and adolescents throughout the state, and then possibly the world after that." Thus, she sees herself as being potentially able to influence a wider community, both as an ordinary community member and in her capacity as a professional, and this was one of her reasons for choosing to go into community psychiatry. However, she also perceives flaws in the community mental health system, and she feels that she must sometimes operate on "a Robin Hood principle" in order to help those who most need this help:

> I think that there [are] a lot of people [who] don't get much consideration,...in psychiatry or anywhere else really. You know, we talk about the poor, but we still keep getting rich off them.... I think there's a Robin Hood principle, [which] I've operated under,...where you see some private patients who pay money and then you have time to go and do stuff in settings where they don't pay much rent and things like that. Right now that doesn't happen to be the case because I get paid a nice salary from the department of mental health so it is nice, it is very nice. I can devote my time to thinking about the community and the state system and that sort of thing.

When the writer then asks whether she sees herself staying in community psychiatry, she responds without hesitation: "Oh, absolutely. Either that or I would leave psychiatry altogether." When asked why she has chosen community psychiatry, in particular, she says:

> Because it's most interesting. Can you think of anything more boring than people who feel entitled to psychotherapy and to have you listen to them and to pay you all that money to do it? I mean, some of them are interesting, but basically...
>
> *OLC: But basically you like getting right down in the community where the real problems are?*
>
> I do, although sometimes I don't think I really belong. I wish I spoke Spanish, for example. In fact, I may learn to do that soon. And I go to black neighborhoods and do home visits and I feel very conspicuous, and a lot of people say "What the hell you doing here, lady?", and I say "Well, you know, I don't really know but maybe if you give me a hand here," something like that...

As to her vulnerabilities, she recalls the loneliness of her own childhood, when "there were times as a child obviously that I was unhappy" due to the fact that her family had had to move so often. Thus, she says, "we didn't have a community...and being in new communities often was very lonely." As an adult, having recently moved to a new city she is still aware of the lack of a sense of familiarity that she and her husband had before they moved, when they would always be running into old friends. When asked by the writer how this affects her now, she realizes she has better ways of coping than she did as a child, and that having children in school has helped her to join in with community activities:

> *OLC: Do you feel in a way lonely [now] in that way...forging new relationships?*

> I have an awareness of what that's like, being much more...cognitive of it than I was in 1956 or something like that....but our son is developmentally delayed and so becoming active in schools and the way people think about kids and being active as a parent has been something I really find interesting...

In answer to the question as to whether she faces uncertainty, she answers:

> Always. Every time I get ready to see a patient I face uncertainty. I always get a little stage fright, especially if I don't know them....
>
> [I] sort of think, "Gee, what's this going to be...like, and are they going to like me, and are we going to be able to do anything?" and that sort of thing.

She mentions that it was the same "even for consultations or stuff," including workshops, but that what helps her to get beyond her feelings of apprehension is when she enters what she describes as a kind of "altered state":

> I really think these things [consultations] are terribly important.... So I do get very apprehensive, but then I think I go into a sort of altered state.... I was thinking about it in terms of before I do a workshop or something, sort of getting one's head totally into whatever it is one's going to be doing, and I can think about it cognitively in order to do it. And it [the altered state] usually happens somewhere towards the beginning of the event itself, where the event itself takes over in some kind of way.

When the writer, after hearing her begin to describe this "altered state," inquires, "So you kind of forget to be witnessing yourself or observing yourself?", Fiona replies: "Yeah, but sometimes observing oneself is a part of being in it."

When asked how she handles any feeling of uncertainty with suicidal patients, or whether any patient has ever committed suicide, she says no, but states that "I don't have much sympathy with that particular choice of a solution."

When the writer asks, "So you don't get all upset and nervous and...?", she replies:

> No. I have to give you vignettes.... One time...I got a message from my answering service that said [that] this woman [had] called and she says that she has a gun at her head and she'll call me back right away. The answering service was, needless to say, quite excited. So I called her back and she said, "Oh, there you are." She says, "I have a pistol and a shotgun and...I want you to tell me which one I should blow my brains out with." I said, "I don't know anything about guns, you're asking the wrong person." She said, "You don't know anything about guns? Well, I'll have to teach you." And I said, "Well, you can teach me anything you want, [but] I'm not particularly interested in guns." She said, "You're not going to tell me what gun to use?" And I said, "No, I can't possibly do that." So she said, "Well, aren't you going to call the police and have me taken to the hospital emergency room?" I said, "Do you want to go to the hospital emergency room?" And she said, "I want you to take care of me." I said, "I'm not taking care of you if you're going to threaten me over the phone about guns.... If you want to go to the hospital, call the police yourself and they'll take you, or drag yourself down to have yourself admitted. By the way, I won't take care of you in the hospital either." So she...said, "You mean I threaten you?" And I said, "Yes, you do and I don't like it." So she said, "Well, I'll come in and talk to you about this" and she made an appointment and she never mentioned it again.

Although in this case Fiona is able to keep herself from being manipulated by a suicidal patient who obviously was asking for some sort of containment, she is also respectful of any suicidal patient's right not to make a contract with a helping professional to contact the latter before attempting to take his or her life. As Fiona expresses it, a person should not make that decision based on its effect on another person. The writer has brought up an example of a patient who refused to make such a contract, and Fiona expresses her opinion thus:

> Well, I don't think people can make contracts. In a sense to make [a] contract is sort of like saying "Don't kill yourself for me [the helping professional]," and somehow I'm not that important in whether people decide to live or die. I don't think they should do it for me or not do it for me.

The writer's initial impression

The writer found it quite easy to interview Fiona, despite the fact that due to time pressure of Fiona's having to leave for the airport, there was not time to find a quieter, more private place to interview her. Thus, although the interview took place in the noisy front hall of the hotel, it was surprisingly easy for the writer to block out the sounds and distractions around them. The writer had also had the opportunity to participate with Fiona in a group discussion earlier and was struck by the way that the latter's manner was informal in both arenas. Here, as in the interview, she noted how often Fiona would make her point by clarifying case examples. The feeling, overall, was as if she and Fiona were playing doubles on the same team.

Joan

Joan is a Caucasian female, forty-six years old, married, with three sons. She describes herself as being of "Northern European ancestry," with an Irish father, who is Protestant, and a Polish mother, who is Jewish. She describes herself as having "no formal religious affiliation." She attended a college in the West as an undergraduate, majoring in zoology and minoring in French. She married and then went to the medical college of a midwestern state while it still served women only, and while there, she gave birth to a son while her husband, who was in the Navy, was on active duty.

After graduating, she began an exhausting rotating internship in a busy city hospital in her home state while her husband was still away. Finding the hours difficult, especially as she was then raising her son alone, she enthusiastically accepted a residency in a new prototypic community mental health center where her hours were tailored to childcare. Thus, she became the first resident at one of the first community mental health centers to be set up by the Community Mental Health Centers Construction Act of l963. She then interned at a medical center in another city in the same state. She had a number of different supervisors in both placements—in her initial community center, as many as twenty to thirty over a three-and-a-half year period, for four to ten hours per week. She was "not able to estimate the number of supervisors or hours of supervision" during her internship, as she "worked too hard."

Her theoretical orientation is "eclectic" and "community psychiatry." She feels that this eclectic orientation, chosen because she "felt intrigued with the multitude of theoretical options," has enabled her to "have a variety of choices." The most important aspects of her formal education were the "supervised, experiential components," and the most important academic courses she took were biological, ecological, and behavioral sciences. The least important aspect was "multiple-choice examinations," and the least important courses were advanced mathematics and research preparatory courses. During the interview, she mentions that one of the most important learning experiences she has had was a seminar with Milton Erickson on Ericksonian hypnotherapy, one of the last that he offered only a few months before he died. She has been working for seventeen years in community mental health contexts since completing her residency.

Initial Contact with Writer

The writer contacted Joan, who was involved with coordinating the 1988 winter meeting of the American Association of Community Psychiatry, to make arrangements to attend in order to interview psychiatrists, as had been suggested by an official of the AACP. At this time, the writer asked to interview Joan herself, and they arranged to do so during the conference.

Present-day situation

Joan is medical director and staff psychiatrist at a community mental health center in the same state where she interned. In addition, she has her own private practice, and she supervises other helping professionals, including some traditional healers from Latino and or Native American traditions.

How Joan describes herself and what she does as a psychiatrist

When asked to describe herself, she begins by emphasizing that she has "a broad training background, so I have no particular philosophy or style that I adhere to, and I draw on many of my other experiences, my other gifts of education and experience." She continues:

> Well, that's a hard one, to describe myself.... I love people. I'm very caring and I enjoy people. I also enjoy humor and I enjoy seeing things in a light kind of way, so I think those two are the most important "colorers" of what kind of psychiatrist I am. I am, I want to say a happy, optimistic kind of person who indulges in people.

When asked what she does, she replies, "[You want to know] everything I do?...Listing tasks? Listing tasks might get me into...." Whereupon the writer clarifies further, "[For instance], in a typical day or week,...what do you do as a psychiatrist?" To this Joan replies:

> My primary obligation is to oversee, supervise, be accessible to a sizeable population of [people including, but not limited to] older people, [ages] thirty-five to ninety who have had some major form of mental illness, some very significant event in their life or else repeated episodes of mental illness, and I relate directly to the patients and I also relate to all of their therapists. I have a particular assignment of ten therapists on my team, but in addition, as medical director, I relate to all of the staff at the mental health center or am available to them, and I relate directly probably to more of the supervisory staff. I'm always available and quickly responsive for problems and emergencies. That's probably my greatest function, to be able to deal with any kind of dilemma, disaster, crisis, what have you, and that sometimes consumes my whole day, just that.

She says that in her capacity as medical director, "I feel a very strong commitment, obligation to assuring good care at our center and to finding bad care, to changing it, exposing it." She continues:

> I think we worded one of our standards [to indicate] that I feel very responsible for [seeing that] all the patients in treatment [here]...have good supervised therapy. And with a staff the size of ours, it's sort of like fishing, it's not easy to find the problems and the bad therapy. Crises always surface on their own—that's not a problem—but maintaining overall high standards of quality [is]. So [to ensure] that, I am on the quality committees, clinical management, some utilization reviews.... We have an unusual-incident committee that meets every week and reviews anything that's unusual, with the usual outcome of changing a policy or expanding a policy to cover something.

She tries to allow for staff members' individual autonomy, yet she must oversee things particularly since, as medical director, she is legally liable:

> I don't tell them what to do, but [since] if they get sued, I get sued,...I like to cover that one. I don't want to be sued, and haven't [been], but when on the outpatient teams I'm still the medical director there. Those two teams are not always...on the premises, and so I have to relate to them through their clinical directors, their team directors, and their other staff, their unit directors with different levels of leadership on each team.

When the writer begins to move on, picking up on Joan's mention of private practice and thinking Joan has reached the end of describing her many administrative roles, she is immediately set straight that Joan has not yet finished describing what she does, and the following exchange takes place:

> Indeed [acknowledging the question about her private practice], but I haven't finished about the other one yet. I cover whenever our own psychiatrists are unavailable for whatever reason—day off, sickness, or just incapacitated—so I always have one extra ounce of energy to cover what ____ should have done and what ____ didn't do, something like that. I think that's a major part of my job.
>
> *OLC: Sort of seeing where somebody needs your help to fill in and being up to date with that patient?*
>
> [I don't] do therapy hours, [so] yes and no. I guess I'm picturing it more that a therapist from another team might call me and say, "I'm the primary therapist for so-and-so, who really is having side effects, and I can't get an appointment with G____ for two weeks. Can you see

> him and recommend something on the spot?"...I would never say no to that. [But] if it's somebody who would like an hour to tell me about the world, I would say forget it.
>
> [However], I do crisis intervention, [which] may take two or three hours, or I do med review, [which] may take fifteen minutes, or I do a case management, [which] may take ten minutes.... It's just one after the other as soon as the day starts.... Someone else always does the initial intake,...the paperwork and the details, and then they consult me, say..."Looks like a depression that needs your attention," and then I schedule in to see that person, and that might be an hour, but I wouldn't do more than five scheduled a week and probably not that many, because I would be doing many more crises in the meantime or fill[ing] in, check[ing] this or do[ing] that or writ[ing] this.... I also circulate quite a bit through our large building. I...talk to a lot of patients and touch a lot of patients.

Joan points out that she thinks she has "a lot more freedom as a woman to do that [i.e., touch patients]...than a man in a shirt and tie and beard [does]":

> I think that if a man [with] that kind of aura does touching, then everyone becomes uncomfortable. [So] I do a lot of back [and] shoulder massaging as I move around the building.
>
> *OLC: So that is to say, if you see a depressed patient that you've done crisis intervention with the day before and you're passing by, you might give them a little squeeze so that you've made contact?*
>
> Yeah, whatever it takes. If I go into a group—perhaps twenty patients, four or five volunteers, and one staff—I might hug the volunteers, I might hug the patients, they may even get up and come all the way around to hug me. If not, I just go around.... Sure, I touch people or [make] very important eye contact with them, it's real important. So I do a lot of that in the daytime,...try to keep a little running thread on everybody in the building whether they're in my program or not.

She sums up her style in this way: "So I do a lot of touching, a lot of hugging patients, and I think I have a reputation as a little woman who dresses casually and speaks in a usually pretty colloquial way." Then, expanding on her way of expressing herself, she adds, "I don't like [medical/psychological] jargon at all. I hate that, I avoid it at all cost. I make everyone define it when they use if with me. I just hate it."

Becoming a psychiatrist

Her extended family includes an uncle and an aunt who were both rheumatologists, and consequently, she was strongly encouraged to go into medicine, particularly by this aunt. She also received encouragement to go into medicine from an older brother, who had a Ph.D. in psychology and knew of her interest in human behavior. He suggested that it might actually be easier to go to medical school than to enter a doctoral program, where she would have to write a dissertation "and [go through] all the rigors of getting a doctorate." At first, she "kind of resisted and said 'Nobody's going to tell me what to do.' " Nonetheless, she went into a pre-med program at college "and then at the last moment...said, 'Oh, I think I'll give it a shot.' " She ended up applying and being accepted at a women's medical college, which was out of state, since she was well aware that in coeducational medical school admissions in the early '60s, men were favored over women. She speaks positively of her medical school experience in terms of the support she felt from her classmates, especially when she gave birth to her first son. At that time, her husband was away in the service, and her entire medical school class was present at the birth, giving her encouragement. At medical school, however, she indicates that she balked at what she considered the conservatism of some of the rules, having experienced a good deal of independence when traveling in Europe alone as a teenager or with one of her aunts. For instance, once during a heavy snowstorm, she defied a rule that forbade medical students to wear slacks because it made no sense to her, and she was willing to take the consequences. Throughout the recounting of her story, she emphasized the importance of significant women in her life, both relatives and friends, and how her relationships with them had given her the space to mature and to develop a strong sense of independence which stood her in good stead, especially during her husband's stint in the military.

Initially, she had "had fantasies about the old country doctors, some of whom were women, in the mountains and the mining camps." She also "had visions of just being a real family doctor," citing as a role model a woman who had been one of her state's first doctors. As to psychiatry, at that point she felt

that the kind of psychiatry "those people are training for is just bunk" since she liked the idea of "families fixing things." She continued her skepticism even after choosing to enter psychiatry:

> [By] my fourth year of psychiatry they knew...that I had just 'garbaged' the word[s] anxiety and depression, [since] how do I know what that means, how can you measure that?...[And] they'd always say "You know what that means"...and I'd say, "I do? I don't [and] I know a lot of things."

Despite this skepticism about certain aspects of psychiatry, she chose it because of the then-new field of community psychiatry, which tied in with her interest in working with families. As she envisioned it, community psychiatry would be "where people treated families and they went into homes and they did what it took and they worked with very disturbed patients and groups and each patient helped each other." Continuing, she says, "I can clearly remember this...mental health center being described, but I had a fantasy that it was medically oriented, a total family care [model], but for mental illness."

> There was a push for some maverick interested in psychiatry to consider that [type of community-based internship]. [So] I went to a rotating internship, worked by butt off. My son was two years old by then. I was exhausted, could just sleep standing anywhere.... I had started to be courted by____ [another community mental health center], because they wanted to get a residency program [started] and nobody was signing up for it...and they were starting to come over to the hospital where I was and convince me.

Thus, she became one of the first psychiatry residents at one of the first model community mental health programs in the United States, a position that suited her preference for public sector psychiatry over private practice as well as her needs as a mother raising a child alone. She thus took advantage of the flexibility of this new community mental health program in choosing a residency that took childcare into account and where women physicians were not expected to carry a full-time load:

> The main thing that convinced me was that I would have a house for $14 a month and have on-call once a week, and have lots of babysitting resources. And the other thing—this was in the '60s too—they said, "We don't believe that we should demand the same from a mother that we do from a man, and...if you want to just work half-time in the summer or want to take a few months off for your kids, we'll do whatever you want in this program." That was [it], I was sold.

Becoming a better community psychiatrist

In answer to this question, Joan repeats what she was told by a female English psychiatrist who was visiting during the first week of her residency there: that one of the most important things psychiatrists-in-training can learn in order to become a better psychiatrist is to get to know as many different kinds of people as they can. This psychiatrist also emphasized the need for them to retain a sense of humor and "lightheartedness," not to take themselves too seriously, "and to be very humble all the time, knowing that everything is uncertain."

What Joan considers are the important ingredients in helping someone

In answer to this question, she first clarifies the terminology: "Well, I like to think that I don't help somebody.... [Instead], I fix things if I have the right tools and equipment, but I don't usually help.... I teach and I fix, but I don't help." As to describing what she means by "fixing," she initially notes that there are so many ingredients that it is hard to choose which ones to mention. Upon some reflection, however, she says,

> [It's] important for me to know what I can fix and what I can't fix, and [to] be real straight with the person about that, and then use it as productively as possible. When I'm confident that I can [fix something], then [I] just build their confidence, but when I'm doubtful, [I try to] just really be square and on the line [that] I don't expect much here.... [It's also important] to be always teaching people what's wrong and how to understand it better—like...trying to understand how the brain and the body and the balance and pain work.

Thus, she feels she must "always teach [patients] as much as they can so they're in control of what's going on."

Relationships

With family of birth: Joan was the youngest child in her family. She has two older brothers and a sister (she had a younger brother who died as an infant, but she has only vague memories of him). Her mother is a Polish Jew and her father was an Irishman who raised horses. She enjoyed a privileged and varied upbringing, including two years at an English boarding school. While she had very close relationships with her maternal and paternal aunts, she experienced a more distant relationship with her mother. As previously noted, it was one of her aunts who influenced her to consider going to medical school.

With friends: She recalls visiting a female friend of her father's who raised horses and was an accomplished pilot. She enjoyed a close friendship with this woman and continued to visit and keep in touch with her after her marriage. She and her husband, who operates an electrical supply company, have a few close friends in common with whom they keep in touch. These friends include a group of older men, whom she jokingly refers to as her "boyfriends" and with whom she and her husband socialize regularly, as well as other couples. Of her friends in general, she says,

> I regard all of my friends as critical supports, just absolute[ly] critical.... I have [a] great fondness and affection [for] several older men—I don't know, it probably developed around my father.... They're married and often they're at our gatherings, both [they and their spouses], and we joke [around]. Many of [these] I call...my boyfriends.... [These friendships are] not sensual or sexual, but we hug.

One of these older "boyfriends" is the lawyer husband of "probably my woman best friend." He is "an attorney and bails me out in a lot of geriatric problems," and he is "just tender and dear." She often skis with one or several of these men.

With spouse/significant other and children: She married quite young and has three sons, the oldest of whom is out of college. Her husband operates an electrical supply company, and the two of them tend to move in different social circles, her husband with his business acquaintances and she with medical colleagues. She admits that this situation is "not easy":

> I miss things, [and] I really envy couples who are very close and compatible and enjoy all the same friends and plan things and do things, but we definitely have our separate group of friends, [although] we have a very small group of our friends, [which are]...our [mutual] friends.

As to her sons, she feels that she has a close relationship with them, although she also feels that probably neither of them would say that she spends enough time with them.

With community: She appears to be very conscious of her community role and to value it in a variety of ways. She makes a point of trying to make herself accessible to all sectors of the community, including the widespread outlying rural areas, by supervising some of the traditional Latino healers and other mental health professionals who serve this area.

With colleagues: Joan considers her weekly socializing with her colleagues to be an important ritual. Every Thursday night they go out to a local pub, where they often run into their patients while conducting a special kind of after-hours "case study":

> I have different groups of friends and we have rituals to meet and drink beer. One of these, on Thursday night, we call "case study," and it's work-related. Many agencies come to a coffeehouse downtown where a lot of our patients are.
>
> *OLC: Oh, how nice, so they get to see you...as you really are, out in public.*
>
> [Yes], and touch me. They can come over and say, "You're drinking beer, what is this?" And I can say, "Oh, give me another." Anyway, it's a "case study" because we study a case of empties! [Laughing]

With mentors: She considers that Milton Erickson, the hypnotherapist, was an important mentor for her and feels fortunate to have had the opportunity, with a group of mental health professionals, to study with him for a brief period shortly before his death:

> I'm...a believer in mind-body and anchoring and a lot of hypnotic techniques...[such as those of Milton] Erickson,...who was one of my mentors,...a major one.... I got to spend some of Erickson's last few days in his home studying—he would take groups of people in for a week at a time. Probably six months before he died.... [It was] an honor.
>
> He wasn't just inspiring right there on the spot. It was something that penetrated later. He put people into trances and to sleep so that they missed a lot.... It's not easy to appreciate him, but lots of his techniques and the people who have studied him have really expanded on it because he never did.

She also emphasizes the importance of her contact with several significant women, including her aunts and a woman business associate of her father's whom she still visits frequently. She implies that these women have provided her with models of independent, intelligent women who can think for themselves, and, in the case of her father's associate, support themselves. While growing up, she did not experience as close a relationship with her mother as she did with her father, but she received "a lot of support from both my parents to have mentors." She attributes her preference for mentors to her lack of closeness with her mother:

> I would say my bonding with my mother was less than a lot. I think she didn't know just how to be a good mother to a daughter and that's why I had some fill-ins.... But you know, we're still so close that...
>
> *OLC: Yeah, I hear that. I really hear that.*
>
> A good part of my day is to worry about what's happening with her.

Now she makes it a point to check in frequently with her mother, who is losing her eyesight but, thanks to the help given by her daughters and sons, can still live an independent life. Prior to the interview, the writer had overheard Joan checking in about her mother and was struck by the fact that such a busy professional, with so many people looking to her for guidance, still made her mother's comfort, independence, and well-being a top priority.

With patients: She is very sensitive to patients' feelings and tries to protect their confidentiality as well as to minimize any bad feelings that they might experience in being mental patients, especially schizophrenic patients who, with the help of medication, can lead relatively normal lives, even to carrying on with their professional lives. She also takes the loss of a patient very seriously, especially those who have committed suicide. She does not hesitate, especially with her depressed elderly patients, to hospitalize them to ensure their survival.

With self: Joan appears to value self-nurturance and sets time aside for herself to exercise and to receive a massage once a week. Likewise, socializing is an important part of her self-nurturance, and she does so on a regular basis with colleagues, friends, and family. She appears to rely on her own judgment with a sense of confidence, and relates to her husband and male colleagues as an equal.

Valued and non-valued learning experiences

In general: She feels she has learned a great deal from a couple of her aunts, including but not limited to the one who was a physician. She emphasizes several times the importance of having had good mentors.

Formal education: She values her undergraduate education for having given her the opportunity to "be very creative,...get a hundred solutions to every problem," and she juxtaposes this with the approach in medical school, where "there was only one solution to each problem." She has found her later training in Skinnerian behavioral modification to have been very helpful: after "train[ing] a few pigeons and...a few dogs, you know that it works" with human beings also. As an undergraduate, where she majored in zoology and minored in French, she also enjoyed studying ecology, being "fascinated [by] how all systems have to fit, and [seeing] that if they don't, they gradually will make themselves fit in some way, whether it's...functional or dysfunctional." Initially, she "hated psychiatry" and its "inability to give definitions," in contrast to the courses that she had taken in ecology, biology, chemistry, and

Skinnerian behavior modification. The psychiatry courses she took in medical school had "no definition, no boundaries, and we [were] just trying to get enough to analyze and put it together." She feels that the traditional medical school emphasis on one solution to every problem was not helpful and did not prepare her for going out into the community "because if [the] solution that I learned in medical school didn't work, I was out of luck.... In fact, it was the problem that was wrong, it wasn't the solution that was wrong." She feels that "the usual traditional medical school format that limits and restricts creative thinking and forces didactic memorization is a real handicap to most doctors as they move on out of it." Such an emphasis does not prepare community psychiatrists, in particular, for what is "most important, [which is] community leadership and financial creativity."

Informal education: Although she does not specifically state it, she implies that her exposure to different sorts of people at an early age, including Latinos who worked for her father, has been helpful to her as a community psychiatrist working with people of various economic and ethnic backgrounds. Thus, it was not surprising to the writer to hear how much she enjoys her present-day supervision of some of the traditional healers in the area, some of whom practice healing techniques such as curanderismo and espiritismo, which are a mixture of Christian with Mexican, South American, and Native American teachings.

As both of her parents had European backgrounds, she traveled widely in Europe when she was growing up. This included a year of a high school at an English boarding school and a summer by herself in Paris, experiences that helped her develop a sense of independence and self-confidence.

She also makes a point of saying how important some of her relationships with women have been. These include a couple of her aunts and a female business associate of her father's. She still maintains these relationships and visits and travels with these women.

Challenges and vulnerabilities:

Although she says that there are of course moments of uncertainty and challenge, she does not elaborate further, saying only that such moments are difficult to put into words. She tends to dwell on the positive aspects of her family and professional life.

The writer's initial impression

The writer interviewed Joan after the conference had ended and after having interviewed three other psychiatrists at the conference, and she found that she had already established a nice rapport with Joan from participating in the conference with her. The writer was impressed by Joan's ability to juggle her many roles, while at the same time still managing to make her own physical exercise and receiving therapeutic massage once a week a top priority. She also was interested by the fact that, unlike most psychiatrists, Joan used touch to connect with both patients and staff. Joan also made a point of seeing her clients in social situations, which seemed more aligned with healers educated according to education as transformation, wherein a healer above all does not hold him- or herself apart due to a special status but instead contributes to all aspects of community life as an ordinary member of the community. Finally, the writer was impressed at the extensive influence that Joan's relationships with women mentors had had on her development, and wondered if she would find this same phenomenon in the educational stories of other women in the sample. To return to our tennis image, the interaction between the writer and Joan was like a friendly rally for the pure enjoyment of the game.

Eleanor

Eleanor is a Caucasian, Protestant female, thirty-nine years old, recently divorced, with two young stepdaughters with whom she keeps in touch. She describes her religious affiliation as Quaker or "Friend." Her mother, a nurse, emigrated from England to the United States, where she practiced as an LPN. Her father was in the Army, necessitating that the family move quite often until she was in her teens. She was the middle child, with one brother who was three years older and a second brother one year younger, who committed suicide at age nineteen. In the interview, she mentions how strong an influence her parents and their values of hard work had had on her. She attended a college in New

England as an undergraduate, majoring in biology and minoring in classics. Subsequently, she went to medical school in the South, specializing, first of all, in family practice and secondly in psychiatry. She did her residency and internship in the Midwest. She had four supervisors over three years (two at a time): one analyst, two in biology and pharmacology, and one in developmental psychology, but due to "dissatisfaction and distrust of on-site supervisors, I bought one hour per week of outside supervision involving countertransference work.... This person is still my teacher and colleague." She considers the clinical exposure to have been the most important part of her formal education. The most important courses were physics, molecular biology, anatomy, community medicine, law, and medicine; least important were microbiology and physiology, although she mentions that, when she took these courses, she already had an "unusually good background" in these areas. Her orientation is developmental, and she particularly emphasizes how this has been especially helpful, as it "allowed many things to fall into place very useful[ly].... Equally useful [were] the years in family practice" using a biopsychosocial model. Although she has been practicing psychiatry for only one year, she had done family practice in community health environments for five years before switching to psychiatry, and thus she was included in the sample.

Initial contact with writer

While attending a lecture by a medical professional, the writer approached the speaker during an intermission to ask for help in finding possible participants in the study. As a result, this speaker introduced the writer to Eleanor, who also was attending the lecture. When the writer explained briefly what the study entailed, Eleanor not only agreed to be interviewed, but also informed the writer of the next Institute for Hospital and Community Psychiatry to be held in Boston in October of that year. Eleanor was the first psychiatrist to agree to be interviewed for the study and was instrumental in helping the writer to gain further access by introducing the writer to some of her colleagues at the Institute, which the writer attended.

Present-day situation

Eleanor conducts a private practice in the same area in which she interned which involves a case-management-oriented partnership practice with another ex-family practitioner. Additionally, she is a staff psychiatrist at a community mental health center, as well as sharing an office with the psychiatrist who had been her supervisor/teacher and remained her colleague.

How Eleanor describes herself as a psychiatrist

In reply to this question, Eleanor stresses both her commitment to providing psychiatric care for ordinary, even poor people, rather than to the wealthy, and her belief in the meaning-making aspect of her work:

> I would say that I am fairly committed to...being a psychiatrist for the working class and poor people. I don't ever want to be a rich person's psychiatrist. No interest. I see myself as being a teacher...although there is that other role too of being a doctor, and I do go back and forth between those two roles.... I guess the thing that teachers and doctors both have in common is that they take people's unstructured, painful experiences and they help them make meaning out of them, and in some cases it's the medical meaning that's really the most appropriate and useful, and in some cases it's a different kind of [meaning that gives it] a structure, a positive structure, a way of taking the raw materials of your history and making a newer, healthier story out of it.
>
> *OLC: So in a way...you're like a storyteller or a person who helps other people to tell their story?*
>
> Yeah, we make up a new story together out of the same raw material, a better story.

How Eleanor describes what she does as a psychiatrist

In the following passage, Eleanor discusses at length her developmental approach, commenting that, regardless of what level of development her patients are at, she serves "as a bridge between the past and the future" for her patients:

> The answer depends on the patient. I operate out of the developmental model for a lot of my stuff, and what this means is that I vary my approach quite considerably based on my perception of what level of integration the patient is at. There are some people where it is straight instruction. I'm very much providing the cognitive exoskeleton for somebody who doesn't seem to have much for themselves, and [in some cases] that includes medication for their psychosis and really gearing things to...teaching them cause and effect and helping them learn [how to] reduc[e]...stimulation. You know, some of it gets pretty behavioral. For somebody at a somewhat higher level of development [but] still with a fairly severe character pathology, it's much more of a cognitive form of therapy where, again, I sort of tell somebody who they are.... It's very much here-and-now therapy. It's not "Here's what you do when you get on the bus and here's how you talk to the bus driver," it's much more what's happening right now. The "abandonment button" just got pushed or something like that, and we go back over that.... And then I've actually been in the practice long enough so that I'm getting a few...high-level neurotics, which is quite different, where their tolerance for letting things just be "in the soup" is much higher, and so we can go for weeks along a certain vein with my only asking an occasional question or, at some point when it seems right, providing a "Gestaltan" overview of what's been happening in our sessions for the last month...because they can hold set better than the more primitive and the more obedient people.
>
> *OLC: I know you've talked about it in developmental terms—are you thinking about it in terms of Piaget or something in that kind of model of development?*
>
> Oh, definitely. I think Piaget is one of the great undiscovered...psychiatrists. ...I have seen more things in the psychiatry literature—which I'm sure you know is totally separate from the psychology literature—that is beginning to try to make Piaget comprehensible to us. So I think a lot of other people also think there's something here, that could pull some of these models together.
>
> *OLC: Is there anything else that you can think of in what you do as a psychiatrist, maybe putting it a little differently?*
>
> Well,...it may be that theories don't have as much to do with it as the fact of being with the person you're with. One of the things that I found the most exhausting at first was giving somebody your total, undivided attention for fifty solid minutes. I had no idea how much an attentive person is really flipping in and out of focus all the time, and you pick up enough of it so that you can reconstruct what somebody says, but if you pay complete, undivided, focused attention to somebody, it's amazing. They think you can read [their] mind! Because they'll say something and then you'll say, "But what about...?" and they'll say, "Well, how did you know that?" and it took me a while to realize, "Hey, wait a minute, you just told me that."
>
> *OLC: It sounds like they're not used to being heard, too.*
>
> They're not being heard, and people don't listen to themselves either. So I guess the thing that you are is that you provide continuity across time, between somebody's past and their present.... For the less integrated people that continuity is over a period of five minutes; for more integrated people it can be over a period of a month. But the thing that's in common is...[that] you're a bridge between the past and the future.

Becoming a psychiatrist

Eleanor began her medical training as a family doctor before quite recently going into psychiatry. Thus, in answering the interview questions, she also talks about what interests her about medicine in general. When asked how she decided to become a psychiatrist, she replies:

> Well, I liked psychiatry when I was in medical school. [But] I'm a real monkey with my hand in the peanut jar. I hate to give up anything, and the most inclusive thing seemed to be family practice. [Psychiatry] was not highly valued in my school. It was thought that intelligent people went into family practice, the more brilliant people of course went into tertiary specialties, but we had our little family practice club and we all went out to the "boonies" and I did that for a number of years because I really loved it. [However], I did feel a certain affinity for psychiatry when I was in school. I have just about all my life been the kind of person people will come up and start telling their problems to.... I haven't always liked that, but [since] psychiatry was so undervalued in medical school,...I think one of the things that I had to do was go out and prove that I wasn't a sissy [i.e., by learning first how to be a general medical doctor] before I could feel comfortable making another career choice [i.e., psychiatry].... I actually did quite a bit of psychiatry [when training in general medicine] and worked closely with the one psychiatrist in a hundred-mile radius.... [I also] looked after a number of chronic schizophrenics as a family practitioner.

When she returned to the city (where she has continued to practice), however, she found it was "'specialty city.'...There really is no role for family practitioners that was accessible to me [for although] I had no trouble getting customers,...I had a lot of trouble getting professional respect and collegiality and hospital privileges." So she chose to go back into training in psychiatry in "a very medical-model program" at a community hospital because it seemed like the "most familiar" in that it would put her in touch with people from all sorts of different ethnic backgrounds, and she could continue her work with the disadvantaged, but she also felt torn since she "didn't want to give up family practice." However, she found that "to my delight I just loved it.... People were paying me money to listen to their stories...and help them rewrite them some of the time, and it was a lot of fun." In addition, however, she found herself getting "more and more restless with the medical models as my training went on."

Eleanor's interest in medicine began early, and by the time she was eight years old she had decided to become a doctor. She was strongly influenced by her English mother, who had been trained as a nurse in England. Subsequently, as an LPN in the United States, she became, in a sense, "the neighborhood nurse" in the community where Eleanor lived from approximately age fourteen until she got out of medical school:

> [It's] sort of like an informal triage system that hospitals don't even know are out there. [She was], I guess, a folk healer of sorts, where people would come to her and say "Would you look at that wound of his?" and she'd either scrub it up or she'd say "Hmmm, it looks like the infection's spreading, he needs an antibiotic and to go to the doctor"...She would go visit a neighbor or evaluate the situation, all very informally, and...people would bring her a bowl of cherries or something like that.... [Hers] was a very respected kind of position [within] a four-block radius.

Eleanor thus experienced her mother as an important role model for learning family practice, which "was certainly something that I learned to know at my mother's knee, listening to people's problems more than telling them yours. That was definitely the model. And also not gossiping." This was a trait she says she learned from her father as well: "His work for many years was like top secret stuff."

> And so there were very strong traditions of work being something that interpenetrated family life,...that there were these kind of...rules around it to protect each other and there were times when someone would come to see my Mom and they'd sit in the kitchen and drink coffee. But then there were other times when it was a very different thing. Mom would go with somebody into the living room and talk, and she would tell me from a very early age some of these things that were going on, but it was understood that it was the "living room talk." You didn't repeat it, [and you knew] that you were being included inside a confidential network.

In addition, she feels she learned a lot as a child about human nature when she would visit the homes of her friends and could be "invisible, [as] kids can move in and out of other people's houses in a way that adults can't." And later on, as a babysitter, she would notice "awful things" going on "behind the scenes" that appalled her. Finally, she felt that the fact that she had an emotionally disturbed younger brother "just made me aware of how much of the misery that went on in our house was chosen or created by people's being stubborn."

> But there wasn't anything I could do about it, so I felt helpless—and I hate feeling helpless. So being in a field like medicine is a way of over and over and over again being able...to intervene, for instance, to do for people what I could not do for my brother. [But] I'm beginning to need that less and less, or get a more abstract kind of satisfaction out of it than I used to a few years ago.

Becoming a better community psychiatrist

She feels that she reached an important turning point during her psychiatry rotation when she was able to take the advice of her supervisor not to overidentify with her patients. Until this point, she had kept "catching everybody's symptoms" and wondered whether she would be able to continue with that rotation. While listening to an interview of a young schizophrenic man during group supervision, she lost her boundaries and, from this experience, learned about the necessity to detach:

> I'm listening to this guy put in this horrible light, and it's clear that he's not really homosexual, he just wants some man to hold him,...he's still trying to get through to Daddy or something like that. And I'm looking at this grown man and I'm thinking, "He needs to be a little baby again."...[And] I'm getting stomachaches and I'm getting headaches and I'm beginning to feel schizophrenic myself and...really identifying very strongly with the experience.
>
> Afterwards she sought out her supervisor for advice and has never forgotten what he said:
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> He said "You are a doctor, a specialist, and the question that you have to ask yourself is, do you really want to be a healer, how is [your] feeling helpful to the patient, and if your feeling is not helpful to the patient, then you have to take your feelings elsewhere." And it was really good because it wasn't angry or judgmental, but it was like a bucket of cold water on my hysteria.... That's when I really realized that there's a difference between overidentifying with people and being compassionate. I think I really already knew that because, [for instance], I was always the one in biology who would grab somebody's frog and pit [kill] the damned frog because they were feeling so sorry for it that they were sitting there jabbing it and torturing it. And I couldn't stand it anymore and I'd say "Give it here." And they'd say, "Oh, you're so cruel" and I'd be sitting with my feelings hurt and saying "I'm so cruel? You're the one that was torturing him." So that [question of my supervisor] really helped to clarify [this matter of detachment]. [His] was a very useful question at times, when I found myself getting depressed, extremely depressed: "OK, how is my feeling helping the patient?" It gave me, I think,...a big head start on understanding what countertransference is.

What Eleanor considers are the important ingredients in helping someone

Eleanor stresses the importance of respect, awareness of context, and awareness of different cognitive styles:

> I think probably the most important [ingredient] is respect. I think that's probably even more important than love. You know, people talk a lot about love [but] I'm seeing a lot of people who have been loved practically to death and what they haven't got [is] real respect as a truly equal human being with me and with anybody else. So that would be the main one. You know, love is important but real respect comes first. And education: I think that psychiatrists a lot of times—sometimes because of a theoretical model, sometimes because of temperament...—just really fall down on their responsibility to teach people.

> [Another] ingredient of being a good psychotherapist? Be very careful about not operating in a vacuum. We live in a society,...in a culture, people live in families, you know, there are politics involved in what we do. This is not some kind of value-free, neutral technique where we aren't inadvertently becoming agents of behavior control for the state,...those kinds of issues. And the people that we see—at least that I see—tend not to be terribly well protected, they are having to cope with things that are political issues, you know, for women especially.... Sure, their husbands are being mean to them, but everywhere they go outside of the home, they're being told that's okay.
>
> *OLC: So it's important, in other words, to not teach the person something that takes them so far out of their context, but to understand where they are coming from? Have tools that fit the environment that they're in?*
>
> You have a choice. Nobody can ever take your freedom of choice.... We talked about education and respect, being aware of context. I think...that you need to be aware of temperament and you need to be aware of people's cognitive style, and that's another area where psychiatrists tend to be [lacking]. You know, people really do think in different ways. There aren't as many different ways of thinking as there are people, but there are differences in cognitive style and it could be that you could make a very nice analogy for a lot of the affective disorders and character disorders being a form of learning disability, [though] not the kind of learning disability that gets picked up in core evaluations for schools. For example, they found that kids with right hemisphere damage cannot pick up social cues and some people think they're jerks at a very early age. And just being aware that people's cognitive styles are different and not labeling people as difficult patients if their temperament or cognitive style is just not compatible with mine, recognizing that I have some limitations, and either figuring out a way to compensate for that in the relationship or referring them to somebody who could do better with the client, and without that being a failure of either me or the person who comes to me. Just a recognition of the essential difference.

Relationships

With family of birth: Eleanor describes herself as closest to her mother, her maternal grandmother, and her older brother, until the latter detached himself from the family when he was in his late teens. She had also been as close to her emotionally disturbed brother as possible, and after his suicide, when she was twenty, she had to work through feelings of guilt at not being able to prevent it.

With friends: Her only reference to friends is in recalling how as a young child she spoke going to play at friends' homes. There, she witnessed some "awful things" since children, unlike adults, are able to be "invisible" in a way that escapes notice. Regarding her adult friendships, she mentions how she has always enjoyed utilizing the massage skills that she learned as a child to work on her friends, who very much appreciate it, and which make her very "popular."

With spouse/significant other and children: She mentions only that she was married briefly to a school teacher but is now divorced and that she continues to keep in touch with her school-age stepdaughters.

With community: She appears to be very community-oriented and attributes this to her mother's British values, which subsume the rights of the individual under those of the community to a greater degree than is generally the case in the U.S.:

> [I have] very British ideas about responsibility to use your brain and talents for the good of the community.... I didn't realize...how deep that goes in me until I find myself beginning to get annoyed with the way in psychiatry, now, you have...individuals' right[s] to privacy and control over their own pathology...protected by American law over the rights of the community.... I think that there's a balance that probably feels more comfortable to me in other countries between the community's right and the individual's right.... I think it's out of balance.
>
> *OLC: The individual has too many rights?*
>
> [Yes]...Actually, it's very liberating, I think, to realize you are a citizen and member of the community and that sometimes you can act in an altruistic way because you care about

> something larger than yourself. That would be one of the things that I would hope that I could teach those patients of mine that need to learn it, and that's not the same thing as giving up your autonomy or fusing with the group, to be a responsible group member.

Having had the experience of living in a small community for a number of years, she appears to have gravitated toward and felt very comfortable with being a family doctor during her residency. She feels that some of her younger fellow residents must learn, as she did, that "in a small community you cannot step out of the role": she was always "Doc," whether she was buying chewing gum or going down to the pub to share a pitcher of beer with friends. Although not expected to be "this formal city-type of doctor,...there was a definite role there, the role of the keeper of the secrets, that you're not allowed to step out of ever":

> I mean, even if I went out...drinking with people and heard everybody's gossip around the table about "Do you suppose so-and-so is pregnant by so-and-so? Do you think that she went to...get an abortion?"—you know, this kind of stuff—I just had to kind of sit there and...[keep quiet] because often I knew what the answers to their questions were. But people respected that, and nobody would ever have thought of pressing me for information. So I was used to that being-a-part-and-yet-set-apart role and had gotten very comfortable with it before I started working at day treatment.... I think part of the reason the level of comfort is there is because I feel very clear about the role and I feel comfortable with that in a...very traditional way.

She feels that her mother's European influence also taught her not to overinvest doctors with authority extending to all spheres of experience—a common American practice, in her opinion:

> Doctors in this country get so used to being authoritative in their sphere of professional influence and then they think that spills over into people's... [having] to treat them with utter respect in every other way and that they should be allowed to voice opinions about a Democratic candidate,...or about economics and have people listen to them with the same awed respect, and they get a little carried away. My mother never let me do that. [Her] respect for me in my role as the taker of the Hippocratic Oath is utter, [although] it was a little bit disconcerting at first, when I started treating people as a doctor.... But, boy, if I got too big for my britches in any other way, it's zing! And the doctors she [her mother] worked with loved her because she was very good at reminding them who they were.

Eleanor also contributes to her community through her activities as a member of the local Friends Meeting, where she participates in an AIDS education project and serves on a Committee on Living with Dying. She experiences herself as affecting her community in a beneficial way by volunteering in such projects, as well as by doing staff training and development at the community mental health center, which she regards as "treating the whole community as well as the individual." Likewise, with individual psychotherapy patients, "If I'm looking after [a] stressed-out mother, by providing her with an exoskeleton, a holding environment,...she can go home and be a better mother to her kids." In some cases, however, she may not see much progress in the way a patient is relating to her, such as in the case of one "borderline" mother who spends most of her time in the hospital after repeated suicide attempts:

> [Nevertheless] she is changing more than I ever thought she would...[as] she is doing volunteer work at her local hospital...and her local church that is impacting in a positive way on the life of people I haven't met and never will [meet]. And yet part of my satisfaction working with her definitely comes from that. And I think of it when it seems like she's not changing a lot with me I think of how much her life apart from me has changed.

With colleagues: She mentions the importance of one of her supervisors, who had a developmental orientation and with whom she decided to go into her current partnership.

With mentors: Although she does not refer to her former supervisor as a "mentor," per se, she alludes to the fact that he has been and continues to serve as a teacher, although they presently have a private-practice partnership.

With patients: Eleanor emphasizes the importance of providing her patients with the experience of being "truly respected," rather than merely being "loved" in the therapeutic relationship. She mentions more than once the importance of maintaining her detachment vis-à-vis her patients for their good as well as her own. She thus emphasizes the importance of good boundaries and tells how she learned the hard way to set clearer boundaries with one "bright and appealing" borderline patient, a woman "who

had had just a horrible childhood with all kinds of sexual abuse." Eleanor describes how she "made the mistake of over-identifying" with this patient and "wound up giving her a lot of services without really checking things out."

> Then, her boyfriend, who really was an antisocial personality disorder, got into the picture and he scared me a little bit, and I got into reaction formation about...feeling intimidated and [I] got a little adversarial.... In other words,...I lost my detachment and then I got depleted.

Eleanor has also learned some lessons about detachment in the process of working through her guilt around her brother's suicide, so that she does not to fall into the trap of feeling that it is up to her to "keep [suicidal patients] alive." Thus, as she has dealt with her own family's pathology and her brother's choice to take his own life, she has learned things that benefit her patients as well. Describing the process of coming to grips with this personal tragedy, she notes that for two years she was in denial about her brother's suicide and would, without even being aware of it, "walk out of the room...whenever his name was mentioned":

> [I] later worked that through and realized that even though he was nineteen years old and even though he was a victim of some of our family pathology, that was the hand he got dealt and that was the hand he had to play and he had choices and he made them. And I couldn't keep him alive. He's the only person that could keep himself alive, and that's what I say now to suicidal people. I ask them, "Do you need to be in the hospital until this impulse passes?" and if I get any ambivalence, boom, they go into the hospital. [However], a lot of people say to me, "I feel suicidal all the time," [and I reply], "But you can't live your life in the hospital. This is just one of the things that you're going to have to cope with and I'm here to help you cope with it, but I can't keep you alive." I can't take that responsibility.

At the community mental health center where she works, she enjoys the opportunity to spend "a little bit of just ordinary time with [patients], you know, go in and shoot a little pool, be interested in the fish tank, and I think that's an important part of role-modeling." She continues:

> People who see things in such absolute ways...probably imagine me going to bed in the same clothes I wear to work or something like that. Their capacity to see that somebody can be competent in a given role but can also step outside that role without losing their sense of self and becoming fragmented is a very useful thing. So I think that is a very important thing that I do.

With self: She appears to have taken the time to reflect on her own development in order to know her strengths and her weaknesses and to have learned as well how to turn some of her weaknesses into strengths, in part by choosing the profession of psychiatry. For instance, she feels that her "hypertrophied right brain," to which she attributes her strong emotional sensitivity, is one of the major forces in shaping her as a psychiatrist and it is a force that she regards as both an asset and a liability. Thus, she identifies strongly with the children of narcissistic parents described by Alice Miller in The Drama of the Gifted Child, feeling that at times her own mother having recognized her daughter's intuitive healing ability, utilized them to fulfill her own needs, treating Eleanor almost as an extension of herself and expecting her to provide emotional support at the level of an adult. Specifically, her mother taught her anatomy and massage at a very early age so that she could receive therapeutic massage for her own rheumatic condition.

> I think when I look back on it that my parents did not protect me from having to take on responsibility, in terms of giving people emotional support that went way beyond my years, and there were reasons for that but it would have been better for me in a way if it hadn't happened. I did have a long time working that through, you know, I spent years trying to discard this skill. I discovered that I couldn't discard it but even better, I could control it and detach from and get it channeled into a structure where I didn't have to do it all the time, or I didn't have to do it at my expense. That's one of the reasons why psychiatry is such comfortable work, not just because it's sort of free-flowing within the boundaries, which I like, but also because the boundaries are clear and traditional and don't go beyond it.... Everybody realizes those boundaries are just so important,...not just to protect the patient...but to protect us.

Elaborating further on her "hypertrophied right brain," she describes an altered state of consciousness that she experiences when she feels confident about what she is doing:

> [There are] critical moments in family practice, like when you're actually delivering a baby's head and shoulders, or in psychiatry at moments where it's time to do a very specific, clear intervention, and you know what it is,...I sort of slip over into right-brain gear or something, because I don't have a lot of verbal access to this. What happens is little chills start going up and down my spine, my heart beats faster, my attention and even my vision becomes very tunneled and focused, and it's a very intense moment, and I just know at this important moment exactly what I need to say.
>
> *OLC: So that's when you feel most confident, it's like a state of consciousness?*
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> It's a state of consciousness, it's not even a decision to try this out, although of course I do a lot of that too for the purpose of confidence. But it's a moment that goes beyond confidence, and I really do think it's an altered state of consciousness,...that there's been a fit somehow between what's happening to me, both affectively and cognitively, and what's happening with the patient. It just clicks. And there's no question of being sure I can handle it, because I know it's going to work.
>
> She describes feeling least confident when she notices that she is:
>
> fighting off accepting that I really don't like somebody very much and wish they'd go away. Their problem is so messy and scary that I can't get a formulation around it and so I'm fighting off feeling that I wish they would just go away. So I always have to be kind of consciously monitoring myself to make sure that I'm being fair in making my decisions.

With a power greater than the self: She appears to separate her connection with theoretical knowledge as a psychiatrist, and her connection with an innate knowledge as to how to touch which appears often to be accompanied by what she describes as an altered state. She experienced this first in learning from her mother how to give massage, and then, she developed in knowing how to give a physical examination as a family doctor. She is careful, however, not to mix this in with the way she maintains boundaries with her patients where a psychiatrist trained psychoanalytically refrains from touching the patient.

Valued and non-valued learning experiences

In general: As mentioned above, she particularly values her strong biological background in understanding how the body works, as well as having learned the importance of detachment vis-à-vis patients.

Formal education: Eleanor believes very strongly in the value of her formal education, and especially the importance of having "massive amounts of information" that provide her with a firm foundation in biology and "knowing how the body works." Although she does not necessarily talk about it directly in great detail with patients, this biological substrate nevertheless influences how she relates to patients and, she believes, sets her apart from "other practitioners of psychotherapy who are not M.D.'s" and whom she believes often devalue this knowledge:

> I don't think anybody who hasn't been through it can truly realize how deep that particular iceberg goes and how much it just becomes part of your bones.
>
> *OLC: Being a doctor?*
>
> You know, knowing how the body works, and knowing the connection between the something that happens to be inside and a particular social event, like a thought or a "word act." I know a lot of people think that doctors tend to be [distanced] from that—and a lot of them do [distance themselves]—but I think that people who really understand it deeply become mystics. You know, when they're referring to biology, they're referring to the relationship between, [for instance], neuronal connections and kids reaching a new level of development, things like that. They're not being reductionistic—this is a mirror.

She experiences pleasure from this understanding and appreciation of "the elegance" of the "biological sphere" and

> could see how...some of the first people to do dissections could actually write poems about it because eels are the most beautifully put-together things you ever saw in your life. It could practically make you cry if you were in a certain state of mind.

Although she sees beauty and derives pleasure from this precision in biology, it is one of the first things that she had to learn to balance when she switched to psychiatry:

> In fact, you learn so much precision [that] one of my tasks later in psychiatry... and in family practice, was to unlearn that precision [and] to increase my comfort level with ambiguity.

Informal education: She feels that two of her most important informal educational experiences were the volunteer work she did in an alternative clinic as a medical student and the two summers she spent as a physician's assistant. This doctor, fifteen years older than she, "just let me follow him around and see how he talked to people" and "welcomed me into his family in a very generous way." She had been "looking for something like that because I could see again it wasn't an experience I was going to get within the academy."

Challenges and vulnerabilities

After learning to develop a healing touch through giving massage to her mother and other community members as a young child, and later, as a family doctor, when she palpated her patients during physical exams, Eleanor believes that "one of the challenges in psychiatry has been to learn to project that healing energy across the room, [since] there's a no-touching rule." However, she believes that "it can be done." When asked by the writer whether she has ever thought of doing massage as well, she replies, "Not as part of my psychiatry therapy practice,...[because] I've learned that you can heal without the touching." She adds that "even though I felt like, gee, I wish I could get the person on a massage table a few times, I would lose so much credibility with my treating community that it's not worth it—especially since I can do it in other ways" or refer patients to people who specialize in massage.

Eleanor also regards her heavy workload as a challenge in that it requires her to look after her own health by eating properly (especially staying away from coffee), getting enough sleep, exercising, and managing stress. She has recently begun practicing yoga and Vipassana meditation. In fact, this is the advice she offers to psychiatric residents-in-training: to pay attention to maintaining good sleeping, eating, and stress management habits, as well as joining together to insist on "more humane scheduling." She also suggests to residents that they "study Piaget," and she cautions,

> Don't fall into the trap that's so inherent in our profession of either disrespecting people's other disciplines or thinking that you have to be buddies with them by buying their views of situations and devaluing yourself and your own training,...which is something I see a lot of people do. They want to be not "Doctor-God" and so they start bad-mouthing themselves and saying "Really, I can't do it, or anything, any better than you"—that's just not true and it's not necessary. The respect has to be mutual.

Regarding vulnerability, she sees her early tendency to overidentify with patients as one of the challenges she has had to face, as described earlier in her thoughts about what has made her a better psychiatrist.

The writer's initial impression

Eleanor was the first psychiatrist of the sample whom the writer had met and asked to be part of the study. She and the writer had been introduced by a medical colleague after the latter had given a lecture which both had attended. The writer had approached the lecturer about being interviewed and had asked her to suggest other community psychiatrist colleagues who might want to participate in the study. At that very moment, Eleanor also was waiting to speak to her friend, who said, 'Well, you're in luck, because Eleanor is one," and proceeded to introduce Eleanor and the writer to each other. Out of this meeting grew other opportunities to be introduced to community psychiatrist colleagues, and from this group the writer began to construct a suitable sample. After hearing about the study and the writer's interest in interviewing psychiatrists about their education, Eleanor told the writer about the national conference to take place in Boston and suggested the writer attend. She particularly expressed an interest in the fact that the study would look at community psychiatrists in the United States in relation to

traditional healers. With Eleanor, the writer also sensed a wounded healer who had grown from her wounds and used her understanding to provide better service to others, but she was struck also at how Eleanor left a great deal unsaid, especially when speaking about her younger brother and how his suicide had affected her. Nonetheless, it was obvious by her community work with the AIDS education project and the Committee on Living and Dying, as well as her obvious caring for her patients, that Eleanor had grown from this tragic loss. It appeared to the writer that this was Eleanor's way of reaching out to help others to meet the challenges of illness openly, perhaps in a way that she felt her own family had been unable concerning her brother's illness. All in all, the writer found the flow of interaction with Eleanor was like playing on the same side in a set of doubles.

Robert

Robert is a Caucasian male, thirty-nine years old, and married with a five-year-old daughter. He had married during medical school to a woman who was a high school teacher, but since beginning to raise a family she had stopped working. He was raised Protestant but does not now practice any particular religion. His father was a business executive, while his mother worked with children with cerebral palsy; both are now retired. The eldest of three siblings, he attended a state university in the South as an undergraduate, majoring in biology (zoology) and then attended a medical school in the Northeast. He listed no particular area of specialization. He did his residency and internship at urban hospitals in the Northeast. He describes his orientation as "object relations" and feels that what was most important of his formal education was the supervision he received during his residency. Likewise, psychiatry was most important, and the object relations and psychopharmacological orientation he received has been most useful in providing service to his clients, and that surgery was the least important. He has been working in community mental health contexts for over three years since his residency.

Initial contact with writer

The writer met Robert at the Institute for Hospital and Community Psychiatry in Boston in October 1987. During a break in which they struck up a conversation about community mental health contexts, they discovered that both had friends in common at a particular community mental health center. In addition, Robert had just completed a year's residency under the direction of a community psychiatrist whom the writer had also met and had taken a seminar with in psychopharmacology.

Present-day situation

Currently, Robert is the assistant director for admissions at a state hospital in a small city in the Midwest.

How Robert describes himself as a psychiatrist

In answering this question, he rewords it slightly and responds briefly:

> How would I describe myself personally? I see myself as someone who likes to work with people over the long term.

How Robert describes what he does as a psychiatrist

> I think what I do is much more treat people acutely, handle crises, and do a lot of work giving medication. I do have an outpatient practice, which is also primarily working with sicker patients, where I follow patients over the long run, but I think what I do [now] is different than what I have been doing recently and what I will ultimately do again is treat chronic patients over the more long term.

Becoming a psychiatrist

When asked how he became a psychiatrist, he responds at first by saying:

> I don't know, really. It was something I was drawn to when I was in medical school—I wanted to be a general practitioner or a primary care medicine person or a psychiatrist. I was personally more drawn to that type of medicine. I did my internship in internal medicine and disliked it and then a lot of acute care kind of medicine, and went into psychiatry from there, but from early on in medical school I knew that I didn't want to be a surgeon, I didn't want to be a specialist. I was just personally more attracted to family practice, psychiatry, working with people.

When asked whether there had been any particular event, either before or during medical school, that led him to decide to become a psychiatrist, he answers:

> Well, I...graduated from college in 1970 and I had done a lot of social work [including volunteering at a suicide hot line], kind of jobs in the early '70s and enjoyed doing that kind of work, so it wasn't like the field was brand new to me. And then I had gone back to study with some psychiatrist that did neuropsychopharm so again this has been something that I had done some work in for many years before going to medical school and researching it in medical school.

Becoming a better community psychiatrist

When asked whether there was any person or event that has made him a better helper or psychiatrist, he answers:

> Yeah, I think there are some role models that I have worked with as I've gone through. I think therapy has helped me be a better therapist. I think that there was a group therapy that I was involved with in residency training that was very helpful, and I think that one of the leaders at the hospital was a role model for me in terms of public sector psychiatry.

When the writer requests permission to know whom he means, Robert gives the name of a new psychiatrist director whom the writer had considered interviewing. As he volunteers no further information, the writer moves on to another part of the questions concerning whether anything in his community had influenced him to become a psychiatrist and about whether he feels his relationship to his community has changed since becoming a psychiatrist. To these he responds briefly:

> I guess it depends on how you define community.... In terms of the town that I live in, [it's] a "neighborhoody" kind of neighborhood, and I just moved in three months ago but have gotten to know the people. It's a friendly neighborhood and that sort of thing and it's also a community of professionals through [the mental hospital where he is presently working] and through the ...university, so that there are some connections there. I wouldn't call myself a particularly outgoing, "people person" and active in community affairs particularly.

When the writer inquires as to whether his relationship to his community has changed, and if so, in what way, he states, simply, "No." Again, the writer finds herself probing further: "And before you were saying that you weren't a very actively involved person..." To this, he responds:

> Right. That['s] really...not completely true.... Politically there are things that I get involved with and I still would, and I guess one of the other things that's changed is I have never lived as a psychiatrist in a community that I've worked in, quite purposely, and that has made some difference. I lived in ___ for three years when I socialized in the community that I worked in and was invariably running into patients...and so that has changed that relationship. I purposely do not live in the community that I work in.

What Robert considers are the important ingredients in helping someone

> I think that to make an honest connection with people, to have some sort of an empathic understanding, is important to work[ing] with them. I think obviously, too, diagnostic skills

> are important and medication treatment is also important with the group that I'm working with. I think at least as important is to make some sort of empathic connection and to work with people over some time.
>
> When asked what else, he responds:
>
> I think a[n]...ongoing knowledge of changes in psychiatry, psychopharmaco-logy, I think all of that's important.

Relationships

With family of birth: He does not give any details about his childhood and mentions his parents only in response to the question about influences that had shaped his character as a psychiatrist. This however, seems to have been a somewhat negative influence, in that he feels he chose to go into psychiatry partly to rebel against them, as they would have preferred that he had gone into internal medicine or surgery—both of which, elsewhere in the interview, he makes a point of saying he did not enjoy learning about.

With friends: He gives very few details about his present relationship with friends and only points out that he purposely does live in the same neighborhood as the one where he works, having once had the experience of socializing in the same neighborhood where he worked.

With spouse/significant other and children: Again, he volunteers very few details about this area of his life.

With community: In response to the question as to whether he sees himself as primarily helping individuals or also as improving the quality of life in his community, he replies that he thinks he does improve the quality of life in the community, although this was more the case previously than in the present:

> Certainly [in] the community that I came from in ___, I felt like that was the case. I was the community psychiatrist for the county and the county politics and the community mental health politics were something I was very much a part of and where the [health] center was going was very much part of where I was coming from. I cannot honestly say that that's the case right now. Part of the problem is [that where I'm presently working] isn't a small community. This is a whole number of large communities.... So I can't say that I feel it's the case right now, but it has been for the last few years. I felt that it was a community I tried to work very closely with the National Alliance [for the Mentally Ill] also.

When the writer asks whether he was also working in a community mental health center there, he replies in the affirmative and adds that the community there was ethnically mixed:

> There were two parts of the county. One part, the town that I worked in, was really an old classic southern town and there were two sides of the tracks, so there were a group of blacks who got services at the community mental health center and a group of whites. There was also a large influx in the southern part of the county of northerners who were coming down, retired people who were coming down to live [and some of whom were patients].

With colleagues: Robert does not go into his relationship with his colleagues, except to say that he currently enjoys living in a community where professionals from the state hospital as well as other professionals live together and lead a life separate from their patients.

With mentors:

> Again, I think there are a number of role models who[m] I've seen as I've gone through, people who have met some adversity, in particular public sector psychiatrists—people who have to deal with really unpleasant kinds of situations but have remained in [it] and continued working and feel good about what they do and enjoy it. I mean, they've made a career out of it. I think that they have been role models for me.

With patients: He mentions patients in response to the question as to when he feels most confident: "Oh, I think I feel the most comfortable in working one-to-one with people and doing ongoing therapy." However, after considering the question further, he also says, "That's not always true.

Sometimes I feel the least confident at those times, but I have had periods where I felt it was very rewarding."

With self: When asked what he does to reduce stress or to nourish himself, he mentions that he tries to swim every day and that he enjoys free-form dancing. Other than these leisure-time activities, he enjoys reading, both medical and non-medical literature, and playing with his daughter.

When asked whether there have been major forces that have changed his character, he mentions his parents:

> Yeah,...my parents,...[but this is] pretty hard.... I'm not sure how honest to be [or] not to be, but I think that...
>
> *[OLC reassures him that what he says will be confidential]*
>
> ...I think that this [his going into psychiatry] is a compromise for me in terms of doing something that my parents want me to do but not really what my parents want me to do, so that I can at the same time not get into a big struggle with them, but do my own thing and continue to rebel,...kind of. [I'm] a medical doctor but it's not acceptable medical or....It's something that they have had some trouble with and confusion about, particularly my father.

He then mentions other psychiatrist "role models" as major forces that have shaped his character as a psychiatrist, and, in particular, the director of the hospital he was working at prior to this present position. He suggests even that the writer might want to interview him for the study, as well.

When the writer asks what, in particular, it was about this individual, he answers:

> Well, I see him as a very giving kind of person. He's also someone...who went through a real struggle with...the legal system and that sort of thing, and yet came back and has remained in the public sector and appears to be enjoying himself. My therapist [a psychiatrist] is someone who was doing some private sector and public sector work and appeared to be enjoying himself.... I guess that I think that a mix [is best]. Right now I'm doing more public sector psychiatry, to be frank with you, than I think I will in the near future, but I think a mix makes the job more interesting.

Thus, part of the reason that he admires this person is because he is able to handle the challenges of public sector psychiatry and stick with it, while even "appear[ing] to enjoy himself." Robert, on the other hand, wistfully looks to the time when he can leave or at least reduce his participation in the public sector. When asked what aspects of his character he considers most important in influencing his ability to be a psychiatrist, he replies: "I think I'm bright and I think I'm honest."

With a power greater than the self: Robert did not mention anything in this category, and the writer did not ask him directly.

Valued and non-valued learning experiences

In general: He mentions his own therapy, which he did not begin until the end of his internship or the beginning of his residency. When asked whether he considers this therapy to have been, in a sense, a part of his training, he answers that it was, but without elaborating as to why he found his own therapy helpful:

> Well, I'm not in therapy now, but I think that it was helpful in terms of my doing therapy [for others]. In fact, I know it was helpful, and some more would be more helpful.

When asked what he would tell a psychiatrist-in-training is the most important thing he or she could learn in order to be a good psychiatrist, he answers:

> Well, again, I think that learning to be empathic with people or to connect with people, but at the same time being able to maintain some distance and objectivity, is most important. I think that, for myself, being in therapy and being in a residency-sponsored group was very important in that regard. I think something else that could have been more helpful but it was a good idea was that the senior therapist do some therapy behind a one-way mirror.... I think that those sorts of activities are helpful. I think maybe the other thing is supervision. I think that supervision through training was very, very helpful.

Formal education: He feels that his psychiatric training was an important formal aspect of his education, noting that he "enjoyed psychiatric training [and] I got a masters in psychopharmacology before I went to medical school" and he found his psychiatry course in medical school helpful. He did not enjoy learning surgery as a medical student.

Informal education: He mentions working at a drop-in center for runaways in the early '70s and for a halfway house "and that sort of thing.... I was into social community kind of jobs early on and enjoyed doing it." He began to do this kind of work immediately after college. When prompted for more information, he replies, "Well, it was a hands-on kind of experience working with street people, runaway kids and that sort of thing that I found rewarding."

Challenges and vulnerabilities

When asked whether he ever faces moments of uncertainty, he replies, "All the time" and then elaborates:

> Working in the public sector right now is working in an area that's filled with land mines, and every place you turn there's a difficult situation. Patients come in with their lawyers in tow and it's very difficult, no question about it. I've had more legal involvement in the last three months than I had in the previous seven years, which I am not happy about. There's constant pressure and there's constant second-guessing and if you get enough second-guessing in the system, then you can get into second-guessing yourself.... Things move very quickly, [and] there's a large social system that you have to interact with. Again I think that the mix is going to change in the near future for me—I prefer working with people over time and getting to know them and that sort of thing, but I think that there are tremendous pitfalls right now in the public sector, particularly in [a certain area of the country].

When the writer asks about his last statement, Robert replies that the legal climate in that region is such that "everything you do goes to the courts." Thus he feels that psychiatrists are more controlled by the courts than in some other areas:

> Legally, I'm brand new to the system and I don't feel confident with what's going on. I think there are all kinds of things that are being done that are going to lead to or could potentially lead to future litigation, and it makes for an adversarial rather than an empathic relationship, as far as I'm concerned.

When asked whether he has ever had to deal with a suicidal patient, he replies that "I guess I have two feelings depending upon what the suicide was about":

> I had a severely depressed patient who tried to commit suicide, and we got ECT [electroconvulsive therapy] for him and treated him, and I guess my feelings were really more of sadness and feeling bad for the guy if it's someone who's quite severely depressed. [But] I think most of the suicidal patients I deal with are more characterologically disturbed and more angry and [I have] to watch various kinds of transference responses with those people and...try...to maintain empathy at a time when I'd just as soon not be empathic [and could] be quite angry with them.
>
> *OLC: So it's hard when you have an angry patient who is suicidal to deal with your own feelings of being [angry]? Can you say a little bit more?*
>
> Deal with my own feelings...about being angry?
>
> *OLC: Yeah, because this person is suicidal?*
>
> Right, that they're suicidal and the suicidality as I see it in people who are in therapy with me [is] a form of manipulation. It's not conscious necessarily but there's a statement, there's an angry statement, and I think that what helps me, one of the pluses...is to maintain some perspective in terms of what's going on yet to maintain some empathy and to try to understand where this person is coming from, which is not easy, but also for them it's not a personal insult. It's really there and it's important to step out of my personal feelings and maintain some objectivity. So I try to do that. It's helpful, I think, for those kind of patients.

The writer's initial impression

The writer caught Robert, on the run, when he was about to leave the Boston Institute for Hospital and Community Psychiatry Conference. He agreed to be interviewed, right then, thus, but, understandably was needing to watch the time. Thus, unlike some of the other interviews, such as with Harriet, there was somewhat of a feeling of time pressure on the part of both parties. The writer noticed, however, how there seemed to be a different Robert who had been more connected with his community, including his patients earlier in his career, when he had been a social worker, and in his early days with community psychiatry. She wondered whether she would encounter other psychiatrists who appeared to distance from community psychiatry the more they became involved with it such that they chose not to live in a community where they would encounter their patients as had Robert.

Louis

Louis is a Canadian male, fifty-eight years old, and married with four children. His mother was Protestant and his father Catholic, and he was brought up in both religions. As an adult, he does "not follow any organized religion." His undergraduate majors were English and biology, and in medical school he studied to become a general practitioner, practicing it for a while and then opting to go into psychiatry because he believed it would help him deal with his patients' emotional difficulties. He completed two years of residency with a psychiatric training facility in the United States, where he was assigned to work with mental patients at a state hospital, and one year at another institute in another northern state. He specified a "rotating internship" for the question concerning his internships. His theoretical orientation is psychoanalytic and sociobiological, though he is "mildly skeptical" about this orientation, feeling that it is useful in providing service to patients "to a moderate degree." In the course of his career, he has served as associate commissioner for a department of mental health in the United States and as director of an association for the mentally retarded in Canada. In addition, he was involved in launching a community mental health program in a Canadian province that became a prototype for treating patients within community contexts. In this latter capacity he was called back to the U.S. in the early '80s as a consultant in a case that involved the question of euthanasia in the case of a child with Downs Syndrome. He has been working for more than twenty-five years in community mental health contexts.

Initial contact with writer

The writer struck up a conversation with Louis when both were attending an experientially oriented role-playing presentation at the Institute for Hospital and Community Psychiatry in Boston in October 1987. When he heard about her research, he expressed an interest in being interviewed. This interview, unlike the others which took place at one sitting, took place over two days, spaced around the very full schedule of the conference.

Present-day situation

Currently, he holds the position of director of rehabilitation services at a psychiatric hospital in Canada. Due to health problems he is, to his regret, no longer working in community mental health contexts as a clinician, and he misses it a great deal, saying that "the setting I'm working at now is probably the antithesis of everything I think that good psychiatry should be."

How Louis describes himself and what he does as a psychiatrist

In describing what he does as a psychiatrist, he describes himself as feeling "a little over the hill in terms of my career in psychiatry" now that, for health reasons, he has accepted an administrative position. However, working with patients in mental hospitals is what he has most liked about his career in psychiatry, and he also feels very positive about the work he did in the '60s and '70s in developing and implementing a provincewide program of community mental health services in Canada.

Yet in answer to the first question, Louis emphasizes that he does not think of himself primarily as a psychiatrist:

OLC: I'm going to begin by asking you how would you describe yourself as a psychiatrist.

I don't think of myself as a psychiatrist. I happen to be one but that's not really how I identify myself. I guess that before I [think] of myself as a psychiatrist I'd think of myself as a physician, and before I [think] of myself as a physician I'd think of myself as a member of my family and as a member of my community. And it would only be after I had thought in terms of those things that I would think of myself [as a psychiatrist].... I've done a lot of things over time and for a while was a family doctor, [and I] still like that probably as well as anything I ever did for a living. But it's not a question I've ever thought about, and it's not a question I would answer by saying, "I am a psychiatrist."

Reflecting on his experiences working in mental hospitals, he notes that he frequently adopted a "common sense" approach. He gives two examples of patients with whom he found this to be the best approach—first, of a woman who had been in long-term seclusion, then of a man, formerly an engineer, who was functioning at a higher level but nevertheless was not having his needs met due to the way he was being stereotyped by the staff. With the first, his common sense appears to have dictated that he simply treat her as a human being, rather than as a caged animal:

One of the gals that I remember very well, a person named Mary, had literally been in seclusion for ten years, and at that time the way they dealt with her was they fed her through a hole in the seclusion room door, slipped the tray under the door, and then at the end of each week, five guys would come in [with a] fire hose. Three of them would go in and grab her [and] hustle her to the floor, [then] they'd hose her down and they'd hose the room out. They didn't give her any utensils other than paper plates. So, to go in and be nondirective and silent in a room with her [seemed useless].... It seemed much more sensible to me to approach her by going in there and asking if she'd like to go for a walk and chatting about what it was like to be out of the seclusion room.... It didn't make any sense to try to find out why she hated her mother and what her sexual fantasies were.

OLC: Are you saying then that you went through your training and you learned the content that you needed for certification...

To pass the exam, yes...

OLC: But you've really been adapting to each individual case...

Yes.

OLC: ...how they can be treated like a human being?

Yes.

OLC: So that whatever it takes...would you do differently with other patients, in other words?

Yeah, like I mean that I think that with her again it just made no sense to me to approach her in terms of any kind of organized, structured, individual psychotherapy.

Louis goes on to share how, using this common sense, individualized approach he was able to help another patient to improve his functioning by getting him a job that the patient welcomed, even though the staff felt the job was beneath him. In this instance, he appears to place the patient's sense of what his own needs are as an important priority in determining the best treatment:

I remember a guy that had been an engineer, for instance, and he wanted to work as an elevator operator...and everybody had refused him that opportunity because they felt it was beneath his dignity, but they were satisfied to leave him locked up in a mental hospital in preference, instead of simply saying "Okay, if that's what you want to do, let's see if we can arrange it," [i.e.], getting [him] the job. Now he ended up being the engineer and superintendent of maintenance at a state hospital.

OLC: Isn't that wonderful!

Like I never did anything therapeutic for him but somehow got him back to work, a guy who [was] chronically depressed and then was ready to work.

Louis adds, however, that "that isn't to say that I don't feel that there are people that I see in individual therapy where I think it's useful to do therapy with them and use a variety of techniques, and once, in a while draw on my analytic training, but I don't find it useful for most of the people whom I deal with."

In addition to his work with individual patients, he talks about his experience in developing and implementing community mental health services. His life experience growing up in a small town taught him that a key concept in community psychiatry is to have a system that is serving a small enough number of patients to be manageable, in order to ensure, among other things, continuity of care. He "can only think of community psychiatry in terms of neighborhoods" and feels that it is necessary to divide large groups up into sectors or catchment areas. Thus he advocates having a team "with one or two individuals identified as being the people who are charged with maintaining the relationships. If one of them leaves, another one takes over and a second, a third is identified, and so on." When this isn't done, he maintains, "bad things happen."

> I think that...there are [a] few concepts that are so integral to my sense of how things should be done. [Specifically], the concept of team, the concept of that team focused on a defined population, and the concept of their working with the individual within his neighborhood in that area and providing him with continuous help on the basis of relationships that members of the team develop.

Louis developed these ideas during the '60s and '70s, when he served as director of a provincewide community mental health services program. He refers to this as "probably the best thing I've ever done." This was a period of deinstitutionalization in Canada as well as the U.S., and in the other provinces it resulted in patients being "dumped...out of mental hospitals, often with no adequate services in place." The program he directed, however, was so effective that "there was no further need for [the provincial mental] hospitals." However, when asked how the program is functioning presently, he replies regretfully that the program has suffered from diminishing government funding, so that "it's functioning progressively more marginally." When he visited the program the summer before the interview, he found that "it's really struggling" and that "the budget that we had in 1966 was more than the budget that they have now."

After this experience in Canada, he worked in the United States for ten years to try to deal with similar problems, but he found that "the muddles were huge" and essentially nothing could be done.

The fact that he is no longer actively involved as a community psychiatrist feels "terrible" to him, but he feels that "I've sort of moved all the mountains that this old head [could]." He feels that what he does now "is encourage other people...through doing some teaching and literally helping people [to] beat the system."

Becoming a psychiatrist

In answering the question of how he became a psychiatrist, he replies, "It's not that I'm in community psychiatry so much as that I think it's in me." Thus, he sees himself as espousing "a point of view and a frame of mind that is portable" to different situations to a greater or lesser degree. Before becoming a psychiatrist, he was a general practitioner, and his interest in medicine began when he was a boy growing up in a small town in Canada:

> I grew up in a tiny little town [where] a big town had a hundred people, and...there were only five or six kinds of people. There were farm people, and there were...local merchants. [There] was just a single general store in town where you could have a sandwich as well. There was an elevator operator...because grain was the heart of the community. There was a station agent—my father was the station agent. And then somewhere within a large area there would be a doctor and a minister. And so, if you were thinking of a career as a child, those were your choices, you had no notion that there were any other kinds or ways of living. [We went to] a one-room schoolhouse and it just never occurred to us that [there was anything better] than a teacher or a doctor, and of those, the one that...I found most exciting was a physician.

Thus, he became a family physician after completing medical school and went back to practice in the area where he had grown up. When the writer asks how he got into psychiatry, specifically, he

explains how it grew out of his experiences as a family physician, and the feeling that he might better provide help for his patients' emotional problems with further training in psychiatry:

> A number of the people that I saw came to me without acknowledging that they had no physical problems, but it [became apparent] that they had lots of troubles.... Family physicians in those small...Canadian towns...were seen as the closest thing to a psychiatrist, social worker, or any of those things.

He feels that his medical training did not prepare him adequately to deal either with people who were presenting with no physical problems at all or those who suffered from psychosomatic illness for which he could determine no cause, and he discovered that he could help these patients best

> simply by listening and spending time with them and doing the only thing that I knew how to do, that seemed like common sense.... If they were in trouble financially, it was trying to figure out how, with two heads, one could come to some notion of how to address that. But at the same time I felt dissatisfied, believing that maybe if I were better trained,...I could be more helpful.

Consequently, he opted to come to the United States to enter a five-year psychiatric training program. During the majority of that time, he worked with mental patients in a state hospital, while at the same time having the opportunity "to sit at the feet of a lot of the masters," who taught at a well-known mental health facility affiliated with a number of teaching hospitals. Despite the fact that he enjoyed this latter experience, however, he also found it to the "completely ludicrous" and "totally inappropriate" in relation to his work at the state hospital:

> I enjoyed it—it was great fun. I found at that time the analytic movement was extraordinarily strong , and [if] you were prepared to speak the jargon, I found it intellectually stimulating and fun, but I [also] found it completely ludicrous. I would be seeing a patient five times a week as an outpatient who was, say, neurotic, and practicing analytic techniques on them and then going back to a state hospital where there were a thousand people, 200 of [whom] spent their time daily in seclusion,...and...anything I was being taught at the feet of the masters seemed totally inappropriate.

He believes that had he not had a chance to work at a state hospital, he probably would have gone into private practice:

> If I'd been in one of the conventional training programs, I think I would have probably...been [a] private practitioner because that was very much the role model, or gone into [an] academic [position]...[But] ,if you're seeing literally hundreds of patients who are utterly ignored by organized psychiatry and seeing how little anybody knew to do on their behalf...
>
> *OLC: So, in other words, because nobody else was doing it, [you kept working in state hospitals]?*
>
> That would be [accurate]

His overall assessment of his psychiatric training is that "I didn't feel [that it] offered me very much help in anything that I wanted to do." Instead, even after completing his training in psychiatry, he continued to rely on his common sense rather than on theoretical expertise in sizing up what each individual patient needed in order to improve his or her functioning in the world.

Becoming a better community psychiatrist

Louis notes that he has always de-emphasized the fact that a patient is mentally ill. Instead, he has always tried to meet that person's "basic needs" and, by his example, show "everybody that's working with that person [how to put] a great deal of time and effort into seeing that those basic human needs are met," and then continue to monitor this "over a very long period of time." Another way in which he considers he improved his ability to provide service as a community psychiatrist was by developing an application of principles of physical rehabilitation to mental health, with the help of a grant from the National Institute of Mental Health. When the writer asks him to further clarify this "physical" approach, he explains that he tries

> to work with the healthy part,...to look at ways of making up for deficiencies that a person had.... For example, [if] someone [is] missing an arm, then one could work to develop a prosthesis for it and to help them change their attitude toward it.

Likewise, he explains, he applied this same approach to a couple having difficulty with communication:

> There wasn't a "prosthesis" for it, but perhaps you could do things to help them with their communication skills and through that kind of skill development, help them to make a difference...in the same way that your task, if they were physically disabled, was to look at whether they needed to think about different occupations. I felt that the same applied.
>
> *OLC: You mean going for their strengths, would you say, building on their strengths?*
>
> Yes.

Thus, part of becoming a better community psychiatrist for Louis was continually coming up with ways to address the practical problems of patients in coping with their everyday lives. His broad-based preparation as a family practice physician and his interest in helping the disabled have allowed him to borrow from other areas of medicine in order to provide better service.

Louis feels that both patients and people from nonmedical backgrounds have been helpful in teaching him how to be helpful: "If I were rank ordering I guess I'd say that the patients who told me how to be helpful did more to influence me [in my ability to be a better psychiatrist] than anybody else, and then people from nonmedical backgrounds."

As an example of the latter, he cites a hat manufacturer who had allowed the hospital he was working at to set up a business enterprise in his factory so that many of the women patients who "had a lot of artistic talent [but] just couldn't make a living at it" would have an opportunity to have a meaningful job.

What Louis considers are the important ingredients in helping someone

First of all, he considers people to be the most important ingredient, in that "people are best able to help people." In his opinion, there is a "chemistry" between people that makes this possible, "rather than what their training is or what techniques they have mastered." In his current working situation he has observed that among practitioners of a number of different disciplines—Registered Nursing Assistants (RNAs), nurses, psychologists, social workers—"there...seems to be very little correlation between what their background is and how able they are to help human beings":

> [For example], someone that...you least expect to be helpful, because you sort of stereotype them as helpers, will suddenly find someone who is a match somehow and they'll do quite marvelous things for reasons that aren't easy to identify. I'll give you a concrete example:
>
> Recently, an RNA who was sort of a scapegoat—being lazy, union-oriented, out of the team, and not a very good person generally—became identified with a...patient who was the bane of everybody's existence, a guy who had had an amputation and was not going to make any adjustment to it, [with] a long-standing...history of having been a borderline personality, for lack of a better label, before [his amputation] and just drove everybody absolutely crazy, and somehow they found each other and [they both] blossomed.... It was a very professional relationship, it wasn't a personal relationship in the sense that they knew each other as two people outside their work. [But] she turned around his life and, [in so doing], her image of herself and others' image of her, and they [she and the formerly unmanageable patient] worked [together successfully] and fit in[to the team setting].

Louis notes that what seemed to turn the patient around was the way the RNA did "very simple little things," like finding him a place to live other than a nursing home. Up until that time he had resisted almost any effort that had been made because everyone had been thinking in terms of nursing homes, as the staff "had such a low expectation of him that they'd been thinking of highly structured places." The RNA, on the other hand, "did not see him in that light [and] as she listened to what he thought he needed, she was empathetic to that and looked for it and found it, against all sort of odds." Following this incident, the RNA continued to see and follow up on his case, and she "is [now] different in terms of how she relates to people." Louis continues, "I don't know a better word than 'chemistry' or

'timing' " to explain this, but "it turned around most of that team and made them look at all of the people they were working with differently."

The writer then asks, "Is there anything else that you consider important besides this chemistry or being empathetic?" To this Louis replies, "I guess common sense." Then he continues,

> I guess I've always been impressed with [the fact that] if people were in trouble and were labeled mentally ill, still their basic needs were no different than yours and mine. They need an opportunity to work and an opportunity to play and make some human contact, an opportunity to have a decent roof over their heads and some money in their pockets, and that if you provide those things,...so much else melts away in terms of the illness over time.
>
> *OLC: If you treat them like human being?*
>
> Yeah, and in any of the work I've done in community psychiatry, the emphasis has always been away from the illness—not to ignore it, to do what one can for it, but towards having everybody that's...working with that person putting a great deal of time and effort into seeing that those basic human needs are met, and one does that over a very long period of time.

He goes on to emphasize the importance of this long-term relationship, noting that

> in our society there are so few times that people have the opportunity to have that kind of long-extent relationship.... So much of what helps us to hang in and to change is a relationship...that's stable and has some trust built into it, and that's such a rare, rare thing for someone who is labeled mentally ill to have.

Relationships

With family of birth: He speaks highly of the influence that several family members have had on him. His paternal grandfather, a farmer until he was ninety-eight years old, continued to work full-time as a night watchman even after retiring from farming. He had "a very fantastic sense of humor, [a] very deep commitment to [the] land, [and was] very active,...just a very nice guy to identify [with]." His maternal grandfather, who had ten children, ran the small general store that was central to the life of the community. In the 1930s, this grandfather ran "his own welfare agency" of sorts and "helped a lot of people." Louis also feels that both his father, a telegraph operator and station master, and his mother, a teacher who was "very interested in things academic [and] reading,...had a great deal of influence on me." Yet another influential relative was an uncle who was a musician who used to play at weddings and dances. He was "very nice, fun-loving, [and] did a lot of stuff in the community in a very quiet way."

People such as these "made me want to do things for people individually and for the community, and [medicine and psychiatry] just became one way of fulfilling that."

With friends: The friends that Louis mentions are a group of about a dozen colleagues whom he met in medical school and has made a point of keeping in touch with (cf. below).

With spouse/significant other and children: He married and moved to the United States with his wife and firstborn son when he began his training there in the 1950s. He and his wife subsequently had a second son and two daughters, one of whom has gone into psychiatric nursing. He remains in close touch with his grown children and tells the writer that he is enjoying attending the conference with his wife, whom he introduced to the writer before the interview. He has relied on his family to help him set limits for himself since his coronary episode.

With community: He feels that his desire to help people has been very influenced by growing up in a small town where everybody knew everyone else and where they were very isolated, especially in the winter. "If anyone in town was sick, it was a community concern" and everyone tried to help:

> If there's fifty people in town, then the whole town is on the one hand frightened and on the other hand does what they can—whether they boil the water or they bring a cake—and...they...came together in a very special way, and it had a whole range of qualities about it from excitement to fear, to wonder, to feelings of inadequacy, to feelings of "Maybe if I do this, it will make a difference."

He also mentions that when the roads were impassable, his father, the station master, would drive along the train tracks in a railroad vehicle to fetch the doctor from the next town. This community outpouring of concern and support had helped his family several times when his mother was seriously ill.

In answer to the question about his relationship to the community and how it was affected by his becoming a psychiatrist, he offers these reflections:

> I don't think that becoming a psychiatrist changed my perception of my place in the community. I had always tried to be active as a member of the community before I became a psychiatrist and I continued that after...[by being] active in any number of organizations [such as] the Scouts, and active again in terms of being aware of what was going on...[and] knowing...the people that made it work and those that didn't. So I don't think that changed appreciably, [except] maybe I became a little more knowledgeable of what the interplay was between elements of the community—the police and the church groups and so on—but I don't think it changed how I felt about my place.

With colleagues: Louis formed close friendships with a group of about a dozen fellow residents in medical school, including some from other countries, and has continued to keep in close touch with them and to see them from time to time. He feels that "we had a lot of influence on each other...around discussion after a particular problem or just watching each other and how we deported ourselves in terms of grappling with problems in a state hospital."

Regarding what he would tell psychiatrists-in-training is the most important thing to learn, Louis suggests,

> I guess to tune into the people that [they are] working with and take [their] cues from them.... I don't think we do that."
>
> *OLC: Instead of telling them what you feel?*
>
> Yeah.

He also says that he would "tell them to see as much as they can [by] seeing other cultures." He gives as an example his own travel to Japan where "I didn't spend any time with anybody in the field but just walked around, and sitting in a garden that was a thousand years old somehow was very effective in giving me perspective."

In advising trainees how to nourish themselves, he believes that they should have "a network" of people whom they can rely on to both give and receive help, "to be very close to, to count on me the way that I want to be able to count on them." Personally, he feels his own network cannot exceed fifteen or twenty people.

With mentors: He mentions only that one of his teachers at his university "had probably influenced me most of all my formal teachers." This was a professor who held special seminars during lunch for general practitioners who were interested in psychiatry. He impressed Louis as "very down-to-earth." He also mentions another community psychiatrist who was involved in the implementation of the province-wide plan to cope with deinstitutionalization and who used to come over and share meals with him and his family and who was very amusing as well as very practical.

With patients: As we have seen, Louis feels indebted to his patients as teachers. He also believes in the patient's ability to identify what is important and is willing to follow the cues that the patient offers. For instance, he tried to match patients' jobs with their interests at a time when there generally was "no attempt to relate what [patients] were doing to what [they] wanted to do." Noting that every mental hospital used to have its own working farm, he mentions that he used the state hospital's farm to involve patients who showed an interest in the work. "The head farmer was a good friend and a remarkable guy and we managed to get a lot of people who had been from rural backgrounds interested in the farm again."

He mentions one patient who "constantly decked people when she was sent out to pick beans on the farm every fall...and no one [had] bothered to find out that she was an accountant, [and] that this [farm work] was offensive to her." This woman, who at the time was mute and spending much of her time in seclusion, nonetheless "impressed me enormously." He describes how he and his colleagues were able to persuade her to go and help out in the business office, "and she took over and corrected any number of errors [when] their books had become a hopeless mess." After this, the patient had "turned herself around" and had "held a very good job for years."

Because he cared about treating patients as human beings, he was able to arrange that they would be paid a wage for their work, thus providing a reward system. This enabled patients to "become part of their own planning...and when they did that, how little their illness mattered." Louis also emphasized the importance of relationships.

With self: Since suffering a massive coronary a few years earlier, Louis has had to learn to pace himself and in so doing has had to change his professional orientation: The writer mentions how psychiatrists have been confirming for her how difficult and time-consuming the practice of community psychiatry is, and Louis points out that his deteriorating health has regrettably forced him to cut back, and that he misses the way he used to work, and has tried as much as possible to continue to work closely in community contexts and provide public service.

> You mentioned how difficult community psychiatry is and that you really [have to] give a lot of yourself.... I had to find a setting [after the coronary] both where I could get insurance, since I had never thought about things like that, and where somebody else could control my hours of work, since I had never done that either.... Public service in a provincial hospital satisfies both those needs and still gives me an opportunity to do some kind of experience that I like to do.

In relation to nourishing himself, he relies a lot on family and friends to help him pace himself, and he does a lot of "walking and thinking" every day.

> I take a lot of nurturing from others.... I find that contact with people is nourishing,...like our [to the writer] spending time together I find rewarding. And I find that the work, if it's going at all well, is nurturing.... It's only when it's piling up or it's not going as well as I'd like that...the flow reverses and at times like that I turn to my other sources of support.

Louis states that what gives him the greatest confidence is "people and their resilience and their ability to bounce back from incredible bad fortune and to find their way if society at all will support them." He hopes he can "be some small influence on that, and to [help them to] find a way of knitting themselves into some kind of network."

What makes him least confident is his discouragement with the political system. "I think that it lets us down more and more.... I liked it when life was simpler [and] you could touch all of the groups." As an example of this frustration, he describes the situation with one patient:

> She was...very vulnerable, and we decided to call everybody that was trying to be helpful to her together, and there were over thirty-seven different agencies involved.... She was somehow trying to keep her sanity in the midst of relating to all of these different agencies, each of which had a very different view of how she should be supporting herself.

The sheer weight of the numbers appears to overwhelm him in trying to be of help, and he wistfully reminisces about what it would have been like fifteen years earlier:

> If even fifteen years ago...one had met that same lady in that same circumstance, there might have been eight or ten different groups who then might have been...in a much better position to come together [and] to come some consensus of assistance instead of just [making] noise...
>
> *OLC: So you feel least confident when there's...so many people that you don't have control over...?*
>
> I don't like controlling people and I don't like being controlled, but it's sort of the anomie that seems to be creeping into society that worries me, troubles me, and makes it much harder to do the things that come easier in a simpler society. Whenever I get discouraged I go back to a place like [the town where he was born] where it's still very much rural, you can still go into a small town there and within half an hour identify the helpers.

He feels that the aspect of his character that is most important is having "a mixture of patience and impatience":

> I can be infinitely patient with somebody that's in difficulty, but I can be terribly impatient with the situation that puts them in difficulty. And so I think that's one of the characteristics that's helpful. I think I am good at listening and then synthesizing what the problem is and what it isn't and helping people to see for themselves what it isn't and to sort that out in a way that they then can get active in [solving it].

With a power greater than the self: Although raised in both the Catholic and Protestant churches, he no longer practices any organized religion, but he has "read a lot about a lot of them [and] I do feel some sense of an order in the universe and of a power that I hope is organizing it." When the writer asks him whether he feels this affects his ability as a psychiatrist, he answers, "I think it probably does, in ways that are hard to define. I have a great sense of the mystical without being able to be very definitive about it."

He attributes this sense at least partly to the fact that he has had several near-death experiences. These have been

> very variable,...very different [one from the other]. When I had mumps and encephalitis and a number of seizures when I was in my forties,...[I] had the usual one of flow[ing] out of your body and watch[ing] all that's happening around you and see[ing] rather impressive bright lights. And then when I had my coronary,...it was a massive one and I had to be resuscitated and was very certain that I was going to die, just absolute, utter conviction. But it was very comfortable, very pleasant.
>
> *OLC: You weren't afraid?*
>
> No, it was really like a great sense of peace and satisfaction. It was just a very comfortable feeling and then things began to get grey and then black and [there] was just absolute, utter, incredible darkness,...it was a velvet kind of darkness.... You think of black as foreboding, but it wasn't. It was very enveloping,...so...I just faded more deeply and gently into that.

Valued and non-valued learning experiences

In general: He mentions several times how much he values the learning he received from his patients in state mental hospitals, in particular.

Formal education: He found the experiential aspects of his formal education, including supervision, to have been most important; "most lectures" were least important. He answers the written question concerning his most and least important academic courses as "too wide a variation to answer simply." However, he emphasizes that

> There were teachers that certainly influenced and impressed me a lot and that had an impact on me, but I think it was more an interest in them as personalities than the formal aspect of lecture.
>
> *OLC: Or the content?*
>
> Yes, or the content. Well, sometimes the content because sometimes what they had to say again was more substantive and that in turn made them really aware. [That] impressed me a lot and...had an impact on me.

He recalls meeting Anna Freud when he was training in the United States and she was lecturing at a university to a small group of residents. "I don't remember much of what she said, I just remember her presence, what a nice person she was and how, again, how human she was." After meeting her, he made a point of going back and reviewing some of her writings "and following her as a result of that experience.... But if you were to ask me now what her thesis was or what she said, I don't have any recollection of it but I have a vivid recollection of her."

Informal education: Again, what made the greatest impression on him was people, such as meeting a fellow psychiatrist who developed the concept of a province-wide plan. This man "was a character to end all characters, so that he popped down to have dinner at our place and told great stories of all his experiences generally, but, in particular, around psychiatry.... He was a very down-to-earth, common sense kind of guy." What had made a difference was "just...knowing him well, spending time with him and just seeing what kind of person he was—a very unusual man for a bureaucrat, very antibureaucratic in that position."

Challenges and vulnerabilities

Louis has found it difficult to have to cut back due to his deteriorating health which has necessitated his becoming less involved community-wise a as a psychiatrist, and when asked how this feels, he answers, "Terrible!" Thus, a major challenge or vulnerability is his own deteriorating health. He attributes his coronary episode several years earlier to overwork while on assignment in the United States, away from his support network. He was involved as a consultant in a case involving a child with Downs Syndrome and was "working frantically":

> It was a youngster with Downs Syndrome and the parents had insisted that it be allowed to starve rather than have a very simple operation, and I had very strong feelings that that wasn't right and that they were free to give up the baby. There were several families that were willing to adopt the child, and...I was asked by the then-Secretary of Health to come down and be part of a working group.... I was doing much more than I should have been doing, and [when] I was asked to do that I couldn't say no, and it was the straw that broke the camel's back.

Louis also feels very vulnerable when one of his patients commits suicide. Although he has lost only three patients in his long career, he says that "I don't know that one ever does [come to grips with suicide as] it's such a final act." His first experience with having a patient commit suicide happened before he became a psychiatrist, and Louis was treating the patient, a young man, for diabetes rather than for any mental condition when the patient shot himself after hearing that his fiance wanted to break off their engagement:

> I'd seen no evidence at all that he ever [would commit suicide, as he seemed to be] an upbeat, compulsive guy, on top of the world. He was a very simple farm guy who was very offended by feeling ill—he's strapping, husky, but he didn't like the idea that he was in any way flawed physically, and so his diabetes bothered him a lot. But I felt that we'd really come a long ways and he was feeling in charge of that. He'd come in in a diabetic coma, and he'd made a lot of progress.

In looking back on this incident, Louis feels that losing this particular patient was another influencing factor that led him to change to psychiatry from general medicine. He has found himself asking often what he might have done differently that might have alerted him to the seriousness of this patient's condition, and what he might have done to save him: "Time and again I've wondered [whether] I had missed something

The writer's initial impression

The writer conducted her interview with Louis second after that of Hassan. Unlike Hassan, whom she had met at a social occasion, the writer had participated with Louis and his wife in a psychodrama workshop targeted toward community mental health professionals. And, in contrast to Hassan, she was left at the end of the interview with a feeling of having a clearer sense of who Louis was as a person and the importance of family and community relationships with several examples that added to her understanding as to what Louis meant by this. Even after having to interrupt the flow and resume the interview the next day, she still reported having a sense of enjoyment and ease in interviewing him. In her notes, she remarked being struck by the way that his wife had accompanied him to the conference, unlike the other participants in the study, and how he made an effort to include his wife in most of his activities, such as in attending the conference offerings, although he was interviewed by the writer when his wife was not present. Following along with our tennis metaphor, it felt as though this was an enjoyable tennis match with time between shots to position oneself and shift one's position so as to connect directly with the ball coming over the net in a series of long volleys, rather than the faster-moving barrage of net shots returned to the writer by Hassan. In some ways, the interview with Louis felt as if the writer and he were playing on the same team as in a doubles match, or perhaps, if playing singles, there were ample stops at the net when retrieving a ball to stop and chat, purely to enjoy each other's company. Also, as with Lynn in the pilot interview, the writer was impressed at the importance that Louis placed on having and maintaining relationships.

Harriet

Harriet is a Caucasian, Protestant female, sixty-three years old, twice divorced, who was brought up in a fundamentalist Protestant community. She was pre-med as an undergraduate at a fundamentalist college in the South but notes that her music and art appreciation courses in college were "broadening" and that her most useful college course was physics, which taught her "how things work." She received her M.D. degree from a medical college in the Midwest and completed an additional M.Sc. in psychiatry at a university nearby, then completed a hospital rotation that she describes as "controlling" and "punitive." Her clinical training at the university was psychoanalytically oriented with an "eclectic" staff. She regards the most important aspect of her formal education to have been her postdoctoral research in social psychiatry at the university, and she does not specify which was least important. She feels that her learning experience in graduate school allowed her to explore options and find out what works for her, whereas the hospital rotation taught her what not do, remarking that it reinforced her "aversion to coercive 'therapy.' " She has been working in community mental health contexts off and on since l955, when she first started general practice. At that time, she conducted a survey of the community and wrote a feasibility study for setting up a community mental health center several years before any community mental health legislation had been enacted. At one point she retired from public practice in order to devote herself to writing and research, but she had to resume working after a second divorce settlement about ten years earlier had wiped out her savings. Although currently she describes herself as an independent consultant in research and social psychiatry, she has been included in the sample on the basis of her previous experience.

Initial contact with writer

Harriet attended the winter meeting of the American Association of Community Psychiatrists in March 1988, to which the writer had been invited. Upon hearing about the writer's research, she agreed to be interviewed for the study.

Present-day situation

Currently, Harriet is about to move to another state, where she plans to continue her private practice as a social psychiatrist and consultant, with a specialization in working with battered rural women. Although she is not currently working in a community mental health center, she has done so in the past and continues to consult for them, and to fill in temporarily for other colleagues on a short-term basis.

She indicates that she does not wish to work in institutional environments as they now exist because she feels that "mental health centers, at the moment, foster more mental illness than they...help." However, she has continued to consult within institutional settings, arriving at a compromise with which she can live. As she puts it, "in institutional settings, where I may not be myself, I practice a certain amount of limited expectation and limited involvement." For instance, she will do so only if it is short-term and only if "either a research fund pays or something else so that I'm not completely at the behest of who[m]ever I work for." She equates institutions in general with her native religious community, as "they go by rules that are arbitrary...[for] the greater good of the institution, and it doesn't matter whether they grind people up in them or not." One of the things she feels is sacrificed for the good of the institution is true confidentiality regarding patients. She thus distinguishes between the legalistic meaning of the term (which she believes is "self-protective [for the psychiatrist] and it's not made for the patient") and true confidentiality. Within a pessimistic world view that makes her doubt that "anybody can really change our society," she has found that "the only difference I can make is primarily on a one-to-one, small-group basis." Above all, she prides herself on her ongoing ability to adapt and change within these parameters, and she sees herself, unlike many of her colleagues, as "never having fossilized."

How Harriet describes herself and what she does as a psychiatrist

Harriet considers herself to be one of a small number of "social psychiatrists" in the United States. In addition, when asked this question, she replies, "I am a self-disclosing, feminist psychotherapist." She immediately goes on to qualify her analytic training in this light:

> I use a lot of analytic techniques, some of the philosophy, but I reject and did reject from the beginning the chauvinistic Freudian perspective. And I find it very hard for a woman in psychiatry to survive with that kind of perspective, so I try not to ever get into the middle of an institution. I don't like their hierarchy. And I survive by being a consultant where I can move in and out of things.

She is careful to say that "I don't argue against individual men, but the system is so all-pervasive,...this is a male value-identified system."

How Harriet describes what she does as a psychiatrist

She stresses how she positions herself on an equal level with her client from the very beginning of therapy:

> I do not believe that I am on any different level than my client. I start from the base that women are all equally oppressed, and I am more effective if I acknowledge that to my client right from the beginning, that she and I are in a common predicament in this culture. And that I am not a therapist to help her; I am a therapeutic facilitator to throw light on obstacles so she doesn't stumble over them or to show optional paths around those things. And for me the most exciting thing is to facilitate other people's self-discovery, and when they discover themselves, they become self-empowered, and they do not become dependent on me.
>
> Most people think when you get intensely involved that that's overinvolvement, countertransference, and all that. I think those people don't know what we're talking about, and they stay detached because they're scared and frightened. They think they will go over the edge. I'm not afraid of the edge, and I love to work with people who are afraid and don't realize that you don't have to be afraid once you know what it is you're afraid of. Frieda Fromm-Reichmann has influenced my work.

She feels that her own ability to relate to her patients as an equal, rather than holding herself above them in her professional capacity, is one of the most important factors responsible for establishing the therapeutic bond and in influencing her work as a psychiatrist. Thus, she self-discloses when appropriate: "When the bond has been established and the patient knows I'm real and I'm not going to play tricks, then we've got it no matter what happens."

She places her trust in her patients and in her network of women, which serves to help her with limit testing "[so] that I don't go off the deep end." She then can communicate to her patients that "there is no such thing as a wrong question" and that "knowing my center, whatever it is, doesn't need to be approved by anybody else." She also believes in not giving herself or others "false hope" and disagrees with the current trend to "[tell] somebody that's in trouble, "Oh, you can do anything you want" since "that's a bunch of b____t!" Rather, she teaches them, "You <u>can</u> within limits.... I'll show you...how you can get where you're going but you can't go <u>that</u> way."

Teaching her patients how to relate to self and to others remains her main focus regardless of the diagnosed problem. With one patient, a woman who was diagnosed with temporal lobe epilepsy, Harriet identified that there had been a broken bond between the patient and her mother that had begun in infancy and resulted in the daughter's anaclitic depression:

> She remembered an experience and the mother said she was two at the time. And something just wasn't right, there was a barrier. So...I worked with her to acknowledge and realize the shape that that ha[d],...to help her become nourished and nourish herself and have a realization that she is not a hollow shell. She can be filled and be somebody. Then she can cope better with the organic symptoms [of temporal lobe epilepsy].
>
> She speaks of empathy as something that it is closely related to intuition, which she defines

> as not some mysterious thing, but rather if one is open and allows oneself to associate and is not afraid of those [boundary] lines, then you can perceive things and understand empathically. So...I think people get frightened...when they're not sure of their own boundaries yet.

Becoming a psychiatrist

She grew up in a close-knit fundamentalist community in the Midwest and wanted to be a doctor from about age thirteen. "In those days, I was religious, and I was going to be a missionary doctor." Once she got into medical school, however, she initially decided to become a family doctor and practice in the rural community where she had grown up. However, she "realized that I was more challenged and interested in the counseling aspects than I was in just the medical." This eventually led her to choose psychiatry, where, she feels, she is able to pass on her own "survival techniques," particularly to other oppressed women. When asked what in particular led her to decide a to become a psychiatrist, she replies that she does not feel that it was any specific incident that happened or person she met; rather, "it was working with my clients in general practice and seeing that I was doing psychiatry and fantasizing that I could be a better psychiatrist if I went into training."

When she left her rural community to begin her psychiatric training, she was "shocked at the level of practice in the city." However, this disappointment in the quality of psychiatric service helped to make her realize her own capabilities, which she had previously undervalued. She states, "I thought I was stupid until I was thirty-five...and when I found out that I wasn't,...I was angry, very angry."

She started out her medical career as a family doctor making house calls, and she has continued this practice with some of her psychiatry patients, as a part of getting to know them in their context, especially when she must serve as an expert witness in court cases.

She underwent analysis as a requirement of her psychiatric training. After training for one year at an urban hospital, which she feels was "a real snake-pit,...a 'Cuckoo's Nest,' " she continued her training at the university near her medical school, which at that time was psychoanalytically based and which she considered to have been "a real good experience." However, she "never bought the Freudian stuff from the beginning...because I just knew it wasn't true." At that point, however, she felt that "I couldn't talk back." She concludes from this that "in this culture, you have to do your own thinking...[and] you don't buy what they say unless it feels right." When the writer probes further to see if this is the reason she rejected her religious upbringing, Harriet replies, "I wouldn't have survived if I hadn't,...but I didn't realize that [this was the case] in this culture also [i.e., the wider American culture],...that the whole world was [like the community she grew up in], everybody was trying to tell you what to do."

After completing her medical studies, she joined the faculty at her medical school and immediately found herself caught between two psychoanalytic schools, one at her medical school, where the faculty was drawn from the more conservative Psychoanalytic Association, and the other at the university where she had studied social psychiatry, where the faculty came from the more liberal Psychoanalytic Society." They "were always at war with each other." After a somewhat rocky start at the former, she was able to find a professional affiliation of sorts within psychiatry when she became the director of the suicide prevention program for the city in which she was teaching, as well as in participating in the formation of the Association for Existential Psychiatry. She was also influenced by the work of Frieda Fromm-Reichmann, but later her advocacy of battered women led her to a feminist perspective vis-à-vis psychiatry.

Becoming a better community psychiatrist

She considers that her growing feminist self-awareness has been largely responsible for making her a better psychiatrist. By stating her position from the very beginning, she places herself on an equal footing with her clients:

> You see, I was a feminist before I knew the word, and I think that when I realized that there was reason for my dissatisfaction with the culture, [I realized] that...it wasn't anything wrong with me. It's this whole self-empowerment, self-esteem, sense of self, and I think when I realized that I was not stupid and that when people didn't understand my questions or felt I

> asked too many questions, there wasn't anything wrong with [me]. I was just trying to fit in [but]...I made people uncomfortable, because I asked questions you shouldn't ask.

She believes that becoming a psychiatrist has helped her to "cope better,"

> [as] it helped me see that it wasn't me, it helped me see that it was hopeless to think that I would ever be part of this culture. My values are so different from traditional culture that I don't even try anymore.

She has given up trying to conform with the growing psychopharmacological trend in psychiatry or to the view that increasingly limits the psychiatrist's role to deciding when patients should be hospitalized. She experiences this as a narrowing of the psychiatrist's role, and "I refuse to waste the rest of myself." In her opinion, the fact that she has come to understand the oppressed and disempowered position of all women has not only increased her own self-esteem, but it has made her a better psychiatrist as well. As a result of her own experience with abuse, she emphasizes the importance of cultural precursors to mental illness, particularly those affecting women:

> I'm willing to go along with the biological if they give equal weight to...cultural learning. I believe that anorexia, bulimia, what they call borderline personality [disorder], [self-]cutting, women's depression...are all part of the oppressed condition of women, and... psychiatry is not going to acknowledge that.... There are beginning to be a few people say[ing] it in print, but I've said it for years.

She feels that her generation had "some limitations" because "we were either rigid analysts or we were rigid biogeneticists,...psychobiolog[ists]." The current trends, however, produce "medical students [who] are like the machines they operate." To counteract this depersonalization, she believes that, ideally, a resident's training should include the experience of being hospitalized as a mental patient in order to learn about the process from the inside out.

When asked what she would tell a psychiatrist-in-training was the most important thing that he or she could learn to be a good one, she replies:

> Find out who you are, remember where you came from, and always acknowledge that to your client. Be honest with...clients, even if you have to tell them that you disagree with the institution or whatever. You don't set them up for rebellion for the sake of it, but you acknowledge that they're right and that it isn't the institution that's right. Because if you do that, you just confuse them, and I think that's why we're so ineffective in mental health centers and hospitals, because we lie all the time. And that's really why I can't stand being in an institution, because I couldn't be honest or be myself. And my integrity is all I've got left.

What Harriet considers are the important ingredients in helping someone

She replies that "the most important thing is to establish that bond in a way that you are believable and real to the person as a person first." She emphasizes that she doesn't try "to do techniques or trick questions." Regarding the establishment of the initial bond, she says, "If it can happen, it'll happen, [but] if the bond can't happen, for whatever reason, if you're different-cultured or whatever, then I shouldn't be working with that person." When asked whether she thus finds it hard to work with people of another culture, however, and whether this makes it impossible to establish such a bond, she replies that this is not necessarily the case "because there are so many alienated people in every culture." She is adamant, however, in stating that she refuses to work with "perpetrators" or "batterers" since she was "a formerly battered woman," having been raped and battered in the early '60s by her first husband, a physician—but "of course nobody believed in those days that [this] could happen."

She feels that another important ingredient in helping someone to be "listening to the client and believing them." Again, she states very clearly her belief in the patient's ability to "know themselves better than any doctor ever can" and thus to be "a good reporter" of her or his own experience.

Yet another important ingredient is "being willing to go and learn the patient's context":

> I go to the house, and when I testify in court [in custody or divorce hearings] that I've gone to a patient's home, the attorney from the other side will say, "Well,...is this usual, that you go

> to the patient's home?" And I say, "Yes." And they don't know what to say because they expect me to say no.

Relationships

With family of birth: Her father was a fundamentalist preacher, and she was one of nine siblings. The children's ages were spaced so that there were, in effect, three different "families," of siblings; Harriet was one of the "neglected middle" children who were brought up largely by their older siblings.

The family, except for one brother, switched to another similar denomination when she was in college (she did not explain why). After leaving home at age nineteen, she distanced from her family in fulfillment of a growing need for such a separation, which she sensed was connected with the need to insure her own survival, and at the time of the interview she remains in touch only with two sisters. After becoming a doctor, she returned to work as a general practitioner in the same rural community where she had grown up, but this was only because her family had moved away; otherwise, "it would have been too big a conflict." She refers to a period during her junior year in medical school, when she was around twenty-seven, when "the bottom dropped out of everything" and she became disillusioned with her religious search. She had always been "thinking there was something else" until she "discovered that all the religions were patriarchally based and there was no place for women," at which point "religion was no longer relevant" in her life.

With friends: She has survived in part by seeking out other alienated individuals, such as one time forming a connection with a fellow trainee who was a homosexual. "He and I kept this side dialogue going, like an obligato, [and] he taught me what was wrong with what they were teaching." An advantage of being from another culture is that "you learn things to survive and see things that other people don't see."

She appears to regard her network of battered women and their care givers as her primary emotional support network. Since her friendships are not primarily geographically based, her preferred mode of remaining in touch for emotional survival while serving in isolated areas is an extended telephone network.

With spouse/significant other and children: She has had two failed marriages, with no children. Her first husband, a physician, was physically abusive. Her second husband was responsible for depleting her remaining financial resources in the divorce settlement ten years earlier.

With community: Her relationship with the religious community into which she was born was largely a negative one. She felt trapped and constrained by it and during her teenage years despaired of ever being able to escape from it. Although she later came back to this community as a doctor, she ultimately decided to leave again and go into psychiatry, stating that "it was just too isolating to be practicing in that community...and there was no way to build a support network.... There were not enough people...[to make it] ego-syntonic for me to stay."

In the years since, she has created a sense of community for herself, but it is "not community in the usual sense." Rather, "wherever I go, the first thing I do is find [and] develop a network of women [so] that I can have some kind of nourishment for myself." She insists adamantly that for her own well-being she "will not move to someplace where I have absolutely no connection or network." This psychological sense of community provides her with the necessary support for her to carry on her work in isolated areas and in a culture where she otherwise feels like an outsider.

With colleagues: She does not mention affiliations with particular individuals, although she mentions that she values going to conferences for the opportunity to network, exchange ideas, and keep abreast of current developments in her field. However, she mentions colleagues in general terms when she speaks about honesty and integrity, and she notes that she has been disappointed by many of them for their willingness to compromise themselves

> I've seen a lot of people walk across that line because they compromised here and there, and they thought they knew the difference, but they didn't know anymore where the line was. Once that happens , they're finished. I've seen so many colleagues that it's just painful to know that they don't know the difference anymore, and they totally changed, they became part of the system.

She also notes that "I never forget where I came from, and I came from the bottom, and my identification is much more with the woman who cleans my office than with my colleagues."

With mentors: She has been strongly influenced by the writings of Frieda Fromm-Reichmann and considers her to have been a mentor of sorts. Although she regrets that she did not meet Dr. Fromm-Reichmann before her death in 1957, she was fortunate enough to make the acquaintance of Dr. Edith Weigert, one of Dr Fromm-Reichmann's friends and colleagues, who then served as a mentor for Harriet for several years.

With patients: Her work centers around helping illiterate, rural women, particularly those who have been abused, and in so doing, "I do believe I am able to give voice to the voiceless."

> I don't have one theory that fits everybody. Every patient that I have I listen and then I figure out what's going on and try to understand.... I try to find out from the patient what's going on.... I'm so sick of this diagnostic labeling stuff, and I don't like DSM III-R and their attitude about personality disorders. I almost never use the personality disorders because that implies one of two things: either they're hopeless [and] it makes them a victim, or...you have to go into the Freudian thing that you're supposed to change them. I don't think we're supposed to change people at all. If they want to change, then I'm there to facilitate whatever change they want. And people are smarter and healthier than we give them credit for.

She sees her patients as her equals. In reference to one patient she says: "I could just as well be sitting there in prison right now as the woman that's sitting there, and I know that just by chance, sheer luck, that I'm not in [her] shoes." Thus, she identifies with her patients' circumstances and notes that she often teaches her patients how to avoid being hospitalized.

Regarding the patient's right to commit suicide, she believes that

> suicide has become sort of a criterion for the success of the therapist, and it shouldn't have anything to do with that. It should have to do with what...the patient really want[s]...Just because somebody would commit suicide while they were under my care, except for all the legal ramifications, if my sense of myself and my success is dependent on whether or not a patient kills [himself or herself], I'm in trouble.

At one point in her career she served as director of the suicide prevention program for the city where she trained as a doctor. She states that "people have the right to commit suicide, and I believed it back then [i.e., when she was director of the program] but I didn't dare say it." However, when she has worked in an institution where the official policy is that patients "may not commit suicide, I will, of course, have to go along with the system.... You have to stop suicide at all costs."

> [But] I let the patient know, if they're in contact enough, that I myself believe they have the right to kill themselves if they really want to. And that makes a real bond,...that I understand why they want to kill themselves. But I point out, "Well, you didn't really slash your wrists very deep, so part of you wanted to [live] even though [another part of] you didn't want to come back, and I think that [if] somebody has that ambivalence, then I will speak to the side of them that wants to live.... I give them the choice.

With self: Harriet 's view of herself has changed over the course of her sixty-three years, from a feeling of low self-esteem and of unsuccessfully trying to fit in, to a stronger sense of self after "I came home to myself and I knew who I was [and did not] give a s__t anymore what anybody else thinks." She has reached a point where she is able to appreciate her own strengths and intelligence without worrying about others' opinions, and she derives some satisfaction from being able to ask the "uncomfortable" questions that no one "should" ask.

Regarding her own weaknesses or "mistakes," she feels that one "learn[s] more from failures than from successes." She has also learned to be compassionate with herself: "I know when I make mistakes and I can kick myself, but it lasts only as long as till I learn why it happened, and then I say I did the best I could with what I had at the time."

Harriet feels like an outsider, both professionally and in various other ways, foremost because of her gender. She states that she believes that all women are oppressed in American culture. She herself was battered by her first husband but was not believed. Thus, she identifies strongly with her women patients who experience themselves as outsiders, disempowered by the culture, and the fact that she is a fellow-outsider facilitates the establishment of the therapeutic bond. She states that she "can't think of a woman patient that I've never been able to establish that bond with." She speaks of her own intensity, saying, "The women who have gone through trauma all bond with it but people who have been keeping themselves away from bonding find me too intense."

As a part of nurturing this bond, she is careful to hold herself to the same rules as her patients. Thus, she is careful to give twenty-four-hour notice if she has to cancel an appointment, just as she requires it of them. Conversely, she is careful to hold them to limits she has set for her own well-being:

> I had a [depressed] client [who]...knew she could call me. But one Sunday she called and I asked her if [it] was an emergency. [Although she said] no, that time I let her come. [But] then I told her afterwards,..."Sundays are my day and in the future, if it's something that can wait, I would like to."...I practice what I preach. I have to take care of myself too. And they don't feel rejected by it.

As she sums it up,

> My rule is, you're worth at least as much as those you do for, and if you don't do for yourself what you advise others to do, you're going to get in trouble.... I learned that long before I was a psychiatrist.

She does not feel that she is merely "modeling" or role-playing for her patients. Rather, she considers she is acting authentically: "I am what I am and I use that as the model.... But if [you] do it as role-playing and [are] not real, I don't think it will work."

Harriet has "learned to enjoy being by myself." She has been an avid reader and a writer—with some published poems to her credit—throughout her life and uses these as her main means of nourishing herself. She utilizes her writing as her main means to reduce stress and because "I find out what I think when I sit at the typewriter." She likes "to do all-nighters" since "I find I am most creative at about twenty-four hours of no sleep [when I] get in touch with my pre-conscious."

She would like to "pass on what I've learned before I die. I don't want my wisdom to die with me."

With a power greater than the self: Harriet says that she "does not genuflect to/for anybody" but that as long as she feels that her patient's religious belief is healthy for them, she supports them in their belief, even though it is not her belief.

Valued and non-valued learning experiences

In general: She values her ongoing learning from other women, especially rural battered women, and women in her field like Fromm-Reichmann, who as able to work with highly disturbed patients in an empathic manner, and, like Harriet, thus gave voice to the voiceless.

Formal education: Regarding her formal education, she feels that postgraduate study in linguistics and social psychiatry with Birdwhistell and Scheflen was most worthwhile. She regards this as having been "a delightful period of a couple of years." Indeed, she feels this was the only time in her life where she has been "at the right place at the right time with the right people."

Informal education: In her opinion, "the informal is always more important than the formal" and she considers attending conventions to be important not just for the papers presented but for "the people you meet and the chance you have to try out your ideas and bounce them back and forth and have good discussions."

Challenges and vulnerabilities

Growing up in a religious community and then being a woman in more mainstream American society have both been deep challenges for Harriet. Likewise, both marriages which ended up in her divorcing abusive men have also presented her with the necessity to be independent rather then rely on someone to take care of her. Both marriages have also left her in the position where she had to come out of early retirement in order to make a living, since she "used up all my life savings in my last divorce settlement. However, she makes a point that she is not afraid of working "on the edge" with challenging patients, and going where other psychiatrists perhaps would not, or where they would have lacked understanding.

The writer's initial impression

The writer interviewed Harriet at the end of the winter meeting conference, and was immediately struck by Harriet's ability to define herself, what she did, and how she felt about what she did without hesitation. She offered to send the writer a written description of her position as a professional, which she had developed to give patients who were thinking of engaging her as a psychiatrist. Harriet's tone was clear, and she did not hesitate when giving the answers, nor search for words. It was obvious to the writer that she had done a great deal of thinking and reflection as to why she had become a psychiatrist and how to remain a good one in order to serve two particular populations that she felt was underserved by the mental health system—battered women and patients who had been hospitalized and needed help getting released. Thus, for Harriet, going into social psychiatry or community psychiatry was largely because she knew what it had been like to feel like an underdog and she wished to help others in a similar position. The writer noted this after the interview and also noted that she wondered if she would meet other community psychiatrists who had been drawn to this section of psychiatry for similar reasons. With Harriet, the writer felt that there was an example of a wounded healer who had used her own painful learning to grow and to become of greater service to others who shared a similar situation. Being with Harriet was like playing a quick-paced set of singles.

Chapter Seven
Analysis of Psychiatrists' Voices

The Writer's Background Assumptions

We have attempted to show through exploring the appropriate cross-disciplinary and cross-cultural literature how "connection" is closer than is "control" to the principles of education as transformation, and thus it will be seen that the "voice of connection" has many elements in common with education as transformation. It is the writer's contention as well that the voice of connection is an empathic voice in its ability to "feel into" the experience of the other and to infer meaning through resonating with one's own experience, in what amounts to an oscillating movement between self and other. The voice of connection is a voice that seeks to empower the other to empower him- or herself. Furthermore, it was assumed that the healers/helpers characterized more by a voice of connection would also have a high Mehrabian and Epstein empathy score. Finally, following current findings from empathy research and women's psychological and educational development, it was deemed highly likely that women would be characterized more by the voice of connection than would men.

In the remainder of this chapter, we will

(1) summarize the main principles of the education as transformation model;
(2) discuss how the themes of education as transformation emerged as a continuum with eleven subthemes for Western psychiatrists;
(3) report and evaluate the overall results from the Questionnaire Measure of Emotional Empathy for both college undergraduates and community psychiatrists;
(4) analyze the themes and subthemes of the eight psychiatrists in the subsample, each with an accompanying chart.

Tables also follow at the end of the chapter that summarize the presence or absence of the themes of education of transformation (Tables 1 and 2), these principles compared with the Mehrabian and Epstein scores (Table 3), and two tables (4a and 4b) giving two versions of an overall summary of measures (for the subsample only).

Summary of the Principles of Education as Transformation

To recapitulate: in the Kalahari, the principle that precedes all the others is the initial transformation of consciousness, or altered state of consciousness (A.S.C.), whereby the boundaries between the self and a transpersonal realm become more permeable, joining the individual to the community, the ancestor-gods, and the healing power. This permeability is maintained and reinforced when all participate in a ritual of transformation, the healing dance. Moreover, the healer does not change status, but remains an ordinary member of community. Instead of seeking self-aggrandizement, he or she performs the healing act out of a desire to be of service to the community. Thus, this is a transformational model of development where the spiritual dimension governs the way that the healer develops, such that inner development, character, and "qualities of heart—courage, commitment, belief, and intuitive understanding—...are more important than mind or knowledge" (Katz, 1981, p. 72). In this way, healers become "moral explorers" for their communities, defining and embodying the highest ideals of the culture and, in times of crisis and change, helping lead the way to appropriate adaptation.

Likewise in Fiji, the seven principles of the straight path are similar in their spiritual orientation: the importance of telling and living the truth, love for all, proper or correct behavior, humility, respect, single-mindedness, and service. Also, Fijian healers are called into service by "envisioning" or receiving a vision from their ancestors, sometimes in the form of a dream calling them to become healers. The emphasis is on the character of the healer, on the proper following of the straight path, rather than on the amount of knowledge about the healing technology that the healer has. During the ancient healing ritual, when the one seeking healing presents the yaqona to the healer, the healing is considered to have taken place in the healer's accepting of the yaqona. Thus, as in the Kalahari, the healing ritual plays a central

role, and proper performance of the ritual by the healer and the one seeking healing signals that the latter's transformation has taken place.

At the same time, both of these cultures counterbalance these ideals with a conscious acknowledgement that with access to the healing power, the capacity for abuse (including minor infringements) increases, and that the community must be vigilant against such abuses.

The Connection-Control Continuum and Subthemes

Light (1980), in his study of the careers of six psychiatry residents, pointed out that they too were undergoing a transformational process, but in their words we do not hear anything about the spiritual dimension. We do not hear that they feel more of a sense of connection with each other or with their patients as their knowledge of psychiatry deepens. To the contrary, we hear how the farther they get in their training, the less connected they feel to their psychiatry classmates and the more distanced they feel from their patients, who become examples of disease categories (cf. Chapter Two). We have also seen that community psychiatry, in particular, is looked down upon by psychiatrists, especially those who have trained in psychoanalysis and have gone into private practice, the "highbrow" group of psychiatrists (Rogow, 1980, cited in Light, 1980).

Unlike the writer, Light was not researching community psychiatrists. Rather, his sample consisted of six residents training in an urban teaching hospital setting whose interest and training reflected the hegemony of psychoanalysis existing in the field in the early 1980s, for whom community psychiatry was not something to choose as a career path and who were looking toward private practice as a career goal. As we have seen in Chapter Two with the Green Book listings of medical school curricula around that time, community psychiatry was a requirement to get through, and, as with any rotation, time limited. From this last fact, we might expect that psychiatrists who deliberately opt for community psychiatry would hold different views than those trained in orthodox psychiatry.

In contrast, our sample consists of those who have chosen to go into community psychiatry specifically, despite the fact that the original plan set up at the end of the Kennedy era with the passage of the Community Mental Health Centers Construction Act in 1963 calling for monies to be provided to states in order to take over the funding of such centers after three years has not materialized. Let us look more closely at this unusual group of healers who deliberately have chosen to go into an area where resources are limited.

Some of our subsample, indeed, express concern at some of the practices of their colleagues, private-practice-based and otherwise, and feel that they have "sold out." The majority by far, however, express pleasure and excitement at performing rewarding community-oriented work, despite the challenges. Even Hassan, perhaps one of the more cynical voices in the subsample, far prefers community psychiatry to private practice for the interesting challenges it presents him with.

The community psychiatrists in our subsample speak, for the most part, with enthusiasm for their challenging work in the public sector and the importance that connecting with their patients has for them—despite, as with Robert, frustration with the court system. In addition, it appears that these healers have deliberately chosen to work with the disadvantaged out of a genuine and respectful desire to help, while looking out for their patients' autonomy whenever possible. Harriet makes a point of saying how she enjoys teaching hospitalized patients how to "spring themselves out" of mental hospitals, as she sprung herself out of her fundamentalist community. Both Hassan and Eleanor say that they do not want to work with rich people, or, as Hassan puts it, "spoiled babies," as patients; Fiona speaks humbly about not wishing to intrude on the life of the black families she is trying to help; Joan makes time to supervise a group of traditional healers (practicing healing from their Native American or Curanderismo traditions) to make it easier for them to do their work in outlying areas and yet still to have access to good Western allopathic medical care. Louis speaks with affection of the institutionalized mental patients he has helped, such as Mary, and deeply regrets the fact that his health now prevents him from continuing to serve these people in the same way; Dwayne has not forgotten his ghetto roots, and despite his being in demand nationally to serve on drug prevention and anti-violence task forces, thrives on meeting his black gang member patients on their terms, through teaching them martial arts as a means for them to develop "constructive" ways of coping, as he taught himself to do.

Thus, although Light (1980) has portrayed community psychiatrists as the "underdogs" of the profession, our subsample does not mention this, except when Fiona expresses irritation, as well as hurt, that her psychoanalytically based colleagues doubt her abilities as a child psychiatrist of many years'

experience, because she never officially trained at a psychoanalytic institute. Rather, Katz's (1981) suggestion that community psychiatrists, as well as other health professionals, might benefit from learning how to educate themselves from traditional healers educated according to education as transformation seems to be reinforced. This is not, however, because he viewed them as so different that they require help, but rather because he speculated that those who opt for community psychiatry share much in common with the career paths of traditional education as transformation healers.

The data from the present study suggests that this view is correct. When the writer did thematic analysis as to the instances of education as transformation, she found that ten psychiatrists expressed a sense of linkage between themselves and their community that was very important to them and three expressed a linkage between themselves and a greater power. Three reported having experienced altered states of consciousness (A.S.C.) and/or near-death experiences (N.D.E.s), and some said the altered states occurred while they were engaged in the act of healing. It is also interesting to see that seven of the members of our sample had a vision that they wanted to become doctors. Thirteen of the sixteen manifested a service manifestation; ten saw themselves in a similar role as the healer as moral explorer; and eight spoke of qualities of heart being as important as, if not more important than, intellect (see Tables 1 through 4 for measures).

From analyzing the data, the writer has extrapolated two poles along a continuum—at one end, the "voice of control" and at the other the "voice of connection." As noted in Chapter Three, connection and control were initially viewed as simply two juxtaposed themes among other such juxtapositions, but as her thinking evolved, these themes became, rather, the larger overarching themes under which other subthemes could be organized. Thus, the writer presents this continuum and its subthemes as the equivalent of the principles of education as transformation as they emerged from the interview data with Western community psychiatrists. Instead of seven principles, however, the writer found that there were eleven subthemes grouped under two main headings. Just as Katz found that the first principle of education as transformation, altered states of consciousness, in reality contained subthemes of (a) connectedness between the self, the healing power, and the community; (b) envisioning; and © transitioning, so the writer found that there were other subdivisions.

The voice of control is, essentially, the voice of an expert, a teacher who guides with clarity and shows the student, learner, client, or patient *the* "correct" way to proceed. It tends to de-emphasize mistakes and areas of vulnerability, and it seems to exude confidence in its own viewpoint. Inherent in the voice of control is a distancing from emotion and from vulnerability. Overall, this voice is one that conveys a sense of expertise in most areas. In some cases, the voice of control may also convey a sense of superiority or elitism in relation to others who are not viewed as peers. Psychiatrists with a majority of subthemes under control are very aware of the role they play within the community mental health system, convey a sense of mastery in the areas of conducting business (administration), imparting knowledge, keeping abreast of new knowledge, controlling a busy schedule, and controlling emotion.

The voice of connection, on the other hand, is a relational voice in that the speaker appears to experience him- or herself most fundamentally in terms of relationships—with individual patients and with fellow staff members, for instance, as well as with self. Human contact is emphasized, as is human understanding. Mastery of theoretical knowledge, such as psychodynamic theory, is de-emphasized. Like the voice of control, the voice of connection emphasizes the importance of teaching. From the latter viewpoint, however, teaching appears to be not so much a didactic imparting of factual knowledge as a process of learning about relationship directly through the experience of the growth of particular relationships—what it means to be in relationship with another person whom one gradually comes to trust. Indeed, one who speaks with the voice of connection may be well aware that it is not just the patient or student, for instance, who is learning from the experience. With the voice of connection, there is a feeling of respect, of allowing the other space so as not to take away the that person's ability to make choices. This voice is able to acknowledge its uncertainty and vulnerability and the possibility of making mistakes. In addition, the voice of connection talks about feeling connected to a larger community, including, in some cases, a spiritual power.

We can see parallels between the voice of connection manifested by Lynn in the pilot interview and the quality of interaction manifested by Ratu Noa in his conversations with Katz discussed in Chapters Two and Three. We can see this especially in the way that Ratu Noa does not tell Katz what to do, or what to write in telling his people's story. Rather, through teaching Katz by his example, he furnishes him with the tools to know how to follow his own straight path, and therefore the proper way to tell their story. Likewise, Lynn (in Chapter Three) does not give her patient advice to go see a chiropractor contrary to the expectation of her patient (who has apparently always been told by others

what to do). Instead, Lynn provides a learning environment that includes her own self as a model, so that her patient can learn to rely on her own judgment to know how to help herself. Thus, as we recall the wise words of Ratu Noa to Katz in Chapter Two, when the latter was looking to him for leadership, may we not say that education as transformation is closer to the voice of "connection" that we find among psychiatrists in the United States than it is to the voice of "control"? Might we also not say that the principles of education as transformation provide a template for the voice of connection? We will consider more closely whether this is so as we continue to analyze the themes of the rest of the psychiatrists in the subsample.

The subthemes that emerged within this control-connection continuum are delineated in the chart below. While they are not identical to the principles of education as transformation, the writer suggests that the subthemes of connection should be viewed as the Western equivalent to those principles as they emerged in this particular sample of community psychiatrists. Individual charts then follow for each psychiatrist in the subsample to illustrate (1) which of the eleven subthemes were judged to be present under "connection" and which of the eleven were present under "control"; (2) the writer's intuitive sense of the psychiatrist's level of empathy; and (3) how each psychiatrist scored on the Mehrabian and Epstein (1972) empathy measure. The results from these three measures are then summarized and compared with accompanying Tables 1 through 4 (at the end of the chapter). We will discuss the implications of these findings for the future of psychiatric education in the final chapter, which will in turn lay the groundwork for a comparison between empathy and what takes place in the healing process among the Ju/'hoansi and the Fijians.

Summary of Subthemes of Connection and Control

Connection	Control
(1a) Mind connected with body	(1b) Mind separate from body
(2a) Developmental path/transitioning	(2b) Developmental path/hierarchical
(3a) Connected self (self-in-relation)	(3b) Separated self
(4a) Connected knowing	(4b) Separate knowing
(5a) Permeability of boundaries	(5b) Impermeability of boundaries
(6a) Movement in relation	(6b) Movement to deflect
(7a) Vulnerability	(7b) Invulnerability
(8a) Power with	(8b) Power over
(9a) The teacher as healer	(9b) The healer as expert
(10a) The healer as moral explorer for the benefit of community	(10b) The healer as moral explorer despite community, or does not view self as moral explorer
(11a) Synergy	(11b) Scarcity

Summary Charts for Psychiatrists in Subsample

Elements Present: Hassan

Connection	Control
	(1b) Mind separate from body
	(2b) Developmental path/hierarchical
	(3b) Separated self
	(4b) Separate knowing
	(5b) Impermeability of boundaries
	(6b) Movement to deflect
(7a) Vulnerability	(7b) Invulnerability
	(8b) Power over
	(9b) The healer as expert
	(10b) The healer as moral explorer despite community, or does not view self as moral explorer
	(11b) Scarcity

OLC'S intuitive empathy rating (high/medium/low): Low
Mehrabian and Epstein emotional empathy score: -6
Summary: Analysis of Hassan's interview revealed the strongest example of the control stance in the subsample of eight, as well as in the rest of the sample. An interesting finding was that Hassan also had the lowest instance of the principles of education as transformation and the lowest score on the Mehrabian and Epstein instrument, -6. This was well below the mean for males, which was 32.8 in the sample and 33.3 in the subsample. Hassan seems to adopt a position of distance from his own feelings and to use a bantering and sometimes sarcastic humor to maintain a certain distance while answering questions during the interview. On the one hand, one does not get much of a sense of care or connection, in the sense of a self in relation to another self. While we hear him express some care for his family, especially his mother, as well as care and admiration for a female co-worker whom he respects and feels he can be himself with, he also complains about his rich clients, whom he feels act like "spoiled babies" and have boring, inconsequential problems. In fact, he shares nothing about his intimate relationships, and he does not go into describing the ebbs and flows, the movement in relationships, unlike some of other psychiatrists in the sample who are more relationally oriented. He does speak with enthusiasm about his passion for acting and singing and for his hobbies, such as needlepoint, and about his teaching, yet it is a didactic sort of teaching that he describes. Hassan also clearly values the psychiatric body of knowledge and considers himself to be more than competent, although he disavows this, and one experiences a voice filled with confidence in his own command of psychiatry and a lively, inquisitive mind that seeks out further challenge by studying related disciplines rather than limiting himself to psychiatry. He expresses with certainty the belief that the more attractive patients tend to receive the best quality of attention. The writer experienced difficulty in probing further with Hassan to understand his feelings in depth. She felt put off by some of his short, terse answers, as if the ball in a tennis match started by one player was repeatedly not returned by the other. At other times, to continue the analogy, she felt as though she were playing up at the net with an adversary with quick reaction times who was returning the ball with force, so that she had to block it with her racquet to avoid being hit.

Elements Present: Dwayne

Connection	Control
(1a) Mind connected with body	
(2b) Developmental path/hierarchical	
(3a) Connected self (self-in-relation)	
(4a) Connected knowing	
(5a) Permeability of boundaries	
(6a) Movement in relation	(6b) Movement to deflect
(7a) Vulnerability	
(8a) Power with	
(9a) The teacher as healer	
(10a) The healer as moral explorer for the benefit of community	
(11a) Synergy	

OLC'S intuitive empathy rating (high/medium/low): High
Mehrabian and Epstein emotional empathy score: 18

Summary: Dwayne scored second lowest in the sample on the Mehrabian and Epstein score, to the writer's surprise, since she had experienced a good rapport with him during the interview. In line with this intuitive rating, he scored second highest for the presence of subthemes of connection. The writer found only two instances of control. The first was the fact that his career path did not involve transitioning and thus he had had an uninterrupted career as a psychiatrist since finishing medical school. The other, 6b ("movement to deflect"), was scored present as well as 6a ("movement in relation"), which was indicative of the fact that Dwayne was able to set clear boundaries when he needed to—quite literally when he threw his adolescent patient at their dojo (martial arts) session—and yet he also could shift his stance with his patient again when appropriate by letting him win. Dwayne is not afraid to be creative and follow his own path in deciding what is best in order to reach a patient—such as working with them in martial arts. The other instance was when Dwayne had the courage in medical school to disagree with his professor about whether the latter's patient was going to have twins. He thus deflected an attempt of his professor to change his mind in a way that reminds us of Miller's (1986) description of people who use a "power over" stance to discredit an adversary (cf. Chapter One). Although Dwayne sees very much the interconnectedness of all things, he prides himself at being able to move between different groups and to avoid being pigeonholed—he remarks how nothing sticks because he's always "clean, like Teflon 3," and he never goes against his principles. Again, the writer noted Dwayne's mention of easy accessibility to altered states similar to the education as transformation healers in Fiji and the Kalahari. He mentioned being able to shift states easily in order to reduce stress, as well as reporting having had more than one near-death experience. She was reminded of the blind healer Kwa/Dwa who regained his sight each time he participated in the healing dance and was thus able to see into people and pull out the sickness (cf. Chapter Two). Likewise, the writer was reminded of traditional education as transformation healers when Dwayne talked about his knowing he had "the touch" and being somehow able to sense correctly that his patient was going to have twins, even when the X-ray reported only one fetus.

Elements Present: Fiona

Connection	Control
(1a) Mind connected with body	
(2b) Developmental path/hierarchical	
(3a) Connected self (self-in-relation)	
(4a) Connected knowing	
(5a) Permeability	(5b) Impermeability of boundaries
(6a) Movement in relation	
(7a) Vulnerability	
(8a) Power with	
(9a) The teacher as healer	
(10a) The healer as moral explorer for the benefit of community	
(11a) Synergy	

OLC'S intuitive empathy rating (high/medium/low): Medium
Mehrabian and Epstein emotional empathy score: 45

Summary: Fiona scored fifth highest in the Mehrabian and Epstein measure in the subsample overall and third highest of the four women in the subsample. She had ten subthemes present under connection and only two under control. Again, one of these had to do with the fact that she had not transitioned into another medical or other kind of specialty, but had continued to pursue her specialization as a child psychiatrist from the beginning. The other instance of the subtheme "invulnerability" under control was also balanced out by its opposite, indicative of her being able to switch from a vulnerable stance in some situations, where she could admit her mistakes, to an invulnerable one when she felt that she needed to stick to her own opinion, such as with some of her students who might have disagreed with her. Thus, she was able to follow her judgment regardless of whether she was liked by her students. Also, although she expressed feeling hurt and even intimidated by her psychoanalytically oriented colleagues, who looked down on her for not having trained at a psychoanalytic institute and questioned whether she was a child psychiatrist, she could also respond forthrightly and indignantly. She was thus, able to be both permeable and impermeable in relation to her boundaries, depending on the situation.

Elements Present: Joan

Connection	Control
(1a) Mind connected with body	
(2b) Developmental path/hierarchical	
(3a) Connected self (self-in-relation)	
(4a) Connected knowing	
(5a) Permeability of boundaries	(5b) Impermeability of boundaries
(6a) Movement in relation	(6b) Movement to deflect
(7a) Vulnerability	(7b) Invulnerability
(8a) Power with	
(9a) The teacher as healer	(9b) The healer as expert
(10a) The healer as moral explorer for the benefit of community	
(11a) Synergy	

OLC'S intuitive empathy rating (high/medium/low): High
Mehrabian and Epstein emotional empathy score: 51

Summary: Joan manifested both connection and control. Although the ten subthemes under connection dominated, the five subthemes of control were more evenly balanced than with some of the other psychiatrists who manifested only two or three subthemes of control, and thus she was scored with "connection greater than control." In addition, Joan had the fourth highest Mehrabian and Epstein score of the subsample overall and second highest of the four women. She had been given a high intuitive empathy rating by the writer. She manifested four instances of the education as transformation principles and four that were questionable or open to interpretation. Thus, hers presents an interesting case, where someone who had high empathy, both intuitive and in the Mehrabian and Epstein measure, and somewhat high presence of the principles of education as transformation also had a lot of the voice of control. Thus, she provides us with an example of the fact that one can combine the two stances toward the world in different situations. For example, when an elderly patient's life is at stake and he or she is experiencing suicidal tendencies, Joan will step in and exercise the "power over" voice of control and hospitalize them to preserve their life. Likewise, she is not afraid to exercise "power over" to protect others and to ensure good care throughout the community mental health center as well as to ensure that she, herself, will be able to live up to her legal responsibility as the head of a 200-person community mental health center. Her example is illustrative that a combination of both voices can be helpful in managing the complexity of a community psychiatrist's role.

Another interesting way that she manifests connection, in the writer's opinion, is through touch. She herself notes that she feels fortunate that she is a woman so that she can make contact with staff and patients alike, with a little back rub, or by "anchoring" something she is saying by touching someone in a caring way when such a touch needed for morale. She feels that if she were a man, it might be misconstrued. It is interesting to note that "anchoring" is one of the techniques taught by Milton Erickson, whom she reports as having been an important teacher for her when, a few months before he died, she had been able to attend a training seminar at his home.

Another part of her story that stood out for the writer was the strong role that relationships with both females and males played in her life. She had been influenced by strong female friends and family members—although she mentioned she did not feel close with her mother—and yet she valued her friendships with men as well—going skiing with them, or getting together to chat, or spending time with her husband and sons. Another striking event in her life was when she described going to one of the few medical schools for women, still in existence, while her husband was on active duty in the military, and had had the unforgettable experience of her whole medical school class connecting with her by being present at the birth of her oldest son.

Elements Present: Eleanor

Connection	Control
(1a) Mind connected with body	
(2a) Developmental path/transitioning	
(3a) Connected self (self-in-relation)	(3b) Separated self
(4a) Connected knowing	(4b) Separate knowing
(5a) Permeability of boundaries	(5b) Impermeability of boundaries
(6a) Movement in relation	(6b) Movement to deflect
(7a) Vulnerability	(7b) Invulnerability
(8a) Power with	(8b) Power over
(9a) The teacher as healer	(9b) The healer as expert
10a) The healer as moral explorer for the benefit of community	
(11a) Synergy	

OLC'S intuitive empathy rating (high/medium/low): High
Mehrabian and Epstein emotional empathy score: 67.5
Summary: Like Joan, Eleanor was scored with connection greater than control, although she had slightly more evidence of the voice of control (seven vs. five instances). She had all eleven of the connection subthemes and seven of the control subthemes, the highest Mehrabian and Epstein score for the women, 67.5, and the second highest in the overall subsample (only half a point lower than Louis, the highest, at 68). The writer had rated her high intuitively. As for education as transformation, she had seven of the principles of education as transformation present, two questionably present, and two not present. As with some others, the writer was struck at how Eleanor could manifest both voices, adapting her stance appropriately to different situations. Like Joan, but in a different way, it was interesting to see the role that giving backrubs to her friends played in Eleanor's life in giving her a sense of connection. Yet at the same time, she was very clear that it would be inappropriate professionally to combine touch with her psychotherapy patients, choosing instead to refer them to an appropriate professional bodyworker or somatic educator. Indeed, Eleanor's openness to working with other professionals utilizing different models stood out for the writer. Eleanor also reported how she had had to hard to be less permeable with her boundaries after finding it difficult not to become overinvolved with patients. In fact, she pointed out that developing this control or detachment was one of the most important pieces of advice that she had received from her supervisor and had contributed to her becoming a better community psychiatrist. Finally, Eleanor's description of feeling in an altered state while working with patients was of interest as we may recall that the education as transformation healer's experiencing an altered state of consciousness is the first step on the path to becoming a healer in both Fiji and the Kalahari. It is only after one experiences this that one gains access to the other aspects of the education as transformation model.

Elements Present: Robert

Connection	Control
	(1b) Mind separate from body
(2a) Developmental path/transitioning	
	(3b) Separated self
	(4b) Separate knowing
(5a) Permeability of boundaries	(5b) Impermeability of boundaries
(6a) Movement in relation	(6b) Movement to deflect
	(7b) Invulnerability
(8a) Power with (early in his career)	(8b) Power over
	(10b) The healer as moral explorer despite community, or does not view self as moral explorer
	(11b) Scarcity

OLC'S intuitive empathy rating (high/medium/low): Medium
Mehrabian and Epstein emotional empathy score: 53
Summary: The writer had intuitively rated Robert as having medium empathy; thus she found it interesting that he received the second highest Mehrabian and Epstein score for the males (53), second only to Louis (68), while only Eleanor of the women in the subsample scored higher than he (67.5). Yet he also manifested more of the voice-of-control subthemes than anyone except Hassan (who evidenced eleven subthemes of control) and evidenced fewer of the education as transformation themes as well. Nonetheless, in the interview, Robert was one of the few psychiatrists to mention directly the importance of empathy in conducting psychotherapy. Perhaps this split score is indicative of his being in transition from a more connected stance earlier in his career, as a community mental health professional when he was living in the community he was serving and, before that, when he had participated on a suicide hotline working as a community mental health professional in a related field. Only once during the interview did the writer glimpse a bit of vulnerability, when he began to share how he had chosen psychiatry over some other branch of medicine in order to rebel against his father, in particular. As Robert shares this, he hesitates, wondering aloud just how much about his personal life he should reveal to the writer, and, thus, for a brief moment she glimpsed his vulnerability.

Elements Present: Louis

Connection	Control
(1a) Mind connected with body	
(2a) Developmental path/transitioning	
(3a) Connected self (self-in-relation)	
(4a) Connected knowing	
(5a) Permeability of boundaries	
(6a) Movement in relation	
(7a) Vulnerability	
(8a) Power with	
(9a) The teacher as healer	
(10a) The healer as moral explorer for the benefit of community	
(11a) Synergy	

OLC'S intuitive empathy rating (high/medium/low): High
Mehrabian and Epstein emotional empathy score: 68

Summary: Louis manifested high intuitive empathy, was high in education as transformation and in the subthemes of connection (all eleven subthemes), and received the highest Mehrabian and Epstein score of anyone in the subsample or the sample (68). Thus, contrary to what the writer might have expected from the literature, the person who scored highest was a male, not a female (although his score was only half a point higher than the highest female, Eleanor, at 67.5). What might account for Louis's high score on all four dimensions, including both empathy scores—intuitive and Mehrabian and Epstein? As we have seen in Chapter Four, empathy involves knowing how to relate to the other, including knowing or sensing the other's level of development, and being able to adapt accordingly. Louis had grown up in a small community where everyone knew everyone else. He went to a one-room schoolhouse that all members of the town had attended, and they all depended on each other for survival. He expressed the opinion that having grown up in a small town, he can only relate to groups of no more than twenty, and he suggests revamping the size of community mental health teams so that smaller groups are in charge of each patient so that patients would not be overwhelmed by the sheer number of agencies handling their cases. He needs to feel personally connected to his co-workers as well as to his friends. He spoke very warmly about his wife and children as well. The writer noted the fact that of all the psychiatrists in the sample and subsample, he was the only one who mentioned that he regularly kept in touch with a group of former classmates in medical school who were now scattered all over the globe, and with whom he made it a point to have regular reunions. As with Dwayne, Louis also reported having had more than one near-death experience and thus seemed to have evidenced permeability of boundaries in an altered state, similar in some ways to the Ju/'hoansi and Fijian healers. We may recall, in Chapter Two, Katz's attempt at understanding whether indeed Kau/Dwa really means that healers in the Kalahari, when accessing the altered state of consciousness, kia, must learn to die and then come back to life as part of their healing journey:

> "Kwa/Dau", I ask, "you have told me that in !kia you must die. Does that mean really die?...."
>
> "Yes," he says simply, "it is the death that kills us all."
>
> "But the healers get up, and a dead person doesn't?" My statement trails off into a question.
>
> "That is true," Kau/Dwa replies quietly, with a smile. "Healers may come alive again." (Katz, 1982b, p. 116)..

In contrast, we may recall when Louis's experience when he almost died of a heart attack. In answer to the writer's question of whether he was afraid, he replies:

> No, it was really like a great sense of peace and satisfaction. It was just a very comfortable feeling and then things began to get grey and then black and [there] was just absolute, utter, incredible darkness.... It was a velvet kind of darkness.... You think of black as foreboding, but it wasn't. It was very enveloping,...so...I just faded more deeply and gently into that.

Elements Present: Harriet

Connection	Control
	(1b) Mind separate from body
(2a) Developmental path/transitioning	
(3a) Connected self (self-in-relation)	
(4a) Connected knowing	
(5a) Permeability of boundaries	(5b) Impermeability of boundaries
(6a) Movement in relation	(6b) Movement to deflect
(7a) Vulnerability	(7b) Invulnerability
(8a) Power with	(8b) Power over
(9a) The teacher as healer	(9b) The healer as expert
(10a) The healer as moral explorer for the benefit of community	
(11a) Synergy	

OLC'S intuitive empathy rating (high/medium/low): High with women, low with men except with those who have also known oppression, such as her gay colleague.
Mehrabian and Epstein emotional empathy score: 27
Summary: The writer gave Harriet a mixed intuitive rating dependent on gender, and thus, perhaps it is not surprising that she did not score higher with the Mehrabian and Epstein empathy measure, even though the writer heard Harriet describing very empathic interchanges with her clients who were survivors of sexual abuse. Like Joan, but for different reasons, she embodies both control and connection. Having power over a body of knowledge after having achieved expertise in her areas of professional interest is one of the forces that drives her. She has a strong interest in research and writing and also has published poems in the lay press. She expressed pleasure at being able to share ideas with her colleagues at a conference such as the one she and the writer were attending, as most of the time she has felt isolated and unable to obtain books, living and practicing as she did in rural areas. She sets very careful boundaries in order to protect herself from a society that she experiences as male-dominated and oppressive. Thus, she embodies control in these areas.
On the other hand, she also describes herself as extremely relational with a certain group of people, battered women from a rural area. With Harriet, we see an example of a wounded healer—she, herself had been battered, but she has been able to learn from her own self-healing and has been able to become a more effective resource to the oppressed people she wishes to help. She experiences herself as marginal, and thus gravitates toward groups that society might regard as marginal, including not only battered women but hospitalized patients whom she believes should "spring themselves out" of the hospital. She identifies with them, as she herself, when she was young, had "sprung" herself out of her fundamentalist community in order to escape her deep despair. With this chosen group, she manifests the voice of connection, mentioning, for instance, how important her telephone circle of battered survivors is, allowing her to keep in touch and to establish some kind of connection in the new community to which she plans to move prior to that move. She also manifests connection when she feels deeply connected with the woman who cleans her office. Yet she can also manifest control with this group, such as when she firmly sets a boundary with a patient about not calling her on Sundays.
It is also interesting to note that she mentions experiencing an altered state of consciousness, although in a different way than Eleanor, Dwayne, or Louis, through sleep deprivation. She reports how she exercises self-discipline and stays up late, allowing herself to become "sleep-deprived" because she feels that in this "altered state" she can do her best writing and research.

Results from the Questionnaire Measure of Emotional Empathy

The original sample of undergraduates studied by Mehrabian and Epstein included equal numbers of male and female subjects. In the test, which had a possible total score of 132, the overall mean of both genders was 33, with a standard deviation of 24. However, when each gender was taken separately, the mean for women was higher—44 for women, with a standard deviation of 21, versus 23 for men, with a standard deviation of 22. Among the sample of community psychiatrists in this study, on the other hand (where the breakdown between genders was unequal: five women and eleven men), the overall mean for both genders was somewhat higher, 37.6, with a standard deviation of 18.8, or over 4 points higher than Mehrabian and Epstein's sample. With each gender taken separately, the mean for women again was higher—48.1 for women (again about 4 points higher), with a standard deviation of 14.5, versus 32.8 for men (9 points higher), with a standard deviation of 19.1. These results are outlined below:

Comparison of Mean Scores on Mehrabian & Epstein Empathy Measure

OVERALL Mean (undergraduates/M & E study)	33
Mean for FEMALE UNDERGRADUATES (M & E study)	44
Mean for MALE UNDERGRADUATES (M & E study)	23
versus	
OVERALL Mean (community psychiatrists/this study)	37.6
Mean for FEMALE COMMUNITY PSYCHIATRISTS	48.1
Mean for MALE COMMUNITY PSYCHIATRISTS	32.8

The finding that community psychiatrists in general scored higher than Mehrabian and Epstein's undergraduates is not unexpected, since the attribute measured, empathy, is considered to be an important ingredient of psychotherapy, a psychiatrist's main calling, so that one would expect psychiatrists in general to evidence a more empathic stance than non-psychiatrists.

It is also perhaps not surprising to find that in both samples, women scored higher than men. Within the group of community psychiatrists, four of the five women ranked in the top six scores (ranks of second, fourth, fifth, and sixth); all of these had scores of 45 or above. The only woman who ranked lower scored 27, a number of points below the general means.

But what is interesting is that the difference between community psychiatrists and college undergraduates is not as great as we might expect. In a profession that one would hope would emphasize qualities that enhance human connection, it is somewhat puzzling, and perhaps even sobering, that the difference is not more pronounced. While we will not attempt to analyze this further, one could hypothesize either that the test is not as accurate as it might be for the connective aspects of empathy or that it is an indication that this capacity associated with human connecting is not as strong within this group as it should be (or perhaps it is a combination of these factors). The writer feels that the first suggestion is the more plausible, as she was surprised at the fact that people whom she experienced as empathic did not score higher.

The other interesting observation is that whereas the spread between female psychiatrists and female undergraduates was only 4.1 points (the same as the difference between the overall means of the two studies), the increase in the scores of male psychiatrists over male undergraduates was over twice that—9.8 points. Thus, within a culture that tends to treat empathic men somewhat harshly, perhaps those men who do retain fairly developed empathic capacities are able to find something of a refuge in the subculture of psychiatry and psychotherapy. Taking these two observations together, we might speculate that although empathy is not as highly developed in this group as it might be in relation to non-psychiatrists, it is still valued more highly than in the culture at large, and, therefore, perhaps this

profession is one to which empathic men can gravitate and feel that they are able to function effectively as empathic human beings.

The Writer's Intuitive Empathy Rating

Prior to scoring the Mehrabian and Epstein instrument, the writer had rated each subject intuitively on the basis of the field notes taken during and after each interview, ranking them high, medium, and low. She gave "high" ratings to Dwayne, Eleanor, Joan, and Louis. Of these four, three did indeed score significantly above the overall mean and the means for both genders; Dwayne, however, scored considerably lower than expected. Also, the psychiatrist whom the writer had intuitively rated the lowest, Hassan, also received the lowest Mehrabian and Epstein score of the entire sample (-6).

The surprising finding that Dwayne, whom the writer had rated intuitively as second highest in empathy and who had five of the education as transformation elements clearly present, with three perhaps present and only three not present, scored only 18 on the Mehrabian and Epstein measure. This was the second lowest score among the males (14 points below the mean for males) and second lowest of the overall subsample scores (19 points below the mean for the overall sample). Following the writer's background assumptions, she would have expected him to receive a higher score on the emotional empathy questionnaire, since he was clearly manifesting connection, with ten out of eleven possible subthemes for that side of the continuum.

The writer noted also that another traditional healer, a Native American (not part of the sample) to whom she had administered the empathy measure and who likewise had all eleven of the connection subthemes present and all of the education as transformation themes present, received a score of only 20 on the Mehrabian and Epstein measure. Both of these individuals were obviously highly regarded as empathic professionals by their peers and by the people they helped. Perhaps, therefore, the problem lies with the instrument chosen, and perhaps they received such low scores, in part, because the instrument does not sufficiently take into account cultural differences. Perhaps also the instrument does not measure a relational stance in certain ways.

Conclusion

The writer's assumption that healers/helpers expressing more of the voice of connection would also have a high Mehrabian and Epstein score was in part confirmed in the case of Louis, who had both the highest instance of connection and the highest Mehrabian and Epstein score. However, given the literature cited in Chapters One through Four, especially studies reporting that the relational or connected self is found more often among women and the tendency for women to score higher on empathy measures, it is a surprising finding that a male, Louis, scored highest on the Mehrabian and Epstein measure and, except for Lynn in the pilot study, had the highest instance of subthemes of the voice of connection.

When the writer considered what might have set Louis apart from the other men in the sample and made him score higher on the Mehrabian and Epstein than all of the women (although he was only half a point higher than Eleanor, who received a score of 67.5), she noted that perhaps his growing up in a small, isolated community where everyone attended the same one-room schoolhouse, knew everybody else, and was dependent on everybody might have significantly influenced his world view toward connection. In some sense, we could say that Louis's cultural background was closest to the traditional societies of the Ju/'hoansi and Fiji. Robert also scored high (53), which initially was surprising to the writer, but this may reflect some aspects of his development before he became a psychiatrist, when he was still practicing social work and living in the same community he was serving. Also during his career as a social worker, Robert manned a suicide hotline and drop-in center, which would necessitate more contact with the community of troubled run-aways. He was one of the few in the subsample who referred directly to the need for empathy as an important ingredient in the psychotherapeutic relationship.

With the two psychiatrists at either end of the continuum between control and connection, Louis and Hassan, the writer's original expectation was apparently borne out in that the psychiatrist with the highest instance of the principles of education as transformation and the voice of connection was also the most empathic (i.e., received the highest Mehrabian and Epstein score as well as a high intuitive empathy rating by the writer), whereas the psychiatrist manifesting the fewest instances of the principles of

education as transformation and the voice of control would score low in empathy. The writer had expected such a finding in that, in her opinion, education as transformation is a model that fosters the development of empathic connection, or interactive joining between the healer, the one seeking healing, and the community.

A final interesting finding, already noted, is the fact that Dwayne, a black male whom the writer rated intuitively as high in empathy, had the second lowest Mehrabian and Epstein score. Perhaps, therefore, the problem lies with the instrument chosen, and perhaps they received such low scores, in part, because the instrument does not sufficiently take into account cultural differences.

Moreover, perhaps the Mehrabian and Epstein instrument does not address the nature of empathy in its entirety, especially its more receptive, relational aspects, a point raised in Chapter Three. It may be that what it is really measuring might be called "emotional contagion" rather than "empathy." Agosta has called attention to the fact that empathy is not the same as "emotional contagion," for the former goes a step beyond emotional contagion. He explains the difference between the two terms in this way:

> In emotional contagion a representation of the other's feeling is aroused in the subject. That is all that happens. In the case of empathy, in addition to this first representation of the other's feeling, a second representation is mobilized. The subject becomes aware that the other's feeling is the source of his own. Thus, this second representation—which is indeed a representation of the other—is conjoined with the first. (Agosta, 1984, p. 56)

Yet the items of the Mehrabian and Epstein Questionnaire Measure of Emotional Empathy seem to be addressing "emotional contagion" rather than empathy, in items such as statement #16: "Seeing people cry upsets me." Thus, at this point in our discussion, we may wish to look for models of relationship and empathy that might permit us to arrive at a more inclusive understanding of empathy and at more appropriate models to measure it, taking this more inclusive perspective into account. With this in mind, we will compare and contrast our Mehrabian and Epstein instrument with another more relational empathy instrument, the Relationship Inventory (Barrett-Lennard, 1973).

Let us consider a couple of examples from the Mehrabian and Epstein Empathy Measure: statement #1, "It makes me sad to see a lonely stranger in a group," and statement #33, "Little children sometimes cry for no apparent reason." Here the respondent is to respond to a generally phrased statement about "a stranger" or "little children" and thus must stand at a distance from his or her experience rather than being inside of it. The Barrett-Lennard questionnaire, on the other hand, asks the respondent to feel into his or her actual experience in a relationship of the respondent's choice—a family member, spouse, friend, child, etc. The Relationship Inventory consists of sixty-four questions, each of which is looked at from two points of view: in the first part, the respondent (person A) looks at the relationship from his or her own point of view, while the second gives an analogous statement in which the respondent looks at the relationship from the other person's (person B's) point of view. For instance, on the first item, the statement for the respondent (person A) is "I respect ___ as a person," while the analogous item for the person of the respondent's choice (person B) is "___ respects me as a person"; the last item on the questionnaire is, "I feel there are things we don't talk about that are causing difficulty in our relationship" for person A, and "I believe that ____ has feelings he/she does not tell me about that are causing difficulty in our relationship" for person B.

Taking two more similar sorts of statements from each questionnaire, Mehrabian and Epstein statement # 7 reads, "I tend to get emotionally involved with a friend's problems"—again asking the respondent to remain at a distance from the situation. The Barrett-Lennard Relationship Inventory's statement #47, covering a similar situation, reads for person A, "Whether _____ is in good spirits or is bothered and upset, does not make me less or more appreciative of him/her" and for person B reads "Whether I happen to be in good spirits or feeling upset does not make ____ any more or less appreciative of me." The way that each instrument frames its statements thus reveals the kind of model of empathy that the creators of the instrument had in mind, with the Barrett-Lennard questionnaire taking into account the interactive field between two specific people from the vantage point of each and conveying an appreciation for the back-and-forth movement that is involved with empathy.

Barrett-Lennard, in an article entitled "The Phases and Focus of Empathy" (1993), appears to build on the work of Rogers (1975) in a way that, in the writer's opinion, might have been closer to what Rogers intended, taking into account the different phases involved in empathic interaction. Barrett-Lennard thus feels that

> Interpersonal empathy is a subtle and multisided phenomenon which can, nevertheless, lend itself to systematic portrayal and investigation. This paper further refines the author's account of empathy as involving a sequence of distinct steps or phases. Freshly introduced here is the idea of empathic response not only to self-experience but also towards relationships conceived as emergent living wholes with their own felt presence and individuality. Given described preconditions for empathy, three main phases in a complete empathic process are distinguished: reception and resonation by the listener; expressive communication of this responsive awareness by the empathizing person; and the phase of received empathy, or awareness of being understood. (Barrett-Lennard, 1993, p. 3)

We will look more closely in the last chapter at the implications of the assumptions behind the above model in relation to our original question in Chapter One as to whether empathy can be taught, and in relation to the education as transformation model.

Before turning to that chapter, tables follow that summarize the presence or absence of the themes of education as transformation (Tables 1 and 2), these principles compared with the Mehrabian and Epstein scores (Table 3), and two tables (4a and 4b) giving and two tables (4a and 4b) giving an overall summary of measures (for the subsample only).

Table 1:
Presence or Absence of Themes of Education as Transformation in Sample of 16 Community Psychiatrists

Psychiatrist	Themes of Education as Transformation										
	1a	**1b**	**1c**	**1d**	**1e**	**2**	**3**	**4**	**5a**	**5b**	**6**
Hassan	NP	NP	NP	NP	NP	NP	NP	P?	NP	NP	NP
Dwayne	P	P	P	NP	NP	NP	P	P?	P?	P?	P
James	P	P	NP	P	P?	P	P	P?	NP	P	P
Paul	P	NP	NP	NP	NP	NP	NP	P	NP	NP	NP
Matthew	P	NP	NP	NP	P?	NP	P	NP	P?	P	P
Fiona	P?	P?	NP	P?	P	P	P	P	NP	P	P
Joan	P	NP	NP	P	NP	P?	P	P	P?	P?	P?
Eleanor	P	P?	P	P	P	P	P	P?	NP	NP	P
David	P	NP	P?	P	NP	NP	P	P?	P?	P?	P
Robert	P?	NP	NP	NP	NP	NP	P?	NP	P?	P?	NP
William	NP	NP	NP	NP	P	NP	P	P	NP	P?	NP
Louis	NP	P?	P	P	P	P	P	P?	P	P	P
Helmut	P	NP	NP	P	NP	NP	P	P?	P?	P	P
Harriet	P	P	P	P	P?	NP	P	P?	P	P	P
Diane	NP	NP	NP	NP	NP	NP	P	NP	NP	NP	NP
Jorge	P	NP	NP	P?	NP	P	P	P?	P?	P	P

Key to abbreviations:

Themes of education as transformation:

- **1a** Link between self and community
- **1b** Link between self, community, and greater power
- **1c** Presence of altered state
- **1d** Presence of envisioning
- **1e** Presence of transitioning
- **2** Ordinary member of community
- **3** Service orientation
- **4** Inner development with no change in status
- **5a** Character development more important than technology of healing
- **5b** Qualities of heart more important than intellect
- **6** Healer as moral explorer

Presence of themes of education as transformation:

- **P** Present
- **P?** Possibly present; open to interpretation
- **NP** Not present

Table 2:
Number of Community Psychiatrists Showing Presence or Absence of Themes of Education as Transformation

Theme Number	Number of Psychiatrists Showing Presence/Absence of Themes		
	P	**P?**	**NP**
1a 10	2	4	
1b	3	3	10
1c	4	1	11
1d	7	2	7
1e	4	3	9
2	5	1	10
3	13	1	2
4	4	9	3
5a	2	6	7
5b	7	4	4
6	10	1	5

Key to abbreviations:

Themes of education as transformation:
- **1a** Link between self and community
- **1b** Link between self, community, and greater power
- **1c** Presence of altered state
- **1d** Presence of envisioning
- **1e** Presence of transitioning
- **2** Ordinary member of community
- **3** Service orientation
- **4** Inner development with no change in status
- **5a** Character development more important than technology of healing
- **5b** Qualities of heart more important than intellect
- **6** Healer as moral explorer

Presence of themes of education as transformation:
- **P** Present
- **P?** Possibly present; open to interpretation
- **NP** Not present

Also note:
(1) The sum for each theme equals 16, the total number of community psychiatrists in the sample.
(2) This table ties in with Table 1.

Table 3:
Number of Instances of Themes of Education as Transformation Compared with Mehrabian & Epstein Empathy Measure Score (from highest to lowest score)

Psychiatrist	Number of Instances of Themes			Empathy Score
	P	P?	NP	
Louis	8	2	1	68
Eleanor	7	2	2	67.5
Robert	0	4	7	53
Joan	4	4	3	51
Diane	1	0	10	50
Fiona	6	3	2	45
Paul	2	0	9	34
David	4	5	2	30
Helmut	5	2	4	30
James	7	2	2	30
Matthew	4	2	5	30
Harriet	8	2	1	27
Jorge	5	3	3	27
Dwayne	5	3	3	18
Hassan	0	1	10	-6
William	3	1	7	N/A

Key to abbreviations:

Presence of themes of education as transformation:

P Present
P? Possibly present; open to interpretation
NP Not present

Presence of themes of education as transformation:

N/A No Data; questionnaire not submitted

Also note:

(1) The sum of P, P?, and NP for each psychiatrist equals 11, the total number of themes and subthemes..
(2) This table ties in with Table 1.

Table 4a:
Summary of Measures (subsample only)
(psychiatrists listed in order discussed in Chapter Six)

Name	Age	M&E score rating	OLC emp.	No. principles of Ed. as Transf.	Presence of Control/Connx
Hassan	57	-6	low	0	Cont
Dwayne	40	18	high	5P/3P?	Conn
Fiona	46	45	medium	6P/3P?	Conn
Joan	46	51	high	4P/4P?	Conn > Cont
Eleanor	39	67.5	high	7P/2P?	Conn > Cont
Robert	39	53	medium	4P?	Cont > Conn
Louis	58	68	high	8P/2P?	Conn
Harriet	63	27	medium	8P/2P?	Conn > Cont

Table 4b: Summary of Measures (subsample only)
(psychiatrists listed in order from highest to lowest presence of elements of education as transformation)

Name	Age	M&E score rating	OLC emp.	No. principles of Ed. as Transf.	Presence of Control/Connx
Louis	58	68	high	8P/2P?	Conn
Eleanor	39	67.5	high	7P/2P?	Conn > Cont
Dwayne	40	18	high	5P/3P?	Conn
Joan	46	51	high	4P/4P?	Conn > Cont
Harriet	63	27	medium	8P/2P?	Conn > Cont
Fiona	46	45	medium	6P/3P?	Conn
Robert	39	53	medium	4P?	Cont > Conn
Hassan	57	-6	low	0	Cont

Key to abbreviations:

P = Principles judged to be present
P? = Presence open to interpretation
Conn = Connection
Cont = Control

Explanation of presence of control/connection:

If three or more subthemes of the less dominant element were present, then both were noted, with the dominant element shown as greater than the less dominant one; if two or fewer subthemes of the less dominant element were present, only the dominant element was noted.

Chapter Eight:
Discussion and Conclusion:
Lessons from Education as Transformation

Empathy, "Communitas," and Synergy

Katz, in a lecture entitled "Wise Old Healers" (1990), suggested that in the West a more "superficial" level of competency is emphasized in the current ways of educating helping professionals than that of the restructuring of self entailed by the developmental path of Ju/'hoan and Fijian healers. According to Katz, education as transformation stresses the transformation of the healer's character, whereas the current education and training of community mental health professionals in the West have focused on the accumulation of knowledge and on the expert use of the healing technology (Katz, 1981). Among healers educated according to the principles of education as transformation, (1) the path of the healer necessitates a continual confronting of the self in the process of offering healing to the healee; (2) this ongoing confrontation of the self results in a "restructuring of the self" (Katz, 1981); (3) the education of the healer is community-based and the emphasis is on service to the community (Cheever, 1984); (4) prevention is emphasized as much as treatment; and (5) inherent in the healing process, and in the way that healers are educated, is a ritual of transformation.

Likewise, Gilligan and Pollak have offered a similar critique, warning that "ideals of heroic achievement increasingly have overshadowed the value of nurturance and close personal affiliation...[while] technological advances have repeatedly been gained at the expense of the doctor-patient relationship" (1988, p. 246). In conjunction with this, we see that there is a high suicide rate among women physicians (and perhaps in general, the writer maintains, among those who are relationally oriented) that may indeed be the canary signaling the toxic nature of some aspects of the Western allopathic medical education system. In addition to women, there may be medical students of different ethnic backgrounds whose world views are more relational, such as those manifesting a "collectivist ego" (Meza, 1988) or "self-embedded-in-community" (Katz & Kilner, 1987), and whose values thus clash with those of the allopathic system.

It is the writer's opinion that the concept of empathy is the connective quality in the healing relationship in the West that corresponds to the rituals of transformation among the Fijians and the Ju/'hoansi and, moreover, that empathy is an important capacity to foster among psychiatrists and other health professionals to counteract these trends in medical education. Furthermore, empathy—including self-empathy (Jordan et al., 1991)—can also be an antidote for the wounded healer to transform and transcend his or her woundedness so that he or she can provide effective healing rather than falling victim to the various abuses of both self and other that we have delineated throughout this thesis.

In this chapter, we will first address the ways in which empathy is analogous to some aspects of education as transformation, including its synergistic aspects. Secondly, we will address the question of empathy's relationship to the development of character, and thus to some of the problems that we have enumerated stemming from the abuse of power, which we maintain are symptoms of our cultural disconnection and manifest in the allopathic medical system. Finally, we will address how empathy can be effectively fostered in training programs, utilizing holistic or systems models that more truly describe this relational capacity.

Empathy as Transformative Ritual

As discussed in Chapter Two, a Ju/'hoan healer literally "sees into" a person who is ill to determine what is wrong and causing the illness and then "pulls" it out. Thus, the person who is ill can understand the cause of the illness, and suffering is alleviated through this combination of understanding on the part of the person who is sick and the removal of the cause of the illness by the healer. Ju/'hoan

healers actually take sweat on their hands and rub it on each other and all the members of the community, thus allowing all to benefit from the healing energy through the laying on of hands; in this way, they dispense the healing resource to everyone, so that all feel healed even as certain ill individuals are focused on.

Likewise, the therapist in the West who empathizes with a client "feels into" the client's affective experience, and by attentively listening and carefully choosing words or gestures, conveys to the client that he or she is understood. As we have seen in the words of Lynn, in Chapter Four, it is in the all-important experience of being understood and, when appropriate, of understanding (Stark, 1994) that the suffering of the client is relieved. Thus, in both cultures, the healer plays an important role in facilitating the process of meaning-making in relation to the person who is suffering, and this may result in lessening or alleviating the suffering. We have seen that a therapist who is able to empathize not only is able to reference a similar feeling from his or her own experience to resonate with the client; he or she is then able to move back into the experience of the client, experiencing the affect of the client and understanding the client's experience "as if" it were his or her own. Thus, empathic listening involves a back-and-forth movement-in-relation between therapist and client. In this process, a truly empathic therapist neither overidentifies nor maintains too great a distance or detachment. Empathy, thus, is not a static phenomenon, it is not an objectified "it"—something akin to a material object, which can be given to someone—but rather it is a dynamic, relational process that ideally fosters connection. In this way, also, it is similar to the healing dance among the Ju/'hoansi, which by its very nature is not a static phenomenon but a dynamic ritual of transformation.

In the writer's opinion, what emerges through the process of education as transformation among the Ju/'hoansi is a form of *communitas*, which Turner, borrowing from the concept of Buber, has defined as a feeling of connectedness (Cheever, 1984, citing Turner, 1969):

> 'Communitas' means that one is no longer side by side (and, one might add, above and below) but with one another of a multitude of persons. And this multitude, though it moves towards one goal, yet experiences everywhere a turning to, a dynamic facing of, the others, a flowing from I to Thou. Community (communitas) is where community happens. (V. Turner, 1969, p. 51)

Another way of saying the same thing is that the boundaries between persons become permeable in the act of connecting with the healing power during the enactment of the community healing ritual. Community or *communitas* carries with it a sense of connectedness, but, at the same time, this connectedness is transient and hard to define by a particular "structure." As Turner puts it, it "breaks through in the interstices of structure, in liminalilty...at the edges of structure, in marginality, and from beneath structure in inferiority" (V. Turner, 1969, p. 128). This sense of *communitas* is valued by community members, for

> [i]t is almost everywhere held to be sacred or "holy" possibly because it transgresses or dissolves the norms that govern structural and institutionalized relationships, and is accompanied by experiences of unprecedented potency. (V. Turner, 1969, p. 128)

Thus, in the Kalahari, the Ju/'hoansi celebrate their "community" or *communitas* over and over again, reaffirming their connectedness with each other and with their environment by means of a synergistic ritual of transformation, the all-night healing dance (Katz, 1981). As we have previously noted, within a synergistic paradigm, "resources created by *human activity and intentions*, such as helping and healing, are intrinsically expanding and renewable.... Increasing amounts of the resource become increasingly available to all, so that collaboration rather than competition is encouraged. Paradoxically, the more the resource is utilized, the more there is to be utilized" (Katz, 1983/84, p. 202).

It may be, thus, that the most appropriate model to describe the phenomenon of empathy involves a different sort of paradigm, one that describes the terrain better than older models of empathy. Specifically, the writer suggests that a synergistic model of interrelationship might better describe what occurs in empathic interaction; put another way, we might say that empathy is a form of *communitas* that takes place between two (or more) people and can "be accompanied by experiences of unprecedented potency" (Turner, 1969, p. 128). *Communitas* may be analogous to what others in the West have called "a psychological sense of community" (Sarason, 1974), which appears to have synergistic components.

When looking at the experience of our psychiatrists in the United States, then, it would be useful to ask in what ways synergy does or does not inform their experience of empathically interacting with patients. Is empathy characterized by a permeability of boundaries between self and other, as in the

experience of *communitas* among the Ju/'hoansi? Does the experience of empathy involve some kind of synergistic joining that goes beyond the experience of each individual separately? Does empathy represent or lead to a transformation of consciousness within and between psychiatrist and patient in a way that is analogous to the experience of the healer who is participating in the healing dance among the Ju/'hoansi or in the exchange of yagona among the Fijians?

If we return to Lynn, the psychiatrist in the pilot interview who received a high intuitive empathy rating from the writer, we hear a certain awe as she tries to put into words the back-and-forth movement she experiences with her patient as well as the special kind of noncognitive knowing that she is aware of:

> It's hard to find words for this...feeling, there's a quality to what's going on and a feeling of what I'm feeling in response to what they're doing, to what I'm picking up from them, what goes back and forth between us as to what's happening, and sensing that and knowing that and working with that is very important. And it's attending, being tuned, being there...being tuned in, if you will. Being there, being aware, knowing this person over time or coming to know this person, coming to sense what the movement means, what the affect is I'm picking up, how they're saying whatever they're saying—it's more than theory.

As she struggles to understand, she realizes that she enters a different state than her ordinary waking consciousness; it is, we might suggest, an experience of greater permeability between two selves. As Lynn observes, it is very hard to know where this particular kind of knowing and understanding comes from:

> There's a way of being focused, being very much there.... Where's it coming from? Is it coming from me, is it coming from them, what is it? I don't know that I get into an altered state per se, although it's different, I guess. It's certainly not what I do when I pick up the phone. It's a different state.

Is this concept perhaps also reminiscent of education as transformation as a model for development that allows for acknowledgement of the process of establishing paths both within and between individuals, paths that transition back and forth rather than proceed in a linear, sequential manner? If so, then perhaps education as transformation can inform us in our understanding of the in-between (Ekstein, 1978, cited in Myers, 1992) or of the limen or threshold (V. Turner, 1969), the space in which, we might say, the experience of both empathy and *communitas* happens.

Having noted the importance that the ritual of the all-night dance has for the Ju/'hoansi, we might also observe that Light (1980) wrote about a different sort of ritual—that of professional transformation—that six psychiatry residents went through. In this case, however, the result was anything but a sense of synergy and connectedness. We may recall how Ned Reich spoke to his fellow residents about how he had felt closer to everyone the year before when they were all still medical students. Thus, it is not the ritual per se that results in a sense of connectedness, but the type of ritual as well as the attitude that one brings to it. Katz reports that the Ju/'hoansi say that "being at a [healing] dance makes our hearts happy" (1981, p. 34). Moreover, he explains that

> For the [Ju/'hoansi], healing is more than curing, more than the application of medicine. Healing seeks to establish health and growth on physical, psychological, social, and spiritual levels; it involves work with the individual, the group, and the surrounding environment and cosmos. Healing pervades [Ju/'hoan] culture as a fundamental integrating and enhancing force. (Katz, 1982b, p. 34)

Rappaport has pointed out that ritual may function cybernetically as an important means by which living systems—i.e., organisms and associations of organisms (clans, societies, populations, and even ecosystems)—"maintain homeostasis in the face of perturbation" (R. Rappaport, 1978, p. 78). Rappaport observes that, from a systems approach, ritual may function to fulfill the important evolutionary goal of maintaining the status quo. Evolving organisms do better to change as little as necessary, he maintains, for "irreversible changes are likely to decrease systemic flexibility—that is the ability of the system to respond homeostatically in the future to stresses which may be unpredictable and even novel" (p. 79). Ritual falls under the category of "the structure of adaptive systems"—or that which allows for certain "repertoires of responses" that "effect orderly transformations of these adaptive structures" (p. 78). By this means, resilience and flexibility are maintained in the evolving organism—in this case, a social system (p. 79). Performing a ritual together allows individuals to "sense their deep connectedness and realize their communal responsibilities for their own and other's health" (Katz,

1983/84, p. 223). Perhaps one of the reasons this occurs is because in the celebration of a ritual, boundaries between individuals become more permeable, and rather than competing for resources, each can share in the experience of the other and sense their common connectedness.

Unlike the allopathic university-based model of healer education, education as transformation is a synergistic model. All participants—healers, healers-in-training, and ordinary community members—emotionally connect with each other and are empathically moved by the community ritual, and all receive healing vicariously, if not directly.

In this model, the whole is greater than the sum of the parts, and the resource of healing is expanded the more that it used. An appropriate model to describe such a group phenomenon requires one that can encompass a pattern of relating, a moving, happening phenomenon for, as Turner points out, "*communitas* is where community happens" (V. Turner, 1969, p. 51).

Perhaps one of the reasons that "healing pervades [their] culture as a fundamental integrating and enhancing force" (Katz, 1982b, p. 3) is that education as transformation healing involves a particular kind of meaning making, one that stresses "balance, wholeness, and connectedness" (Katz, 1982b, p. 3), and, in the writer's opinion, so does empathy. Both the Ju/'hoan healing ritual and empathy apparently involve a particular kind of state of consciousness accompanied by physiological changes.

Empathy and Character

We turn now to our second question, concerning empathy's relationship to the development of character, and thus to some of the problems that we have enumerated stemming from the abuse of power. In considering this question, we will return to our point in Chapters One and Two about the number of wounded and/or impaired healers who choose careers as psychiatrists or as other types of psychotherapists.

From findings of research into wounded or impaired healers (Sussman, 1992), we know that narcissism has been found to be a common character trait (in the psychoanalytic sense) among those opting to become physicians and psychotherapists. To recapitulate from Chapter Two: pathological narcissistic personalities exhibit "great ambition, highly unrealistic goals, intolerance of failures and imperfections in themselves, and a nearly insatiable craving for love, attention, and admiration, upon which their self-esteem is based" (Nemiah, 1961, cited in Sussman, 1992, p. 100). And Kernberg notes that the main traits of the narcissist are "grandiosity, extreme self-centredness, and a remarkable absence of interest in and empathy for others in spite of the fact that they are so very eager to obtain admiration and approval from other people" (Kernberg, 1967, cited in Sussman, 1992, p. 100). Sharaf and Levenson (1964) also reported medical students' narcissistic tendencies toward grandiosity. Celenza's (1990) research has shown that the narcissist retains the cognitive aspects of empathy but tends not to retain the affective. The narcissist is, by his or her very nature, someone who cannot consider the needs of others as legitimate needs in their own right; rather, all is viewed in terms of meeting the narcissist's needs. Thus, the world is viewed egocentrically; there is never enough to the satisfy the needs of the self. We might say that the narcissist subscribes to a power-over model and a scarcity world view and thus embodies more of the subthemes of the voice of control than the voice of connection.

In contrast to the synergistic perspective that he observed in traditional social systems, Katz maintains that a "'scarcity' paradigm dominates Western thinking about the distribution of a wide variety of resources," including community psychiatry, such that valued resources are assumed to be scarce and "individuals or communities must compete with each other to gain access to these resources, struggling to accumulate their own supply, resisting pressures to share" (Katz, 1984, pp. 201-202). Furthermore, he notes that the sense of community, *communitas*, or connectedness is often missing due to the fragmentation and "pluralization of life worlds" that exists in Western society (Berger, Berger, & Kellner, 1974). He challenges the assumption that such a scarcity paradigm must prevail, and instead proposes an alternative, synergistic paradigm, which he maintains "can free such human resources [as community mental health services] from the grip of scarcity and competition" (Katz, 1984, p. 202).

Katz further notes that "the process of empowerment, and its companion resource of power, can and too often has been cast into the scarcity paradigm" (1984, p. 203). Drawing on Rappaport's (1981) definition of empowerment "as a process of 'enhancing the possibilities for people to control their own lives'" Katz points out that "within the synergistic paradigm, empowerment assumes new potential [as] 'control over their own lives' becomes a renewable, expansively accessible resource, as does the process of empowerment itself" (1984, p. 203). He thus has claimed that community psychiatrists might learn

from healers from other cultures how to better educate themselves so as to provide more effective and equitable help, or healing, for their patients within community contexts (Katz, 1981, 1984).

In contrast to the narcissist's way of relating to the world, where everything is seen and understood in relation to one's own (usually insatiable) needs, a person who is able to engage in the affective aspects of empathy is able to feel into the experience of the other and to care about the needs of the other "as if" they were one's own.

Towards Transcultural Models of Healer Education

The title for this section, "Towards Transcultural Models of Healer Education," implies that it is possible to compare the way that very different societies educate their healers and find similarities as well as the obvious differences. In a previous paper, "The Education of Community Psychiatrists: A Search for Trans-cultural Community-Based Models" (Cheever, 1984), it was demonstrated that certain principles of the education as transformation model of healer education seemed to characterize the educational models of healers in three very different cultures: that of the Ju/'hoansi in the Kalahari Desert, Fijians in the South Pacific, and nurses being educated in a holistically oriented university-based program in the eastern United States known as Therapeutic Touch. Nurses educated according to this method often train in groups and engage in the act of "centering" before making contact with the healee (Krieger, 1979). In centering, nurses describe feeling "connected" as they undergo a shift in perspective from a self-preoccupied stance, in which they are worrying about their individual performance as they attempt to heal, to a more "transpersonal" perspective, which appears to be more community-connected—as with *communitas*—and service-motivated (Quinn, 1981, cited in Cheever, 1984).

The experience of these nurses points to a kind of knowing and understanding that resides in the relationship between individuals, rather than in any individual separately. Thus, it is in the interaction between individuals, in the relational process, that empathy—"a special kind of responsive personal knowing" (Barrett-Lennard, 1993, p. 8)—takes place. Barrett-Lennard's Relationship Inventory (1973), discussed in Chapter Seven, is perhaps more useful than the Mehrabian and Epstein measure (1972) in that it more fully takes into account the ability of an empathic person to place him- or herself in the shoes of the other with whom one is relating, while taking into account the multifaceted and multiphasic movement of empathy and to present the "phases and focus" of this multileveled phenomenon of human interaction in such a way as to provide mental health professionals with a means to round out their empathic proficiency (1993). It might thus provide a means, especially for those who are characterized by narcissism, to develop their affective empathy. For those psychiatrists-in-training who experience a sense of isolation (Gilligan & Pollak, 1988), a curriculum encompassing such an important aspect of human relating might also be a welcome addition. Barrett-Lennard's Relationship Inventory instrument attempts to capture the relational aspects of empathy, or how it unfolds in dyadic interaction. With the development of this instrument, he thus calls attention to a heretofore neglected aspect of empathy:

> It [the Relationship Inventory] taps into their dyad system in the sense that it is not about one partner's experience or perceived response but the convergence between their two frames of reference on a vital aspect of their relationship. This relationship is itself an emergent whole which can be apprehended directly—on a theoretical plane, by viewing the relationship as a (living) system. (p. 10)

Barrett-Lennard has called attention to the importance of establishing the first step of the phases of empathy: "actively attending with an empathic set to another person" (p. 6). In a way that is similar to the Fijian or Ju/'hoan healer who must enter into an enhanced state of consciousness that Katz has described as "an initial transformation of consciousness,...a new experience of reality in which the boundaries of self become more permeable to an intensified contact with a transpersonal spiritual realm" (1981, p. 71), a therapist who seeks to be empathic must, thus, enter into a particularly attentive state of active listening.

The Barrett-Lennard instrument asks the person taking it to look closely at the process of an actual relationship in which he or she is currently involved. Thus, instead of focusing on a hypothetical situation, which allows the person filling out the questionnaire to remain at a distance, the Relationship Inventory asks the respondent to think about what he or she is doing currently in a meaningful relationship, and how he or she perceives the relationship from the point of view of both individuals. Inherent in this model and its instrument is a back-and-forth movement between self and other which, as

we have seen, many theorists believe is the nature of empathic interaction. Thus, perhaps utilizing such an instrument in the training of psychiatrists and other mental health professionals might teach them how to better understand what is involved in empathic interactions they are currently engaged in with patients, as well as teaching those who do not yet know how to empathize.

Another useful and important direction for the education of mental health professionals is found in Corcoran's (1981) recommendation for teaching "experiential empathy." Pointing out that empathy is a phenomenon of mind-body (Schuster, 1979, cited in Corcoran, 1981), Corcoran, like Barrett-Lennard, believes that empathy research has been too narrowly based, focusing solely on the verbal level, or the communicative aspects of empathy. Thus he feels that sensory-motor learning of empathy is also necessary, for "it is through the therapist's body that he or she has an empathic experience, and it is the meaning of this experience that is to be communicated accurately to the client" (1981, p. 33). Corcoran cites Feldenkrais (1972), who developed movement exercises for "learning to listen and respond to one's inner experiences, which is one's felt-level experience" (Corcoran, 1981, p. 35). Like Barrett-Lennard, Corcoran points out that prior to the verbalization of empathy, there is an earlier stage, the kinesthetic awareness within the therapist's own body of what he or she is sensing from the client:

> Body awareness through movement is proposed to influence the development of empathy because it generates feelings, or stimulates one's proprioceptive, kinesthetic sense. This in turn, enables the counselor to become increasingly aware of his or her own inner experiences, or felt-level experience. Since inner awareness is related to openness to the experiences of others (Lesh, 1970), it thus enables the counselor to be more open to sensing the client's emotions as if they were the counselor's own. It is only subsequent to this experience that the counselor or therapist is in the position to verbalize this empathic awareness to the client. (Corcoran, 1981, pp. 35-36)

Corcoran also cites Gendlin, who posits two levels of experiencing: "The first and primary level is the internal body experience of feeling one's emotions, which correspond to the motor reflex and emotional response of neurological excitation,...the felt-level experience. [This involves focusing] on sensory and kinesthetic activities which results in a 'felt shift' in awareness" (Gendlin, 1962, 1969, cited in Corcoran, 1981, p. 33). And he notes that Don "found changes in subjects' brain wave patterns immediately before the felt shift" (Don, 1977-78, cited in Corcoran, 1981, p. 33). Thus, there are physiological measures associated with different phases of empathy, and, in the writer's opinion, one might call this somatically based sensing of the other's somatic experience "somatic empathy."

In this way, perhaps, we are on the way to answering the riddle of the mind-body problem that so intrigued yet frustrated William James a century and a quarter ago:

> I feel that we are nature through and through, that we are <u>wholly</u> conditioned, that not a wiggle of our will happens save as the result of physical laws, and yet notwithstanding we are <u>en rapport</u> with reason. How to conceive of it who knows?...It is not that we are all nature but some point which is reason, but that all is nature and all is reason too. We shall see, damn it, we shall see. (Letter from W. James to T. Ward, March 1869, cited in R. B. Perry, 1935, pp. 472-473)

In closing, we leave with a question, like William James's: Might empathy be a contemporary version of a way of relating left over from the time of hunting-gathering, the mode of existence in which the human race has lived the vast proportion of its time on the earth? Just as the Ju/'hoansi celebrate their connectedness through their ritual healing dance, might we not think of empathy as a kind of dance, where one senses one's partner and adjusts one's own presence, in its totality, in order to move gracefully and fluidly with that partner?

Appendix A:
Description of Sample Subjects

Subject 101: Hassan

Hassan, fifty-seven years old, is a foreign-born Arab-American male whose wife died several years ago. He describes himself ethnically as "Mediterranean Christian," although he was "raised Congregational." He was pre-med as a undergraduate and attended medical school in a country in northern Africa. He then came to the United States several years later and did his clinical training in the Southwest, but he "does not remember" where he did his rotations. He does not specify any aspect of his formal and informal education as either particularly useful or not useful, marking "not relevant" on the questionnaire. As to his theoretical orientation, he describes it as "eclectic" and feels that this has been useful in that it has given him flexibility to meet the varying needs of his patients. During the interview, he also mentions his analytic training as useful. He did not complete the last two questions of the questionnaire ("What position do you currently hold and where?" and "How many years have you been working in a community mental health environment since completing residency or internship"?). However, he indicates that he has spent more than three years in a community mental health environment, the minimum required in order to participate in the sample. He works in a city in a central Atlantic state, in the psychiatric unit of a hospital that works with community mental health centers. He is also doing a lot of teaching about medical as well as psychiatric approaches at schools of social work as well as to hospital staff. His courses have included such varied areas as the use of occupational therapy as a treatment approach, abnormal psychology, sociology, the "rational" use of medication, treatment planning, and the role of the physician in treatment.

Subject l02: Dwayne

Dwayne is a black male, forty years old and married to a Hispanic woman, a lawyer who has one daughter from a previous marriage; together they have two sons. He describes his religion as "Zen Buddhist, I suppose." He went to a state university in the West, where he majored in biology as an undergraduate. He then went to medical school in the same part of the country, but he does not list any particular area of specialization. He describes his orientation as "eclectic, biological, psychological, social," which allows him "to use a model that fits the patient." He considers the most important part of his formal education to have been his "medical training and especially courses in human biology." He is "not sure" what were the least important academic courses. However, he repeats at different times during the interview that he feels that there should have been more courses in medical school about self-healing and more exposure to "real healers." He currently works in a community mental health center and a community hospital in a Southern city, drawing his patients from a largely adolescent population, including gang members. He also holds the position of executive director in this city's Community Mental Health Council. He has worked in community mental health for fifteen years since completing medical school.

Subject l03: James

James, fifty-eight years old, is a white Protestant male, married, with two children. He lists his religious affiliation as Methodist. As an undergraduate, he attended a state teachers' college and then another state college in the Midwest. He does not list an undergraduate major or any area of specialization. He interned at a private hospital in the Midwest. He describes his orientation as "eclectic" and "biopsychosocial" and considers the biopsychosocial orientation to be "excellent," as it is "balanced, flexible," and "made sense." The most important aspects of his formal education were learning the proper use of medication, diagnosis, and developing a treatment plan. He also lists "community psychiatry" as

one of his most important aspects in his formal education, while the least useful were analytic and forensic psychiatry. His most important academic courses were physiology, physical diagnosis, abnormal psychology, and statistics. He did not answer the question about least important academic courses. He is presently a consultant for a mental health center as well as serving as staff psychiatrist at a Roman Catholic hospital. He has been working in community mental health for twenty-five years.

Subject l04: Paul

Paul is a white Protestant male, married, forty-seven years old. As an undergraduate at a private college in the Southeast, he majored in biochemistry, and then attended medical school in the Northeast and did his residency and his internships in the Midwest. He does not give any particular area of specialization. He describes his orientation as "eclectic" and feels that this was a "good" theoretical orientation that was useful in helping patients. He regards all aspects of his formal education, and all academic courses, as important, but especially the liberal arts; in addition, he says that "self study" was important but did not clarify whether he was referring to formal analytic training or to personal introspection. He is the medical director of a mental health center and an associate professor at a state university in a western state. He has spent three years in community mental health since completing his residency and internship and has found himself becoming very interested in helping prisoners and "very involved in public sector work."

Subject 105: Matthew

Matthew is a white Caucasian male, forty years old, and separated from his wife, with whom he has two children. He was raised as a Congregationalist. As an undergraduate at an Ivy League university, he majored in English and then went on to earn a masters degree at a divinity school, where, among other things, he studied medical ethics and reported being inspired by the teaching of William Sloan Coffin. He then attended medical school in the Southeast, specializing in psychiatry. He considers a broad college education in the humanities, his medical ethics training at the divinity school, his personal analysis, and good psychodynamic supervision with good biological training as the most important aspects of his formal education. In response to the question about what was least important in his formal education, he writes that "nothing is unimportant; it's all grist for the growth mill." His most important academic courses included some in the humanities—the Romantic era in music, tragedy, Spenser's "Fairy Tale," black literature—as well as medical ethics. He describes his orientation as eclectic (biopsychosocial) and felt it was comprehensive and "very useful." He is director of the psychiatric unit at a community hospital and staff psychiatrist in the mental health center affiliated with the hospital; he is also an adjunct assistant professor of clinical psychiatry at a medical school. He has worked for eight years in the community mental health environment since completing his residency.

Subject l06: Fiona

Fiona is a Caucasian, Protestant female, forty-six years old, married to a man who holds a responsible position in a social service agency; they have a son and a daughter in elementary school. As an undergraduate, she majored in history and literature, followed by medical school in a southwestern state. She specialized in child psychiatry at the child guidance clinic in one of that state's main cities and interned at the university hospital of the state university. She describes her theoretical orientation as family systems, which she has chosen "because it seems most helpful to work with clients." In her opinion, the "blend of theoretical and clinical" is what was most important in her formal education. What was least important was the "competition." The most important courses were medicine, pediatrics, histology, and cellular biology. She does not specify any that were least important. She and her family have recently moved so that she might become the director of the Division of Child and Adolescent Psychiatry of a midwestern state's Department of Mental Health. She is also director of the Division of Child Psychiatry at the state university, where she teaches family therapy courses and workshops as well, and she holds a position as director at an institute for juvenile research. Prior to that, she had worked at a city in another state's guidance clinic which, although a private clinic, was funded by the county mental

health system. She has been working in community mental health contexts for about fourteen years since completing her residency.

Subject l07: Joan

Joan is a Caucasian female, forty-six years old, married, with three sons. She describes herself as being of "Northern European ancestry," with an Irish father, who is Protestant, and a Polish mother, who is Jewish. She states that she has "no formal religious affiliation." She attended a college in the West as an undergraduate, majoring in zoology and minoring in French. She married and then went to the medical college of a midwestern state while it still served women only. She did her residency in a new prototypic community mental health center where her hours were tailored to childcare. Thus, she became the first resident at one of the first community mental health centers to be set up by the Community Mental Health Centers Construction Act of l963. She then interned at a medical center in another city in the same state. She had a number of different supervisors in both placements—in her initial community center, as many as twenty to thirty over a three-and-a-half year period, for four to ten hours per week. She was "not able to estimate the number of supervisors or hours of supervision" during her internship, as she "worked too hard." Her theoretical orientation is "eclectic" and "community psychiatry." She feels that this eclectic orientation, chosen because she "felt intrigued with the multitude of theoretical options," has enabled her to "have a variety of choices." The most important aspects of her formal education were the "supervised, experiential components," and the most important academic courses she took were biological, ecological, and behavioral sciences. The least important aspect was "multiple-choice examinations," and the least important courses were advanced mathematics and research preparatory courses. Joan is medical director and staff psychiatrist at a community mental health center in the same state where she interned. In addition, she has her own private practice, and she supervises other helping professionals, including some traditional healers from Latino and or Native American traditions. She has been working for seventeen years in community mental health contexts since completing her residency.

Subject 108: Eleanor

Eleanor is a Caucasian, Protestant female, thirty-nine years old, recently divorced, with two young stepdaughters with whom she keeps in touch. She describes her religious affiliation as Quaker or "Friend." Her mother, a nurse, emigrated from England to the United States, where she practiced as an LPN. Her father was in the Army, necessitating that the family move quite often until she was in her teens. She was the middle child, with one brother who was three years older and a second brother one year younger, who committed suicide at age nineteen. In the interview, she mentions how strong an influence her parents and their values of hard work had had on her. She attended a college in New England as an undergraduate, majoring in biology and minoring in classics. Subsequently, she went to medical school in a the South, specializing, first of all, in family practice and secondly in psychiatry. She did her residency and internship in the Midwest. She had four supervisors over three years (two at a time): one analyst, two in biology and pharmacology, and one in developmental psychology, but due to "dissatisfaction and distrust of on-site supervisors, I bought one hour per week of outside supervision involving countertransference work.... This person is still my teacher and colleague." She considers the clinical exposure to have been the most important part of her formal education. The most important courses were physics, molecular biology, anatomy, community medicine, law, and medicine; least important were microbiology and physiology, although she mentions that, when she took these courses, she already had an "unusually good background" in these areas. Her orientation is developmental, and she particularly emphasizes how this has been especially helpful, as it "allowed many things to fall into place very useful[ly].... Equally useful [were] the years in family practice" using a biopsychosocial model. Eleanor conducts a private practice in the same area in which she interned which involves a case-management-oriented partnership practice with another ex-family practitioner. Additionally, she is a staff psychiatrist at a community mental health center, as well as sharing an office with the psychiatrist who had been her supervisor/teacher and remained her colleague. Although she has been practicing psychiatry for only one year, she had done family practice in community health environments for five years before switching to psychiatry, and thus she was included in the sample.

Subject l09: David

He is a Jewish male, forty-four years old, married for the second time, with no children, and practices the Jewish religion. As an undergraduate, he majored in American studies. He then went to medical school in the Midwest emphasizing somewhat community, human ecology, and health services, followed by a residency in the Southeast and an internship in a northern state. He had four to ten hours of supervision per week, with the number of supervisors varying from five to ten; however, some were "co-therapists" and some were peers (e.g., unit nurses). He lists the following theoretical orientations, indicating a broad base: psychodynamic, family systems (e.g. Bowen), group process, Gestalt, Transactional Analysis, mental health administration, prevention, consultation, psychopharmacology, social behavioral. The most important aspects of his formal education were those courses that "teach how to assess and analyze complex situations," and that "[teach] process (as opposed to content)"; he also feels that exposure to role models and to a multidisciplinary approach had been important, as was the writing that had been required. The least important, he found, were those courses emphasizing specific facts and content, but he spoke as well of the "brainwashing" that occurs in courses that teach "ideology without empirical data." The most important academic courses he took were an American studies seminar, basic psychology, analytical and creative writing, logic, family studies, and human ecology. The least useful were advanced math, "hard science," and foreign language, "although I wish I could speak one." He feels that his systems theoretical orientation (e.g., biopsychosocial) was "more than useful, [it was] essential." His systems approach has "been best stated" by Bowen and Auerswald but he had also been influenced by the existential approach of Havens, Yalom, and Bugenthal and the social-political-cultural approach of Frank and Halleck. He notes that "the basic biological and psychodynamic continue to be useful, but tend to be overemphasized. Learning/behavioral theories and technique are very useful. Gestalt theory is helpful, as are cognitive theories (Beck, and Ellis). Szasz and R.D. Laing have important messages, if not 'swallowed whole.' Developmental theories [are] useful" (citing Engel's biopsychosocial orientation). He is the Director of Community Psychiatry Training at a medical college and has worked for thirteen years in a community mental health environment since completing his residency.

Subject 110: Robert

Robert is a Caucasian male, thirty-nine years old, and married with a five-year-old daughter. He had married during medical school to a woman who was a high school teacher, but since beginning to raise a family she had stopped working. He was raised Protestant but does not now practice any particular religion. His father was a business executive, while his mother worked with children with cerebral palsy; both are now retired. The eldest of three siblings, he attended a state university in the South as an undergraduate, majoring in biology (zoology) and then attended a medical school in the Northeast. He listed no particular area of specialization. He did his residency and internship at urban hospitals in the Northeast. He describes his orientation as "object relations" and feels that what was most important of his formal education was the supervision he received during his residency. Likewise, psychiatry was most important, and the object relations and psychopharmacological orientation he received has been most useful in providing service to his clients, and that surgery was the least important. Currently, Robert is the assistant director for admissions at a state hospital in a small city in the Midwest. He has been working in community mental health contexts for over three years since his residency.

Subject 111: William

William is a Caucasian, Protestant male, sixty-seven years old, married for the third time (his first wife died on the operating table while he was still in medical school, his second wife, with whom he had several children, left him after he had finished his residency, and he and his third wife have no children). He is the son of missionary parents and seems to have lost any desire for a religious affiliation. Further information was not given, outside of that shared during the interview, as he did not fill out the questionnaire on his formal education, nor did he return the Mehrabian and Epstein Questionnaire Measure of Emotional Empathy.

Subject 112: Louis

Louis is a Canadian male, fifty-eight years old, and married with four children. His mother was Protestant and his father Catholic, and he was brought up in both religions. As an adult, he does "not follow any organized religion." His undergraduate majors were English and biology, and in medical school he studied to become a general practitioner, practicing it for a while and then opting to go into psychiatry because he believed it would help him deal with his patients' emotional difficulties. He completed two years of residency with a psychiatric training facility in the United States, where he was assigned to work with mental patients at a state hospital, and one year at another institute in another northern state. He specified a "rotating internship" for the question concerning his internships. His theoretical orientation is psychoanalytic and sociobiological, though he is "mildly skeptical" about this orientation, feeling that it is useful in providing service to patients "to a moderate degree." In the course of his career, he has served as associate commissioner for a department of mental health in the United States and as director of an association for the mentally retarded in Canada. In addition, he was involved in launching a community mental health program in a Canadian province that became a prototype for treating patients within community contexts. Currently, he holds the position of director of rehabilitation services at a psychiatric hospital in Canada. Due to health problems he is, to his regret, no longer working in community mental health contexts as a clinician, and he misses it a great deal, saying that "the setting I'm working at now is probably the antithesis of everything I think that good psychiatry should be." In this latter capacity he was called back to the U.S. in the early '80s as a consultant in a case that involved the question of euthanasia in the case of a child with Downs Syndrome. He has been working for more than twenty-five years in community mental health contexts.

Subject 113: Helmut

Helmut is a Caucasian, Catholic male, thirty-eight years old, single, from a European country. At the time of the interview, he had returned for a visit to the United States, where he had done some of his residency training, but he is currently living and working in Europe. He states his father, a physician, has been an important role model for him, describing him as a "perfect family practitioner" who really "talked with people." He is the oldest of five children. At the university, he completed three years of clinical study and then undertook a battery of tests during the fourth year, beginning clinical work as an intern in a hospital doing a surgical and internal medicine rotation and then following up with a specializations in neurology and psychiatry. He wrote a dissertation in neurology (which he explained was similar to receiving a Ph.D.) after completing his internship and before he did five years of residency in a state hospital and in what is analogous to a community mental health center in the United States. He listed no theoretical orientation but then explained that he had gone on to receive some psychotherapeutic training on his own, focusing on a Reichian approach. He states that his Latin professor at the gymnasium was "most motivating," the person with whom he "felt most comfortable." He likes sports and anesthesiology ("where you do not talk much") the least and states that "I like contact." He does not feel that there were any academic courses that were most important, or, at least, it was "difficult to say." He took sociology and psychology on the side during the gymnasium years as they were not a part of the standard medical education curriculum. He considers social psychiatry an "unusual choice" for study and does not recommend it. As he does not really have a formal theoretical orientation, he is in the process of creating his own, taking into account sociology, psychology, and politics. He describes himself as someone who has "a lot of experience." Currently he holds the position of Chief Physician in the Division of Social Psychiatry at a European university, where he does academic teaching 5-10% of the time as well as dealing with supervision of residents and personnel. Unfortunately, doing intakes is the only direct patient contact that he has. Prior to taking this position, he had carried out a two-year community psychiatry residency in the United States, at a community mental health center in a western state. Thus, he "did more than was needed due to interest." Given his varied background in a variety of different medical areas in both Germany and the United States, it was difficult for him to determine exactly how many years he had been working in community mental health contexts, but it was more than six years.

Subject 114: Harriet

Harriet is a Caucasian, Protestant female, sixty-three years old, twice divorced, who was brought up in a fundamentalist Protestant community. She was pre-med as an undergraduate at a fundamentalist college in the South but notes that her music and art appreciation courses in college were "broadening" and that her most useful college course was physics, which taught her "how things work." She received her M.D. degree from a medical college in the Midwest and completed an additional M.Sc. in psychiatry at a university nearby, then completed a hospital rotation that she describes as "controlling" and "punitive." Her clinical training at the university was psychoanalytically oriented with an "eclectic" staff. She regards the most important aspect of her formal education to have been her postdoctoral research in social psychiatry at the university, and she does not specify which was least important. She feels that her learning experience in graduate school allowed her to explore options and find out what works for her, whereas the hospital rotation taught her what not do, remarking that it reinforced her "aversion to coercive 'therapy.' " She has been working in community mental health contexts off and on since l955, when she first started general practice. At that time, she conducted a survey of the community and wrote a feasibility study for setting up a community mental health center several years before any community mental health legislation had been enacted. At one point she retired from public practice in order to devote herself to writing and research, but she had to resume working after a second divorce settlement about ten years earlier had wiped out her savings. Currently, Harriet is about to move to another state, where she plans to continue her private practice as a social psychiatrist and consultant, with a specialization in working with battered rural women. Although she is not currently working in a community mental health center, she has done so in the past and continues to consult for them, and to fill in temporarily for other colleagues on a short-term basis. She has been included in the sample on the basis of her previous experience.

Subject 115: Dianne

Dianne is a black, Protestant female, thirty-three years old, single, and an Episcopalian. As an undergraduate she majored in biology. She then attended medical school in a western state and does not specialize in any particular area. She completed her residency and internship in the Midwest and had five hours of supervision a week with five different supervisors per year. She subscribes to an analytical orientation. The most important aspects of her formal education were supervision and her own analysis, and least important were "certain lectures." The most important academic courses she took were the psychiatric examination interview, and the least important was a third-level psychopathology course. She considers herself to have an analytically oriented orientation but finds that "anything that works is helpful." She currently has a part-time private practice in addition to a position as medical director of a community mental health board. She has been working in community mental health contexts for four years.

Subject 116: Jorge

Jorge is a Catholic, Hispanic male, forty years old, married, from a South American country. He completed both his undergraduate education in the sciences and his medical education in his native country before coming to the United States to continue his training, completing his residency at a medical center in the Midwest and his internship at a medical center in South. He describes his theoretical orientation as eclectic and feels it was useful in helping him provide service to clients in giving him a basic framework to work in psychotherapy. He considers the most important aspect of his formal education to have been supervision "when having a good supervisor." His least important academic courses were psychotherapy, group psychotherapy, hypnotherapy, and personality theories. He holds a position of staff psychiatrist at a state hospital, which includes working in a satellite clinic. He has been working in community mental health contexts for six years.

Appendix B:
Education as Transformation Interview Schedule

1. How would you describe yourself as a psychiatrist?
2. How would you describe what you do as a psychiatrist?
3. What do you consider the important ingredients in helping someone?
   a. What else?
   b. Anything else?
4. How did you decide to become a psychiatrist?
5. Was there anything in particular that happened that led you to decide to become a psychiatrist?
6. Or that has made you a better psychiatrist (e.g., a particular incident, or a person, family members, etc.)?
7. Was there anything in the (your) community that influenced you to become a helper or psychiatrist? If so what community? and how?
8. How do you see yourself in relation to your community now?
9. How did you see yourself before becoming a psychiatrist?
10. Have there been formal (i.e., classroom, residency, internship) educational experiences that have affected your ability to be a psychiatrist (to help others)?
11. What about any informal (out of classroom, residency, internship, etc.) experiences?
12. Are there major forces that have shaped your character in general?
13. Your character as a psychiatrist, in particular?
14. What aspects of your character would you consider most important in influencing your ability to be a psychiatrist?
15. As a helper, do you ever face uncertainty?
16. When do you feel the most confident?
17. When do you feel the least confident?
18. Do you ever feel depleted by your work?
    a. If so, what do you do to reduce the stress?
    b. Or to nourish yourself?
19. Have you ever had to deal with a suicidal patient? And/or a patient who actually committed suicide? If so, how did you cope with it? If not, how would you cope with it? And what would/did you advise a colleague to do in a similar situation?
20. What would you tell a psychiatrist-in-training was the most important thing he or she could do to be a good one?
    a. Anything else?
    b. What about nourishing him- or herself?
21. In your role, do you see yourself as helping only individuals or as improving the quality of life in a particular community? If so, what community, and how?
22. How do you feel about the idea that healers appeal to a power greater than the self when healing to which they attribute their healing ability?
23. Are you in therapy, or analysis, or have you ever been? Was it helpful?
24 Was there anything that you would consider not to have been helpful, or which you consider to have been detrimental in preparing you to become a helper/psychiatrist?"
25. Do you think there are any questions I have overlooked in my effort to understand the formal and informal educational life histories of psychiatrists? (Or that I should be asking, or that you would have wanted to tell me?)

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N.B. The writer constructed the above interview schedule to elicit information that would cover the same areas as education as transformation; the same schedule was used for both the pilot interviews and the interviews with the sample . Since education as transformation emphasizes the importance of the healer's being of service to the community, as well as emphasizing the importance of the healer's character, among its other principles, the writer focused on these areas particularly as appropriate in such a cross-cultural study—the purpose of which is to determine whether this traditional model of healer education can illuminate or offer insight in a helpful way to improve the education of psychiatrists in the United States. The reader may refer to Chapter Two for a detailed description of the seven principles of education as transformation as it manifests both among the Ju/'hoansi in the Kalahari of South Africa and among the Fijian islanders.

Appendix C:
Questionnaire Concerning Formal Education

1. Where did you go to school as an undergraduate?

2. What was your undergraduate major?

3. Where did you go to medical school? Year graduated?

4. What was your area of specialization, if any?

5. Where and when did you have clinical training? (Please list each site and give hours of supervisions/week and the number of supervisors you had)
   For residencies:

   For internships:

   Theoretical orientation:

6. What aspects of you formal education do you consider to have been most important?

   Least important?

7. What were the most important academic courses you took?

   Least important?

8. What did you feel about your theoretical orientation? Was it helpful in helping you to provide service to clients?

9. What position do you currently hold, and where?

10. How many years have you been working in a community mental health environment (since completing residency or internships[s])?

(Please feel free to turn over and write on the other side and to request additional paper if needed.)

Appendix D:
Mehrabian and Epstein Questionnaire
Measure of Emotional Empathy

		Very strong agreement							Very strong disagreement
1.	It makes me sad to see a lonely stranger in a group	+4	+3	+2	+1	-1	-2	-3	-4
2.	People make too much of the feelings and sensitivity of animals	+4	+3	+2	+1	-1	-2	-3	-4
3.	I often find public displays of affection annoying	+4	+3	+2	+1	-1	-2	-3	-4
4.	I am annoyed by unhappy people who are just sorry for themselves	+4	+3	+2	+1	-1	-2	-3	-4
5.	I become nervous if others around me seem to be nervous	+4	+3	+2	+1	-1	-2	-3	-4
6.	I find it silly for people to cry out of happiness	+4	+3	+2	+1	-1	-2	-3	-4
7.	I tend to get emotionally involved with a friend's problems	+4	+3	+2	+1	-1	-2	-3	-4
8.	Sometimes the words of a love song move me deeply	+4	+3	+2	+1	-1	-2	-3	-4
9.	I tend to lose control when I am bringing bad news to someone	+4	+3	+2	+1	-1	-2	-3	-4
10.	The people around me have a great influence on my moods	+4	+3	+2	+1	-1	-2	-3	-4
11.	Most foreigners I have met seem cool and unemotional	+4	+3	+2	+1	-1	-2	-3	-4
12.	I would rather be a social worker than work in a job training center	+4	+3	+2	+1	-1	-2	-3	-4
13.	I don't get upset just because a friend is acting upset	+4	+3	+2	+1	-1	-2	-3	-4
14.	I would like to watch people open presents	+4	+3	+2	+1	-1	-2	-3	-4
15.	Lonely people are probably unfriendly	+4	+3	+2	+1	-1	-2	-3	-4
16.	Seeing people cry upsets me	+4	+3	+2	+1	-1	-2	-3	-4
17.	Some songs make me happy	+4	+3	+2	+1	-1	-2	-3	-4
18.	I really get involved with the feelings of the	+4	+3	+2	+1	-1	-2	-3	-4

		Very strong agreement							Very strong disagreement
	characters in a novel								
19.	I get very angry with I see someone being ill-treated	+4	+3	+2	+1	-1	-2	-3	-4
20.	I am able to remain calm even though those around me worry	+4	+3	+2	+1	-1	-2	-3	-4
21.	When a friend starts to talk about his problems, I try to steer the conversation to something else	+4	+3	+2	+1	-1	-2	-3	-4
22.	Another's laughter is not catching for me	+4	+3	+2	+1	-1	-2	-3	-4
23.	Sometimes at the movies I am amused by the amount of crying and sniffling around me	+4	+3	+2	+1	-1	-2	-3	-4
24.	I am able to make decisions without being influenced by people's feelings	+4	+3	+2	+1	-1	-2	-3	-4
25.	I cannot continue to feel OK if people around me are depressed	+4	+3	+2	+1	-1	-2	-3	-4
26.	It is hard for me to see how some things upset people so much	+4	+3	+2	+1	-1	-2	-3	-4
27.	I am very upset when I see an animal in pain	+4	+3	+2	+1	-1	-2	-3	-4
28.	Becoming involved in books or movies is a little silly	+4	+3	+2	+1	-1	-2	-3	-4
29.	It upsets me to see helpless old people	+4	+3	+2	+1	-1	-2	-3	-4
30.	I become more irritated than sympathetic when I see someone's tears	+4	+3	+2	+1	-1	-2	-3	-4
31.	I become very involved when I watch a movie	+4	+3	+2	+1	-1	-2	-3	-4
32.	I often find that I can remain cool in spite of the excitement around me	+4	+3	+2	+1	-1	-2	-3	-4
33.	Little children sometimes cry for no apparent reason	+4	+3	+2	+1	-1	-2	-3	-4

Bibliography

Achterberg, J. (1988). The wounded healer: Transformational journeys in modern medicine. In G. Doore, Ed., Shaman's path: Healing, personal growth and empowerment (pp.115-125). Boston: Shambhala.

Adams, G. L., et al. (1978). A primary care/mental health training and service model. American Journal of Psychiatry, 135 (1), 121-123.

Agosta, L. (1984). Empathy and intersubjectivity. In J. Lichtenberg, M. Bornstein, & D. Silver (Eds.), Empathy I (pp. 43-61). Hillsdale, NJ: Lawrence Erlbaum Associates.

Alon, R. (1990). Mindful spontaneity. Moving in tune with nature: Lessons in the Feldenkrais Method. Bridport, England: Prism Press.

American Medical Association. (1977). Directory of accredited residencies, 1977-78. Chicago: American Medical Association.

American Medical Association. (1983). Directory of residency training programs accredited by the Accreditation Council for Graduate Medical Education. Chicago: American Medical Association.

Anderson, H., & Goolishian, H. A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. Family Process, 27(4), 371-393.

Apfel, R. J., & Simon, B. (1985). Patient-therapist sexual contact: 1. Psychodynamic perspectives on the causes and results. Psychotherapy and psychosomatics, 43, 57-62.

Aston, J. (1991, Summer). Your ideal body: A new paradigm for movement. Physical Therapy Today, 30-36.

Aston, J., Molnar, M. A., & Krier, L. (1992, Fall). In your best shape with gravity's assistance. Physical Therapy Today, 50-59.

Austin, M. (1972). Acupuncture therapy. New York: ASI Publishers.

Bakan, D. (1965). The mystery-mastery complex in contemporary psychology. American Psychologist, 20, 186-191.

Bakan, D. (1966). The duality of human existence: Isolation and communion in Western man. Boston: Beacon.

Bales. R. F. (1970). Personality and interpersonal behavior. New York: Holt, Rinehart, and Winston.

Balter, M., & Katz, R. (1987). Nobody's child. Reading, MA: Addison-Wesley.

Barnett, M. A., Feighny, K. M., & Esper, J. A. (1983). Effects of anticipated victim responsiveness and empathy upon volunteering. Journal of Social Psychology, 119(2), 211-218.

Barrett-Lennard, G. T. (1973). Barrett-Lennard relationship inventory (Forms MO-64 and OS-64). (Original printing 1964 by University of New England [Australia].)

Barrett-Lennard, G. T. (1993). The phases and focus of empathy. British Journal of Medical Psychology, 66, 3-14.

Basch, M. F. (1983). Empathic understanding: A review of the concept and some theoretical considerations. Journal of the American Psychoanalytic Association, 31, 101-126.

Basch, M. F. (1988). Understanding psychotherapy: The science behind the art. New York: Basic Books.

Bates, C. M., & Brodsky, A. M. (1989). Sex in the therapy hour. London: Guilford.

Bateson, G. (1972). Steps to an ecology of mind: A revolutionary approach to man's understanding of himself. New York: Ballantine.

Bateson, G. (1979). Mind and nature: A necessary unity. New York: E. P. Dutton.

Baynes, K., Bohman, J., & McCarthy, T. (Eds.). (1991). After philosophy: End or transformation? Cambridge, MA: MIT Press.

Beebe, B., & Lachmann, F. M. (1988). The contribution of mother-infant mutual influence to the origins of self- and object representations. Psychoanalytic Psychology, 5(4), 305-337.

Beecher, H. K., & Altschule, M. D. (1977). Medicine at Harvard: The first three hundred years. Hanover, NH: University Press of New England.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). Women's ways of knowing: The development of self, voice, and mind. New York: Basic.

Benedict, R. (1970) Patterns of culture. Boston: Houghton Mifflin.

Benjamin, J. (1988). The bonds of love: Psychoanalysis, feminism, and the problem of domination. New York: Pantheon.

Benson, H. (1975). The relaxation response. New York: Avon.

Benson, H. (1984). Beyond the relaxation response: How to harness the healing power of your personal beliefs. New York: Times Books.

Berger, P. L., Berger, B., & Kellner, H. (1974). The homeless mind: Modernization and consciousness. New York: Random House.

Berliner, H. S., & Salmon, J. W. (1980). The holistic alternative to scientific medicine: History and analysis. International Journal of Health Services. 10(1).

Bertalanffy, L. von. (1950). An outline of general system theory. British Journal of Philosophical Science, 1, 139-164.

Bertalanffy, L. von. (1968). General system theory: Foundations, development, applications (rev. ed.). New York: George Braziller.

Bettelheim, B. (1982, March 1). Freud and the soul. The New Yorker.

Binstock, W. A. (1986). Clarification: Clinical application. In M. P. Nichols & T. J. Paolino (Eds.), Basic techniques of psychodynamic psychotherapy: Foundations of clinical practice (pp. 265-286). New York: Gardner.

Blendon, R. J., Donelan, K., Leitman, R., Epstein, A., Cantor, J., Cohen, A., Morrison, I., Moloney, T., Koeck, C., & Levitt, S. (1993). Physicians' perspectives on caring for patients in the United States, Canada, and West Germany. New England Journal of Medicine, 328(14), 1011-1016.

Bloom, B. L. (1977). Community mental health: A general introduction. Monterey, CA: Brooks/Cole.

Bohm, D. (1980). Causality and chance in modern physics (2nd ed.). Philadelphia: University of Pennsylvania Press. (Original work published 1957.)

Bohm, D. (1980). Wholeness and the implicate order. London: Routledge & Kegan Paul.

Bollas, C. (1987). The shadow of the object: Psychoanalysis of the unthought known. New York: Columbia University Press.

Book, H. E. (1988). Empathy: Misconceptions and misuses in psychotherapy. American Journal of Psychiatry, 145(4), 420-424.

Boring, E. G. (1950). A history of experimental psychology (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Borysenko, J. (1987). Minding the body, mending the mind. Reading, MA: Addison-Wesley.

Bowlby, J. (1969). Attachment and Loss: Vol. 1. Attachment. New York: Basic Books.

Briggs, J. L. (1970). Never in anger: Portrait of an Eskimo family. Cambridge, MA: Harvard University Press.

Brown, D. P., & Fromm, E. (1987). Hypnosis and behavioral medicine. Hillsdale, NJ: Lawrence Erlbaum Associates.

Brown, H. N., & Zinberg, N. E. (1982). Difficulties in the integration of psychological and medical practices. American Journal of Psychiatry, 139(12), 1576-1580.

Brown, L. M. (Ed.). (1988). A guide to reading narratives of conflict and choice for self and moral voice. Center for the Study of Gender, Education and Human Development Monograph No. 1. Cambridge, MA: Harvard University Graduate School of Education.

Brown, L. M., & Gilligan, C. (1990). Listening for self and relational voices: A responsive/resisting reader's guide. In Harvard project on the psychology of women and the development of girls: A selection of working papers through 1991. Cambridge, MA: Human Development and Psychology, Harvard University Graduate School of Education.

Brown, L. M., & Gilligan, C. (1992). Meeting at the crossroads: Women's psychology and girls' development. Cambridge, MA: Harvard University Press.

Bruner, J. (1986). Actual minds, possible worlds. Cambridge, MA: Harvard University Press.

Bruyn, S. T. (1966). The human perspective in sociology: The methodology of participant observation. Englewood Cliffs, NJ: Prentice-Hall.

Bryant, B. (1982). An index of empathy for children and adolescents. Child Development. 53, 413-425.

Buie, D. H. (1981). Empathy: Its nature and limitations. Journal of the American Psychoanalytic Association, 29(2), 281-307.

Campbell, H. D. (1982). The prevalence and ramifications of psychopathology in psychiatric residents: An overview. American Journal of Psychiatry, 139(11), 1405-1411.

Cannon, W. (1932). The wisdom of the body. New York: W. W. Norton.

Caplan, G. (1964). Principles of preventive psychiatry. New York: Basic Books.

Casement, P. J. (1991). Learning from the patient. New York: Guilford.

Cassell, E. J. (1982). The nature of suffering and the goals of medicine. New England Journal of Medicine, 306(11), 639-645.

Celenza, A. (1990). The capacity for empathy in borderline and narcissistic personalities. Unpublished manuscript, Cambridge, MA.

Cheever, O. L. (1984). The education of community psychiatrists: A search for trans-cultural community-based models. Unpublished manuscript, Harvard University, Cambridge, MA.

Chlopan, B. E., McCain, M. L., Carbonell, J. L., & Hagen, R. L. (1985). Empathy: Review of available measures. Journal of Personality and Social Psychology, 48(3), 635-653.

Chodorow, N. (1978). The reproduction of mothering: Psychoanalysis and the sociology of gender. Berkeley: University of California Press.

Clifford, T. (1984). Tibetan Buddhist medicine and psychiatry: The diamond healing. Wellingborough, Northamptonshire, England: Aquarian.

Corcoran, K. J. (1981). Experiential empathy: A theory of a felt-level experience. Journal of Humanistic Psychology, 21(1), 29-38.

Corsini, R. J., & Wedding, D. (Eds.). (1989). Current psychotherapies (4th ed.). Itasca, IL: F. E. Peacock.

Cranshaw, R. (1969). The general practice of community psychiatry. Beaverton, OR: The Benjamin Rush Foundation.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. Journal of Consulting Psychology, 60, 20-30.

Davis, M. H. (1980). A multidimensional approach to individual differences in empathy. JSAS Catalog of Selected Documents in Psychology, 10(4), 85.

Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. Journal of Personality and Social Psychology, 44, 113-126.

Davis, M., & Wallbridge, D. (1981). Boundary and space: An introduction to the work of D. W. Winnicott. London: H. Karnac.

Delgado, M. (1979, December). Puerto Rican folk healers in the big cities. Forum on Medicine, pp. 785-788.

Dell, P. F. (1985). Understanding Bateson and Maturana: Toward a biological foundation for the social sciences. Journal of Marital and Family Therapy, 11, 1-20.

Demos, V. (1984). Empathy and affect: Reflections on infant experience. In J. Lichtenberg, M. Bornstein, & D. Silver (Eds.), Empathy II (pp. 9-34). Hillsdale, NJ: Lawrence Erlbaum Associates.

Dennett, D. C. (1978). Brainstorms: Philosophical essays on mind and psychology. Cambridge, MA: MIT Press.

Dennett, D. C. (1984). Elbow room: The varieties of free will worth wanting. Cambridge, MA: MIT Press.

Dobay, Dezso. (1986). Aggressive and altruistic behavior of children in kindergarten in the evaluation of their teachers. Magyar Pszichologiai Szemle, 43(5), 405-414.

Dossey, L. (1982). Space, time and medicine. Boulder, CO: Shambhala.

Dossey, L. (1989). Recovering the soul: A scientific and spiritual search. New York: Bantam.

Dossey, L. (1991). Meaning and medicine: Lessons from a doctor's tales of breakthrough and healing. New York: Bantam.

Ducey, C. P. (1986). Suggestion: History and theory. In M. P. Nichols & T. J. Paolino (Eds.), Basic techniques of psychodynamic psychotherapy: Foundations of clinical practice (pp. 21-55). New York: Gardner.

Efran, J., & Lukens, M. D. (1985, May-June). The world according to Humberto Maturana: Epistemology and the Magic Kingdom. Networker, pp. 23-28, 72.

Efran, J. S., Lukens, R. J., & Lukens, M. D. (1988). Constructivism: What's in it for you? Networker, 27-35.

Eisenberg, D. M., Kessler, R. C., Foster, C., Norlock, F. E., Calkins, D. R., & Delbanco, T. L. (1993). Unconventional medicine in the United States. New England Journal of Medicine, 328(4), 246-252.

Eisenberg, L. (1977). Disease and illness. In Culture, Medicine and Psychiatry, vol. 1 (pp. 9-23). Dordrecht, Holland: Reidel.

Eisenberg, N., Pasternack, J., & Lennon, R. (1984, March). Prosocial development in middle childhood. Paper presented at the Southwestern Society of Research in Human Development, Denver, CO.

Eisenberg, N., & Strayer, J. (1987). Empathy and its development. Cambridge, England: Cambridge University Press.

Eisler, R. (1987). The chalice and the blade: Our history, our future. San Francisco: HarperCollins.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. Science, 196(4286), 129-136.

Fairbairn, W. R. D. (1952). Psychoanalytic studies of the personality. London: Routledge and Kegan Paul.

Feldenkrais, M. (1964). Mind and body. Systematics: The Journal of the Institute for the Comparative Study of History, Philosophy, and the Sciences, 2(1). Reprinted in Gerald Kogan (Ed.) (1980), Your body works, Berkeley, CA: Transformations.

Feldenkrais, M. (1972). Awareness through movement. New York: Harper & Row.

Feldenkrais, M. (1981). The elusive obvious. Cupertino, CA: Meta Publications.

Feldenkrais, M. (1985). The potent self: A guide to spontaneity. San Francisco: Harper and Row.

Ferguson, M. (1980). The Aquarian conspiracy: Personal and social transformation in the 1980s. Los Angeles: J. P. Tarcher.

Fire, J./Lame Deer, & Erdoes, R. (1972). Lame Deer seeker of visions. New York: Simon and Schuster.

Fliess, R. (1942). The metapsychology of the analyst. Psychoanalytic Quarterly, 11, 211-227.

Ford, E. (1963). Being and becoming a psychotherapist: The search for identity. American Journal of Psychiatry, 7, 472-481.

Frank, J. (1974). Persuasion and healing: A comparative study of psychotherapy (rev. ed.). New York: Schocken.

Frazier, S. H. (1987). Challenges in psychiatric education. In C. C. Nadelson & C. B. Robinowitz (Eds.), Training psychiatrists for the '90s: Issues and recommendations (pp. 7-10). Washington, DC: American Psychiatric Association Press.

Freire, P. (1970). Pedagogy of the oppressed (M. Bergman Ramos, Trans.). New York: Seabury.

Freire, P. (1973). Education for critical consciousness (Center for the Study of Development and Social Change, Cambridge, MA, Trans.). New York: Seabury.

Freud, S. (1925). Mourning and melancholia. In J. Riviere (Ed.), Sigmund Freud, M.D., LL. D.: Collected papers (pp. 152-170). London: Hogarth. (Original work published 1917.)

Freud, S. (1959a). Group psychology and the analysis of the ego (A. Strachey, Trans.). New York: W. W. Norton. (Original work published 1921.)

Freud, S. (1959b). Inhibitions, symptoms, and anxiety (A. Strachey, Trans.). New York: W. W. Norton. (Original work published 1926.)

Freud, S. (1963a). The dynamics of the transference. In P. Rieff (Ed.), Therapy and technique (pp. 105-115). New York: Macmillan. (Original work published 1912.)

Freud, S. (1963b). Further recommendations in the technique of psychoanalysis: On beginning the treatment; the question of the first communications; the dynamics of the cure. In P. Rieff (Ed.), Therapy and technique (pp. 135-156). New York: Macmillan. (Original work published 1913.)

Freud, S. (1963c). Observations on "wild" psychoanalysis. In P. Rieff (Ed.), Therapy and technique (pp. 89-95). New York: Macmillan. (Original work published 1910.)

Freud, S. (1963d). On psychotherapy. In P. Rieff (Ed.), Therapy and technique (pp. 63-75). New York: Macmillan. (Original work published 1904.)

Freud, S. (1963e). Recommendations for physicians on the psychoanalytic method of treatment. In P. Rieff (Ed.), Therapy and technique (pp. 117-126). New York: Macmillan. (Original work published 1912.)

Fuller, B. (1963). Ideas and integrities. New York: MacMillan, Collier Books.

Gabbard, G. E. (Ed.). (1989) Sexual exploration in professional relationships. Washington, DC: American Psychiatric Press.

Gabbard, G. E. (Ed.). (1991). The psychodynamics of sexual boundary violations. Psychiatric Annals.

Garetz, F., & Garetz, D. (1974). The relationship of achievement of psychiatrists to their personal adjustment as residents. Psychiatry Quarterly, 48, 421-432.

Gartrell, N., Herman, J., Olarte, S., Feldstein, M., & Localio, R. (l986). Psychiatrist-patient sexual contact: Results of a national survey, I: Prevalence. American Journal of Psychiatry, 143, 1126-1131.

Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Cambridge, MA: Harvard University Press.

Gilligan, C., & Pollak, S. (1988). The vulnerable and invulnerable physician. In C. Gilligan, J. V. Ward, J. M. Taylor, & B. Bardige (Eds.), Mapping the moral domain: A contribution of women's thinking to psychological theory and education (pp. 245-262). Cambridge, MA: Center for the Study of Gender, Education and Human Development, Harvard University Graduate School of Education.

Gilligan, C., Rogers, A. G., & Tolman, D. L. (Eds.). (1991). Women, girls and psychotherapy: Reframing resistance. Binghamton, NY: Haworth.

Gilligan, C., Ward, J. V., Taylor, J. M., & Bardige, B. (Eds.). (1988). Mapping the moral domain: A contribution of women's thinking to psychological theory and education. Cambridge, MA: Center for the Study of Gender, Education and Human Development, Harvard University Graduate School of Education.

Gimbutas, M. (1982). Goddesses and gods of old Europe, 7000-3500 B.C. Berkeley and Los Angeles: University of California Press.

Ginsburg, C. (1984). Toward a somatic understanding of the self: A reply to Leonard Geller. Journal of Humanistic Psychology, 24, 66-92.

Ginsburg, C. (in press). Somatic self revisited. Journal of Humanistic Psychology.

Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory: Strategies for qualitative research. New York: Aldine.

Glasscote, M. A., & Gudeman, J. E. (Eds.). (1969). The staff of the mental health center: A field study. Washington, DC.

Goffman, E. (1959). The moral career of the mental patient. Psychiatry: Journal for the Study of Interpersonal Processes, 22(2).

Goffman, E. (1961). Asylums: Essays on the social situation of mental patients and other inmates. Garden City, NY: Doubleday.

Gonzalez Ortega, C. A. (1992). Synergy in the classroom: Explorations in "education as transformation" with Puerto Rican children and their teacher (Doctoral dissertation, Harvard University, 1991). Dissertation Abstracts International, 52, 2073A.

Green, S. A. (1985). Mind and body: The psychology of physical illness. Washington, DC: American Psychiatric Press.

Grof, S. (1976). Realms of the human unconscious: Observations from LSD research. New York: E. P. Dutton.

Grof, S. (1983). East & West: Ancient wisdom and modern science (reprint from Journal of Transpersonal Psychology). San Francisco: Robert Briggs Associates.

Grunebaum, H. (1970). The practice of community mental health. Boston: Little Brown.

Grunebaum, H. (1983). A study of therapists' choice of a therapist. American Journal of Psychiatry, 140(10), 1336-1339.

Guenther, H. V. (1977). Tibetan Buddhism in Western perspective. Emeryville, CA: Dharma.

Guntrip, H. (1973). Psychoanalytic theory, therapy, and the self: A basic guide to the human personality in Freud, Erikson, Klein, Sullivan, Fairbairn, Hartmann, Jacobson, and Winnicott. New York: Basic Books.

Gurman, A. S., & Razin, A. M. (Eds.). (1977). Effective psychotherapy: A handbook of research. New York: Pergamon.

Guy, J. D. (1987). The personal life of the psychotherapist: The impact of clinical practice on the therapist's intimate relationships and emotional well-being. New York: John Wiley.

Hackney, H. (1978). The evolution of empathy. Personnel and Guidance Journal, 57, 35-38.

Hahn, H. (1982). Education as transformation: Spiritual and community healing in hunter-gathering societies. Unpublished manuscript.

Hall, C. S., & Lindzey, G. (1978). Theories of personality (3rd ed.). New York: John Wiley.

Hanna, T. (1975). Three elements of somatology: Preface to a holistic medicine and to a humanistic psychology. Main Currents, 31(3), 82-87.

Hanna, T. (1979/80). The body of life. New York: Knopf.

Hart, J. T., & Tomlinson, T. M. (1970). New directions in client-centered therapy. Boston: Houghton Mifflin.

Hartmann, E. (1991). Boundaries in the mind: A new psychology of personality. New York: Basic Books.

Harwood, A. (1977). Puerto Rican spiritism. In Culture, Medicine and Psychiatry, (vol. 1, pp. 69-95). Dordrecht, Holland: Reidel.

Hastings, A. C., Fadiman, J., & Gordon, J. S. (Eds.). (1980). Health for the whole person. Boulder, CO: Westview Press.

Havens, L. (1978). Explorations in the uses of language in psychotherapy: Simple empathic statements. Psychiatry, 41, 336-345.

Havens, L. (1986). Making contact: Uses of language in psychotherapy. Cambridge, MA: Harvard University Press.

Havens, L. (1987). Approaches to the mind: Movement of the psychiatric schools from sects toward science. Cambridge, MA: Harvard University Press.

Havens, L. (1989). A safe place: Laying the groundwork of psychotherapy. Cambridge, MA: Harvard University Press.

Herman, J. L. (1981). Father-daughter incest. Cambridge, MA: Harvard University Press.

Herman, J. L. (1992). Trauma and recovery: The aftermath of violence—from domestic abuse to political terror. New York: Basic Books.

Highwater, J. (1981). The primal mind: Vision and reality in Indian America. New York: New American Library.

Hoffman, L. (1990). Constructing realities: An art of lenses. Family Process, 29, 1-12.

Hofstadter, D. R. (1979). Godel, Escher, Bach: An eternal golden braid. New York: Random House.

Illich, I. (1982). Medical nemesis: The expropriation of health. New York: Pantheon.

James, W. (1950). The principles of psychology (Vols. 1-2). New York: Dover. (Original work published 1890.)

James, W. (1958). The varieties of religious experience: A study in human nature. New York: Collier Books. (Original work published 1902.)

Jonas, S. (1981). Health care delivery in the United States (2nd ed.). New York: Springer.

Jordan, J. V. (1991). Empathy and self boundaries. In J. V. Jordan, A. G. Kaplan, J. B. Miller, I. P. Stiver, & J. L. Surrey, Women's growth in connection (pp. 67-80). New York: Guilford.

Jordan, J. V., Kaplan, A. G., Miller, J. B., Stiver, I. P., & Surrey, J. L. (1991). Women's growth in connection. New York: Guilford.

Kabat-Zinn, J. (1990). Full catastrophe living. New York: Dell.

Kalle, R. J., & Suls, J. (1978). The relationship between Kohlberg's moral judgment stages and emotion empathy. Bulletin of the Psychonomic Society, 11(3), 191-192.

Kapchuk, T. J. (1983). The web that has no weaver: Understanding Chinese medicine. New York: Congdon & Weed.

Katz, M. M. W. (1981). "Gaining sense" in the outer Fiji Islands: A cross-cultural study of cognitive development (Doctoral dissertation, Harvard University).

Katz, R. (1973). Preludes to growth: An experiential approach. New York: Free Press.

Katz, R. (1980). Accepting boiling energy: The experience of !kia healing among the !Kung. Paper delivered at the International Conference on Shamans and Endorphins, Montreal.

Katz, R. (1981). Education as transformation: Becoming a healer among the !Kung and Fijians. Harvard Educational Review, 51(1), 57-78.

Katz, R. (1982a). Accepting "boiling energy": The experience of !kia-healing among the !Kung. Ethos, 10(4), 344-368.

Katz, R. (1982b). Boiling energy: Community healing among the Kalahari Kung. Cambridge, MA: Harvard University Press.

Katz, R. (1982c). Commentary on education as transformation. Harvard Educational Review, 52(1), 63-66.

Katz, R. (1982d). Utilizing traditional healing systems. American Psychologist, 37.

Katz, R. (1983/84). Empowerment and synergy: Expanding the community's healing resources. Prevention in Human Services, 3(2/3), 201-226.

Katz, R. (1985). Hearing healers: The contribution of vulnerability to field work. (Draft of manuscript published in 1987 as The role of vulnerability in fieldwork, in A. Schenk & H. Kalweit (Eds.), The healing of knowledge, Munich: Goldman.)

Katz, R. (1986). Healing and transformation: Perspectives on development, education and community. In M. White and S. Pollak (Eds.), The cultural transition: Social transformation in the Third World and Japan (pp. 41-64). London: Routledge & Kegan Paul.

Katz, R. (1987). The role of vulnerability in fieldwork. In A. Schenk and H. Kalweit (Eds.), The healing of knowing. Munich: Goldman.

Katz, R. (1990). The straight path: A Fijian perspective on healing and development. Unpublished manuscript, Saskatchewan Indian Federated College and Harvard University.

Katz, R. (1990, June). Wise old healers. Lecture at Bureau of Study Counsel, Harvard University, Cambridge, MA.

Katz, R. (1993). The straight path: A story of healing and transformation in Fiji. Reading, MA: Addison-Wesley.

Katz, R., & Craig, R. (1987). Community healing: The rich resource of tradition. The Exchange, 8(2), 4-5.

Katz, R., & Kilner, L. (1987). The straight path: A Fijian perspective on development. In C. Super (Ed.), The role of culture in developmental disorder (pp. 205-234). New York: Academic Press.

Katz, R., & Lamb, W. (1983). Utilization patterns of "traditional" and "Western" health services: Research findings. Proceedings of Annual Meeting of the National Council on International Health. Washington, DC: National Council on International Health.

Katz, R., & Nunez-Molina, M. (1986). Researching realities: The contribution of vulnerability to cross-cultural understanding. Community Psychologist, 19(3).

Katz, R., & Rolde, E. (1981). Community alternatives to psychotherapy. Psychotherapy: Theory, research and practice, 18(3), 365-374.

Katz, R., & St. Denis, V. (1991). Teacher as healer: A renewing tradition. Journal of Indigenous Studies (2), 23-36.

Katz, R., & Seth, N. (1986). Synergy and healing: A perspective on Western health care. Prevention in Human Services, 5(1), 109-136.

Katz, R., & Seth, N. (Eds.). (1993). Synergy and healing: Perspectives on development and social change. Unpublished manuscript, Saskatchewan Indian Federated College.

Kegan, R. (1982). The evolving self: Problem and process in human development. Cambridge, MA: Harvard University Press.

Kipper, D. A., & Uspiz, V. (1987). Emotional and cognitive responses in role playing. Journal of Group Psychotherapy, Psychodrama and Sociometry, 39(4), 131-142.

Kleinman, A. (1988a). The illness narratives: Suffering, healing, and the human condition. New York: Basic.

Kleinman, A. (1988b). Rethinking psychiatry: From cultural category to personal experience. New York: Free Press.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Clinical lessons from anthropologic and cross-cultural research. Annals of Internal Medicine, 88, 251-258.

Kohlberg, L. (1969). The cognitive developmental approach. In D. A. Goslin (Ed.), Handbook of socialization theory and research. Chicago: Rand McNally.

Kohn, A. (1990). The brighter side of human nature: Altruism and empathy in everyday life. New York: BasicBooks

Kohut, H. (1977). The restoration of the self. New York: International Universities Press.

Kohut, H. (1984). Introspection, empathy, and the semicircle of mental health. In J. Lichtenberg, M. Bornstein, & D. Silver (Eds.), Empathy I (pp. 81-100). Hillsdale, NJ: Lawrence Erlbaum Associates. (Paper originally presented in 1981.)

Konner, M. (1993). Medicine at the crossroads: The crisis in health care. New York: Pantheon.

Kottler, J. A., & Blau, D. S. (1989). The imperfect therapist: Learning from failure in therapeutic practice. San Francisco: Jossey-Bass.

Krebs, D. L. (1970). Altruism: An examination of the concept and a review of the literature. Psychological Bulletin, 73, 258-303.

Kreisberg, S. (1986). Transforming power: Toward an understanding of the nature of power in the experience of empowerment (Doctoral dissertation, Harvard University). Dissertation Abstracts International, 47, 3913A.

Krieger, D. (1975a). Therapeutic Touch: The imprimatur of nursing. American Journal of Nursing, 5, 784-787.

Krieger, D. (1975b). Therapeutic Touch: A mode of primary healing based on a holistic concern for man. Journal for Holistic Medicine, 1, 6-10.

Krieger, D. (1979). Therapeutic Touch: How to use your hands to help or to heal. Englewood Cliffs, NJ: Prentice-Hall.

Krieger, D. (1981). Foundations for holistic health nursing practices: The renaissance nurse. Philadelphia: Lippincott.

Krippner, S., & Villoldo, A. (1976). The realms of healing (3rd ed.). Berkeley, CA: Celestial Arts.

Krueger, D. W. (1989). Body self and psychological self: A developmental and clinical integration of disorders of the self. New York: Brunner/Mazel.

Kuhn, T. S. (1970). The structure of scientific revolutions (2nd ed.). Chicago: University of Chicago Press.

Langley, D. G., & Hollender, M. H. (1982). The definition of a psychiatrist (brief communications). American Journal of Psychiatry, 139(1), 81-88.

Laughlin, C. D., McManus, J., & d'Aquili, E. G. (1992). Brain, symbol and experience: Toward a neurophenomenology of human consciousness. New York: Columbia University Press.

Lee, R. B., & Devore, I. (Eds.). (1968). Man the hunter. Chicago: Aldine.

Lee, R. B., & DeVore, I. (1976). Kalahari hunter-gatherers: Studies of the !Kung San and their neighbors. Cambridge, MA: Harvard University Press.

Lee, P. R., Ornstein, R. E., Galin, D., Deikman, A., & Tart, C. T. (1976). Symposium on consciousness. Presented at annual meeting of American Association for the Advancement of Science, February 1974. New York: Viking.

Leigh, H. (1982). Comment: The role of psychiatry in medicine. American Journal of Psychiatry, 139(12), 1581-1587.

Leri, D. (1993, Fall). Learning how to learn. Gnosis, 49-53.

LeShan, L. (1974). The medium, the mystic, and the physicist: Toward a general theory of the paranormal. New York: Ballantine.

LeShan, L. (1982). The mechanic and the gardener: Making the most of the holistic revolution in medicine. New York: Holt, Rinehart, and Winston.

LeVine, R. (1982). Culture, behavior, and personality (2nd ed.). Chicago: Aldine.

Lewin, K. (1939). Field theory and experiment in social psychology: Conceptual methods. American Journal of Sociology, 44, 868-896.

Lewis, B. L. (1989). Self as a system: A second order cybernetic perspective. Journal of Strategic and Systemic Therapies, 8, 65-72.

Lichtenberg, J., Bornstein, M., & Silver, D. (Eds.). (1984a). Empathy I. Hillsdale, NJ: Lawrence Erlbaum Associates.

Lichtenberg, J., Bornstein, M., & Silver, D. (Eds.). (1984b). Empathy II. Hillsdale, NJ: Lawrence Erlbaum Associates.

Lief, V. F., & Brotman, R. (1968). The psychiatrist and community mental health practice. Community Mental Health Journal, 4(2), 134-143.

Light, D. (1980). Becoming psychiatrists: The professional transformation of self. New York: W. W. Norton.

Locke, S., & Colligan, D. (1986). The healer within: The new medicine of mind and body. New York: E. P. Dutton.

Locke, S., & Hornig-Rohan, M. (Eds.). (1983). Mind and immunity: Behavioral immunology. An annotated bibliography, 1976-1982. New York: Institute for the Advancement of Health.

Lyons, N. (1983). Two perspectives: On self, relationships and morality. Harvard Educational Review, 53, 125-145.

Luborsky, L, & Crits-Christoph, P. (1990). Understanding transference: The core conflictual relationship theme method. New York: Basic Books.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). Who will benefit from psychotherapy? Predicting therapeutic outcomes. New York: Basic Books.

Luborsky, L., Mintz, J., Auerbach, A., Christoph, P., Bachrach, H., Todd, T., Johnson, M., Cohen, M., & O'Brien, C. P. (1980). Predicting the outcome of psychotherapy: Findings of the Penn Psychotherapy Project. Archives of General Psychiatry, 37, 471-481.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapy: Is it true that "Everybody has won and all must have prizes"? Archives of General Psychiatry, 32, 995-1008.

Lyons, N. (1983). Two perspectives: On self, relationships and morality. Harvard Educational Review, 53(2), 125-145.

Macht, L. B., Scherl, D. J., & Scharfstein, S. (1977). Neighborhood psychiatry. Lexington, MA: D. C. Heath.

Macy, J. (1978). Interdependence: Mutual causality in early Buddhist teaching and general systems theory (Doctoral dissertation, Syracuse University). Dissertation Abstracts International, 39, 6182A.

Macy, J. (1982). Despair and empowerment in the nuclear age. Philadelphia: New Society.

Malan, D. H. (1979). Individual psychotherapy and the science of psychodynamics. London: Butterworths.

Margulies, A. (1984). Toward empathy: The uses of wonder. American Journal of Psychiatry, 141(9), 1025-1033.

Margulies, A. (1989). The empathic imagination. New York: W. W. Norton.

Maturana, H. R., & Varela, F. J. (1980). Autopoesis and cognition: The realization of the living. Dordrecht, Holland: Reidel.

Maturana, H. R., & Varela, F. J. (1987). The tree of knowledge: The biological roots of human understanding. Boston: Shambhala.

May, R., Angel, E., & Ellenberger, H. (Ed.). (1958). Existence: A new dimension in psychiatry and psychology. New York: Basic Books.

McClelland, D. C. (1975). Power: The inner experience. New York: Irvington.

Mehrabian, A., & Epstein, N. (1972). A measure of emotional empathy. Journal of Personality, 40(4), 525-543.

Meltzoff, J., & Kornreich, M. (1970). Research in psychotherapy. New York: Atherton.

Menary, J. (1982). Transcendence and healing. Unpublished manuscript, Harvard University.

Menary, J. (1988). The amniocentesis and abortion experience: A study in psychological healing (Doctoral dissertation, Harvard University, 1987). Dissertation Abstracts International, 48, 343A.

Messner, E., Groves, J. E., & Schwartz, J. H. (Eds.). (1989). Autognosis: How psychiatrists analyze themselves. Chicago: Year Book Medical Publishers.

Meza, A. V. (1988). A study of acculturation of Chicano students at Harvard College: Evidence for the collectivist ego (Doctoral dissertation, Harvard University). (Not listed in Dissertation Abstracts International; listed in UMN Comprehensive Dissertation Index, 1988, but without index number.)

Michels, R., & Marzuk, P. (1993). Medical progress: Progress in psychiatry (second of two parts). New England Journal of Medicine, 329(9), 628-638.

Miles, M. B., & Huberman, A. M. (1984). Qualitative data analysis: A sourcebook of new methods. Beverly Hills: Sage.

Miller, J. B. (1986). Toward a new psychology of women (2nd ed.). Boston: Beacon Press.

Miller, J. B. (1991). The development of women's sense of self. In J. V. Jordan, A. G. Kaplan, J. B. Miller, I. P. Stiver, & J. L Surrey, Women's growth in connection (pp. 11-26). New York: Guilford.

Mintz, J. (1972). What is "success" in psychotherapy? Journal of Abnormal Psychology, 80(1), 11-19.

Mishler, E. G. (1984). The discourse of medicine: Dialectics of medical interviews. Norwood, NJ: Ablex.

Mitchell, S. A. (1988). Relational concepts in psychoanalysis: An integration. Cambridge, MA: Harvard University Press.

Modell, A. (1968). Object love and reality. New York: International Universities Press.

Morimoto, K. (1957). The need for inclusion in interpersonal relations. Unpublished manuscript.

Moyers, B. (1993). Healing and the mind. New York: Doubleday.

Murray, R. H., & Rubel, A. J. (1992). Physicians and healers: Unwitting partners in health care (sounding board). New England Journal of Medicine. 326(1)61-64.

Myers, S. (1992). An exploration of empathy in the context of relationships. Unpublished manuscript, Harvard University, Cambridge, MA.

Nadelson, C. C., & Notman, M. T. (1983). What is different for women physicians? In S. C. Scheiber & B. B. Doyle (Eds.), The impaired physician (pp. 11-25). New York: Plenum.

Nadelson, C. C., & Robinowitz, C. B. (Eds.). (1987). Training psychiatrists for the '90s: Issues and recommendations. Washington, DC: American Psychiatric Press.

Nadelson, C. C., & Tighe, P. J. (1986). Women and leadership in departments of psychiatry. In L. Dickstein & C. C. Nadelson (Eds.), Women physicians in leadership roles (pp. 271-281). Washington, DC: American Psychiatric Press.

Nason, J. D. (1977). On teaching psychotherapy in a community mental health center. American Journal of Psychiatry, 134(12).

Neihardt, J. G. (1972). Black Elk speaks: Being the life story of a holy man of the Oglala Sioux. New York: Pocket Books. (Original work published 1932.)

Noddings, N. (1984). Caring. Berkeley, CA: University of California Press.

Nunez-Molina, M. (1988). "Desarollo del medium": The process of becoming a healer in Puerto Rican "espiritismo" (Doctoral dissertation, Harvard University, 1987). Dissertation Abstracts International, 48, 1143B.

Ogden. T. (1982). Projective identification and psychotherapeutic technique. New York: Jason Aronson.

Okun, B. F. (1990). Seeking connections in psychotherapy. San Francisco: Jossey-Bass.

Olinick, S. L. (1984). A. critique of empathy and sympathy. In J. Lichtenberg, M. Bornstein, & D. Silver (Eds.), Empathy I (pp. 137-166). Hillsdale, NJ: Lawrence Erlbaum Associates.

Ornstein, R. E. (Ed.). (1973). The nature of human consciousness: A book of readings. San Francisco: W. H. Freeman.

Ornstein, R., & Sobel, D. (1987). The healing brain: Breakthrough discoveries about how the brain keeps us healthy. New York: Simon & Schuster.

Padilla, A. M. (Ed.). (1980). Acculturation: Theory, models, and some new findings. Boulder, CO: Westview.

Pardes, H. (1982). Medical education and recruitment in psychiatry (editorial). American Journal of Psychiatry, 139(8), 1053-1035.

Parry, A. (1991). A universe of stories. Family Process (30), 37-54.

Pasnau, R. O., & Russell, A. T. (1975). Psychiatric resident suicide: An analysis of five cases. American Journal of Psychiatry, 132, 402-406.

Patenaude, K. M. (1994). When the helper becomes the perpetrator: How colleagues view and address sexual exploitation of the client (Doctoral dissertation, Smith College School for Social Work).

Paul, O. (1991). The caring physician: The life of Dr. Francis W. Peabody. Cambridge, MA: Harvard University Press.

Pelletier, K. R. (1978). Toward a science of consciousness. New York: Dell.

Pelto, P. J., & Pelto, G. H. (1970). Anthropological research: The structure of inquiry (2nd ed.). Cambridge, England: Cambridge University Press.

Perry, L. (1982). Special populations: The demands of diversity. In E. Herr & N. M. Pinson (Eds.), Foundations for policy and guidance and counseling (pp. 50-69). American Personnel and Guidance Association.

Perry, R. B. (1935). The thought and character of William James (Vol. I). Boston: Little, Brown.

Perry, W. G., Jr. (1970). Forms of intellectual and ethical development in the college years. New York: Holt, Rinehart, and Winston.

Peterson, M. R. (1992). At personal risk: Boundary violations in professional-client relationships. New York: W. W. Norton.

Phillips, S. P., & Schneider, M. S. (1993). Sexual harassment of female doctors by patients. New England Journal of Medicine, 329(26), 1936-1939.

Pierce, C. M. (1974). Psychiatric problems of the black minority. In G. Caplan (Ed.), American handbook of psychiatry (2nd ed.): Vol. 2. Child and adolescent psychiatry, sociocultural and community psychiatry (pp. 512-523). New York: Basic Books.

Polanyi, M. (1958). Personal knowledge: Towards a post-critical philosophy. Chicago: University of Chicago Press.

Pope, K. S., & Bouhoutsos, J. C. (1986). Sexual intimacy between therapists and patients. New York: Praeger.

President's Commission on Mental Health "Report to the President" (1978). Washington, DC: Government Printing Office.

Preven, D. W. (1983). Physician suicide: The psychiatrist's role. In S. C. Scheiber & B. B. Doyle (Eds.), The impaired physician (pp. 39-47). New York: Plenum.

Quinn, J. (1981). Therapeutic Touch: One nurse's evolution as a healer. In M. D. Borelli & P. Heidt (Eds.), Therapeutic Touch: A book of readings (pp. 59-63). New York: Springer.

Rappaport, J. (1977). Community psychology. New York: Holt, Rinehart, and Winston.

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. American Journal of Community Psychology, 9(1), 1-23.

Rappaport, R. (1978). Adaptation and the structure of ritual. In N. Blurton-Jones & V. Reynolds (Eds.), Human behavior and adaptation, XVIII. New York: Halsted.

Reich, W. (1972). Character analysis (V. R. Carfagno, Trans.) (3rd ed.). New York: Simon and Schuster. (Original work published 1933.)

Reik, T. (1948). Listening with the third ear: The inner-experience of a psychoanalyst. New York: Farrar, Straus, and Giroux.

Reinharz, S. (1979). On becoming a social scientist. San Francisco: Jossey-Bass.

Reiser, S. J. (1978). Medicine and the reign of technology. Cambridge, England: Cambridge University Press.

Rinfret, M. (1989). Body-mind-emotion in Feldenkrais work and psychotherapy. Paper presented at FELDENKRAIS GUILD® Annual Conference, Montreal, Canada.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology , 21, 51-57

Rogers, C. R. (1975). Empathic: An unappreciated way of being. The Counseling Psychologist, 5(2), 2-10.

Rutter, P. (1989). Sex in the forbidden zone: When men in power—therapists, doctors, clergy, teachers, and others—betray women's trust. Los Angeles: Jeremy P. Tarcher.

Rywerant, Y. (1983). The Feldenkrais Method: Teaching by handling. San Francisco: Harper & Row.

Sarason, S. (1974). The psychological sense of community: Prospects for a community psychology. San Francisco: Jossey-Bass.

Schafer, R. (1983). The analytic attitude. New York: Basic Books.

Scheiber. S. C. (1983). Emotional problems of physicians: Nature and extent of problems. In S. C. Scheiber & B. B. Doyle (Eds.), The impaired physician (pp. 3-10). New York: Plenum.

Scheiber, S. C., & Doyle, B. B. (Eds.). (1983). The impaired physician. New York: Plenum.

Schiller, F. (1982). A Möbius strip: Fin-de-siecle neuropsychiatry and Paul Möbius Berkeley, CA: University of California Press.

Schoener, G. R., Milgrom, J. H., Gonsiorek, J. C., Luepker, E. T., & Conroe, R. M. (1986). Psychotherapists' sexual involvement with clients: Intervention and prevention. Minneapolis: Walk-in Counseling Center.

Schwaber, E. (1984). Discussion of "The antithetical meaning of the term 'empathy' in psychoanalytic discourse," by G. S. Reed. In J. Lichtenberg, M. Bornstein, & D. Silver (Eds.), Empathy I (pp. 25-29). Hillsdale, NJ: Lawrence Erlbaum Associates.

Scully, J. H., Dubovsky, S. L., & Simons, R. C. (1983). Undergraduate education and recruitment into psychiatry. American Journal of Psychiatry, 140(5), 573-575.

Shapiro. A. (1971). Placebo effects in medicine, psychotherapy, and psychoanalysis. In E. Bergin & S. Garfield (Eds.), Handbook of psychotherapy and behavior changes: Empirical analysis. New York: Wiley.

Sharaf, M. R., & Levenson, D. J. (1964). The quest for omnipotence in professional training. Psychiatry, 27, 135-149.

Sharaf, M. R., Schneider, P., & Kantor, D. (1968). Psychiatric interest and its correlates among medical students. Psychiatry, 31, 150-160.

Sharon, D. (1978). Wizard of the four winds: A shaman's story. New York: Macmillan.

Shelhav-Silberbush, C. (1987). The Feldenkrais Method for children with cerebral palsy. Berkeley, CA: Advanced Seminars.

Shostak, M. (1981). Nisa: The life and words of a !Kung woman. New York: Vintage.

Sierles, F. (1982). Medical school facts and career choice of psychiatry. American Journal of Psychiatry, 139(8), 1040-1042.

Simonis, J. (1986). Synergy and the education of helpers: A new community psychology approach to counselor training (Doctoral dissertation, Harvard University, 1985). Dissertation Abstracts International, 46, 2196A.

Smith, M. L., & Glass, G. V. (1977) Meta-analysis of psychotherapy outcome studies. American Psychologist, 32, 752-760.

Spence, D. P. (1982). Narrative truth and historical truth: Meaning and interpretation in psychoanalysis. New York: W. W. Norton.

Stark, M. (1994). Working with resistance. Northvale, NJ: Jason Aronson.

Starr, P. (1982). The social transformation of American medicine. New York: Basic Books.

Steere, D. A. (1982). Bodily expressions in psychotherapy. New York: Brunner/Mazel.

Steiner-Adair, C. (1986). The body politic: Normal female adolescent development and the development of eating disorders. Journal of the American Academy of Psychoanalysis 14, 95-114.

Steisel, S. G. (1992). The client's experience of the psychological elements of functional integration (Doctoral dissertation, Massachusetts School of Professional Psychology).

Stern, D. N. (1985). The interpersonal world of the infant: A view from psychoanalysis and developmental psychology. New York: Basic Books.

Stern, L. (1990). Disavowing the self in female adolescence: A case study analysis (Doctoral dissertation, Harvard University). Dissertation Abstracts International, 51, 1524B.

Stone, A. (1980). Conceptual ambiguity and morality in modern psychiatry (presidential address). American Journal of Psychiatry, 137, 887-893.

Stone, A. (1984). Law, psychiatry, and morality. Washington, DC: American Psychiatric Press.

Stotland, E. (1969). Exploratory studies of empathy. In L. Berkowitz (Ed.), Advances in experimental social psychology, vol. 4. New York: Academic Press.

Stotland, E., Mathews, K. E., Jr., Sherman, S. E., Hansson, R. O., & Richardson, B. Z. (1978). Empathy, fantasy and helping. Beverly Hills: Sage.

Sturtevant, A. E. (1985). The relationship of empathy, mood, prosocial moral reasoning, and altruism in children. Unpublished doctoral dissertation, New York University.

Sue, D. W. (1981). Counseling the culturally different: Theory and practice. New York, John Wiley and Sons.

Sullivan, H. S. (1953). The interpersonal theory of psychiatry. New York: W. W. Norton.

Surrey, J. L. (1991). The "self-in-relation": A theory of women's development. In J. V. Jordan, A. G. Kaplan, J. B. Miller, I. P. Stiver, & J. L Surrey, Women's growth in connection (pp. 51-66). New York: Guilford.

Sussman, M. B. (1992). A curious calling: Unconscious motivations for practicing psychotherapy. Northvale, NJ: Jason Aronson.

Tart, C. T. (1975). Transpersonal psychologies. New York: Harper & Row.

Tomkins, S. (1962). Affect, imagery, consciousness: Vol. 1. The positive affects. New York: Springer.

Tomkins, S. (1963). Affect, imagery, consciousness: Vol. 2. The negative affects. New York: Springer.

Tremblay, R. E., Larivee, S., & Gregoire, J. C. (1984-85). Cognitive development of preadolescents: Relationship to fathers' attitudes and nonverbal behavior. Bulletin de Psychologie, 38(1-3), 13-22.

Truax, C. B., & Carkhuff, R. R. (1967). Toward effective counseling and psychotherapy. Chicago: Aldine.

Turner, M. (1991). Two-part inventions: Knowing what we know. In C. Gilligan, A. G. Rogers, & D. L. Tolman (Eds.), Women, girls and psychotherapy: Reframing resistance (pp. 149-168). Binghamton, NY: Haworth.

Turner, V. W. (1969). The ritual process: Structure and anti-structure. Chicago: Aldine.

van Kaam, A. (1966). Existential foundations of psychology. Pittsburgh: Duquesne University Press.

Varela, F. J. (1979). Principles of biological autonomy. New York: Elsevier North Holland.

Varela, F. J., Thompson, E., & Rosch, E. (1991). The embodied mind. Cambridge, MA: MIT Press.

Villoldo, A., & Krippner, S. (1986). Healing states. New York: Simon & Schuster.

Vogel, M. J. (1980). The invention of the modern hospital: Boston 1870-1930. Chicago: University of Chicago Press.

von Eckartsberg, R. (1984). Analysis of life world experience. Unpublished manuscript, Duquesne University, Pittsburgh.

Waldinger, R. J. (1984). Psychiatry for medical students. Washington, DC: American Psychiatric Press.

Watson, P. J., Hood, R. W., Morris, R. J., & Hall, J. R. (1984). Empathy, religious orientation, and social desirability. Journal of Psychology, 117(2), 211-216.

Wax, R. (1971). Doing fieldwork: Warnings and advice. Chicago: University of Chicago Press.

Webster, T. G. (1983). Addiction and alcoholism among physicians. In S. C. Scheiber & B. B. Doyle (Eds.), The impaired physician (pp. 27-38). New York: Plenum.

Weintraub, W., Balis, G. V., & Donner, L. (1982). Tracking: An answer to psychiatry's recruitment problem? (brief communications). American Journal of Psychiatry, 139(8), 1036-1039.

Weiss, J., & Sampson, H. (1986). The psychoanalytic process: Theory, clinical observation, and empirical research. New York: Guilford.

Westen, D. (1991). Social cognition and object relations. Psychological Bulletin. 109(3), 429-455.

Wilber, K., Engler, J., & Brown, D. P. (1986). Transformations of consciousness: Conventional and contemplative perspectives on development. Boston: Shambhala.

Winnicott, D. W. (1958). Hate in countertransference. In D. W. Winnicott, Through pediatrics to psycho-analysis (pp. 194-203). New York: Basic Books. (Based on paper presented to British Psycho-Analytical Society on February 5, 1947, and published in 1949 in International Journal of Psycho-Analysis, 30.)

Winnicott, D. W. (1965). The maturational processes and the facilitating environment: Studies in the theory of emotional development. New York: International Universities Press.

Winnicott, D. W. (1971). Playing and reality.. New York: Basic Books.

Ywahoo, D. (1989). Voices of our ancestors. Boston: Shambhala.

Zwerling, I. (1976). The impact of the community mental health movement on psychiatric practice and training. Hospital and Community Psychiatry, 27(4), 258-262.

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