Values and Ethics When Considering Alternative Psychotherapies

CBT or Psychodynamic?

Saturday February 1, 2014  9:00 AM -12:30 PM
Psychiatry Update Series University of Texas Southwestern Medical Center at Dallas
Course Director: Adam Brenner, MD,  Director of Residency Training in Psychiatry

Transcript of the discussion with the audience and panel
Transcribed and edited by Dale C. Godby, Ph.D.

Dr. Brenner: 1. What are the implicit values that define and drive the technique in these two kinds of psychotherapies? 2. How do you make decisions about referrals? 3. What kinds of ethical conflicts arise with the kind of treatment we recommend?

Audience: Off of the exact question, but how does the patient feel?

Abbey: Rip off that band-aid. Let’s get right in there. I have very little experience with each, as a person that is. I find value in both. Not just being diplomatic. Both got to the heart of the matter from different angles. They made me feel uncomfortable about the right things at different times. By uncomfortable I mean there is always an implicit discomfort in change in self-awareness and waking up to whatever the thing is. You are all going to hate me, I’m not going to pick a side. But I truly find value in both. I think for Sherry understanding why and having practical tools would be a good balance.

Dr. Little: One observation throughout each interview. That you, Robin, mirrored the position of your anxious patient, whereas Jerry, you were laid back. But at the end of each interview, during the interview Sherry never sat back, but at the end of Jerry’s interview Sherry sat back. It would be interesting to hear Robin and Jerry comment on that.

Dr. Melchiode: A lot of this is unconscious. Looking back I saw her as a frightened, shy, not to be politically incorrect, little girl. I guess I was playing off that affect with her. I don’t know whether the turning point in the interview where she sat back was when I was explaining to her how therapy worked. Then I was doing more to take care of her and she was able to sit back and receive that. I saw her as very needy.

Dr. Jarrett: I am going to be honest and say I was most focused on the patient’s eyes. Not so much on her non-verbal or her other… the way she was sitting. If you asked me to replay that I don’t know if I’d be accurate. But what I was focused on was her eyes; she did a wonderful job of crying. We did not have Kleenex. This was bothering me. My mother always said is your plant living and do you have Kleenex. To get to your point I was focused on her eyes. Her eyes to me are the window to where the affect is. Once Tim Beck told me that he first
called cognitive therapy affective therapy because that is what you are really doing is following the affect. I was really more focused when she was hopeful and when she had despair. Even though she had difficulty putting a name on what her despair was. My goal was to have her leave the session feeling like there was hope and feeling that was not going to come because she met me but because she identified something hopeful in herself. I had the advantage of seeing Jerry and I thought both interviews accomplished some hope.

**Dr. Laura Howe-Martin:** I actually have a legitimate questions and am not just cueing you. I have the advantage of having some back-story. I wanted you all to know that Dr. Melchiode and Dr. Jarrett had never met Sherry before. So the interviews were very fresh. I’d like to ask what each of you see as the core values of the perspective from which you work.

**Dr. Melchiode:** The core concepts are what I went through with her at the end of the interview. There is a value in that things are not as they appear. She has trouble leaving her home, but there is a conflict there. I have an assumed value that she doesn’t know all the factors that keep her there, that keep her from leaving. So there are conscious or unconscious reasons that keep her in that situation. That is a value. I have to ferret that out. I have no investment whether she leaves home or goes. I don’t care if Emily Dickenson never leaves the house. My position is, does Emily Dickenson have a rational reason for staying home or leaving. And my goal as the therapist is to smoke those out into the open and give her a chance to make that decision. I am interested in her feelings, how she defends against unpleasant feelings and thoughts. How do these get played out in the relationships she has? Another value or assumption I have is that if I structure this correctly I will begin to see some of those conflicts emerge in our relationship. That’s a value. It’s called the transference. I also have a value that we don’t come to things de novo that our past experiences color how we react in the present. If the past is not resolved it has a way of pervading the present. This is another value I hold. These are the core values. There are things we need to separate. I may understand a patient psychodynamically but I may not recommend psychodynamic treatment.

**Dr. Jarrett:** What I was trying to do is get an understanding of the patient’s view of her self, the world, and the future, which is what Beck called the cognitive triad. I was trying to build that during our conversation. What I took away was that this is a young woman who emotionally is not quite her chronological age. She views herself as almost having switched places with the mother perhaps. She has a view of herself as a caretaker, but also in a normal way as it is time to move on. She does seem to be hopeful about the future. She is not presenting as severely depressed. When she talked about other people there wasn’t a whole lot of richness to her interpersonal communication. She told me about being an art teacher and then got into being an art therapist taking care of an older adolescent, I was afraid she was going to tell me about some inappropriate
behavior. There is really not a lot that she is talking about in her interpersonal view of the world.

**Dr. Brenner:** Robin, can I ask you to elaborate on that? I thought that at that moment when she brought up the past situation with the art therapy student, I thought you were working from a value that was respecting what she said she wanted to work on.

**Dr. Jarrett:** Perhaps...It was more the demand of this situation. That was going to be more complex than what we could do here. But even if had been a first interaction my goal was for her to leave hopeful and for us to establish a bond, and didn't think that going in that direction was going to facilitate that. I would have made a note that it was something to come back to. Like Jerry I think there is something else we don't know about there always is. In terms of staying with values I am going to take her word for it, that what she wants is out. She wants to move on and I am going to help her accomplish that goal. I was first trained as a behavior therapist and then became a cognitive therapist although I don't think there is much difference. But I would be focused on this is a useful therapy if you end up with your own apartment and you are dating and you still have a relationship with your mother that makes you feel like you have a connection. I would view that as a successful outcome.

**Dr. Godby:** Jerry, would you say that is a difference in values? Robin has clearly articulated some goals and if you think about Bion’s without memory or desire and you were saying you didn’t care if she came or went.

**Dr. Melchiode:** My emphasis is her understanding her situation the fact that she may leave her mother and get into a relationship, I wouldn't necessarily see the behaviors as a good outcome. If she is sitting in her apartment worried to death about her mother not being able to attend to anything else in her life. If the relationship is empty and she is not getting her needs met there.

**Dr. Jarrett:** Oh come on, do you think I’m going to settle for that...you are setting up a straw man.

**Abbey:** The gloves are off...

**Dr. Melchiode:** No, no, no, I am setting up a straw man. I don’t think just by the behaviors themselves, I mean that was listed as the successful outcome. Doesn't necessarily mean that was a successful treatment.

**Dr. Brenner:** I think in listening to the both of you and underlying what Dale was saying. There is something about the acceptance at face value of her goals versus, Jerry, your sense that she may or may not know what her deepest needs and satisfactions may or may not be. Let me ask Abbey, Do you want to say
anything about whether you came away from the meetings thinking that different kinds of values were at work with each of these therapists.

**Abbey:** I felt clearly from both of them that the main value was to help me. Whether it be to help me help myself or to help me achieve what I say I want. It all fell under the same umbrella.

**Dr. Brenner:** This is very much in keeping with the literature that says what helps in psychotherapy is related to common factors. That is a helping person who could offer hope.

**Abbey:** I also felt in both ways an encouragement in that I wasn't going to get better because you help me but because I change, the vehicle being the sessions and the aid. At the end of the day it is my choice about my habits and my awakening about why this is the way it is.

**Dr. Lumpkin:** I'm coming in at the caboose end of this discussion. Both therapists showed me something it is hard to get words around. The first session I thought as I put my self in the patient's place, I thought Robin was trying to help me become objective about myself, that term kept coming back to me. Subjectivity is important but only to get to a place where I could see a relationship between feelings and thoughts and take action on that, the objective perspective through the imagining, advising a friend, stepping out and looking at my situation more objectively than I could on my own. The second time around I felt I would be invited back into my own subjectivity. How did I feel about that? Not to go anyplace, but to leave me with that and see what came up. There were a couple of abrupt turns in the discussion when the question would go off to another place, like what are your goals but I thought maybe because the patient had gone as far as she could with that subjective invitation.

**Dr. Godby:** I would like to ask Robin to say something about how you conceptualize unfolding the patient’s subjectivity and how important is that?

**Dr. Jarrett:** By subjectivity what do you actually mean?

**Abbey:** Is it like the way they view themselves versus the facts of the situation?

**Dr. Godby:** Yes, and let’s take the situation, since I interviewed her I know some of what you were wondering about. That is, there is more to this story than what I am getting. Maybe we don’t have the time right now. I am wondering how you would go about unfolding that and how important it is. The hunch that there is something else happening.

**Dr. Jarrett:** When I was younger I would want to get to it like now or yesterday. What I learned was that it is important to wait because it will come out if it is there. I have this value or trust that it will come out. The cognitive model starts
with the phenomenological model. So it is important for me to understand the way she views herself, the world, and the future. So one of the things I hope I demonstrated, I kept asking her, do I get it. I kept doing what cognitive therapists call capsule summaries to see if my understanding is the way she views it. It is very important for me not to put my own values onto what she is saying. I am always checking to make sure I am in line with her views of herself, the world, and the future. Having said that, there is a paradox. The paradox is in trying to get to what someone said, the objectivity, I think it was Dr. Lumpkin. You are using what you know about herself, the world, and the future. You are 24 and still living with your mother. Most people don’t do this. That is a little out of bounds. So I’m trying to use that when we get to the logical restructuring to see how much she is in tune with that. She was very much in tune with it. She said that is kind of weird, that is ridiculous. She had some insight into that.

**Dr. Melchiode:** What you experienced today is not only a simulated patient but a simulated therapist. I would have never have tried to do all that in one session. I would have spent a couple of sessions hearing about the history of the present illness. Then spent some time hearing about her past life and then after all that was done finding out what her goals were in therapy and then telling her whether it was appropriate or not for this kind of therapy and if it was then explaining to her how I work. The second comment I’d like to make is that she had trouble with her angry. She had trouble being angry with her scattered brained sister who wasn’t on deck to help out and her father who had bailed out on her. These were two very important issues for her. I couldn’t push on that because she was pretty far away from that because she uses lots of reaction formation and solicitousness to care of people. But that would have been an important issue for me because I think her difficulty separating was that something awful was going to happen to her mother. What was the awful thing? I think it had to do with her aggression. I know how I would deal with that, but I don’t know how you would deal with that in a cognitive therapy.

**Dr. Brenner:** Let’s…I think some of this may get addressed as we move on. I want to open up the floor to what should we be recommending and how do we make that decision.

**Audience:** My question is for Dr. Jerry in the psychodynamic session. I noticed sometimes the client said something in a softer language like my father needed a break and you reflected back and used stronger language saying your father abandoned your mother.

**Dr. Melchiode:** I wasn’t aware of that.

**Dr. Brenner:** I heard it in your introduction of the word 'disappointed.'

**Dr. Melchiode:** Yes. I was thinking about that whether I could go with that word or would it be too upsetting for her. But I wanted to see how she dealt with that. I
think that is part of her problem that she can’t disappoint people. And she has trouble getting angry with people who disappoint her. I was prodding that, but every time I prodded that she would give excuses she’d give reasons why the father wasn’t there. He sent nice post cards. She gives rationalizations for others. I knew I had my work cut out in trying to get her to understand why she needs to excuse other people. That was a good pick up. I didn’t realize that.

Dr. Ligocki: Along the line of what you were talking about. My perception of the patient Abbey was playing is that she was highly suggestible, passive dependent, and kind of a pleaser. I am wondering how both of you think that would play out long term in your orientation specifically, and whether you think one might be better at addressing those tendencies than the other.

Dr. Jarrett: I asked her several times do I have it? What was it like? She says positive, positive, positive. I’m thinking to myself that she hasn’t developed the skills to say not good or I wish you had done something else. One of the things I would do is to use the structure of cognitive therapy to begin to teach her to be more assertive. When she says I think it was a great session, I’d say what was good about it? Or I’d say I didn’t like this part, how did you like that? I’d try to start modeling for her. The other thing that I think is very much on the table, like the elephant in the room that no one is talking about is that I am the age and the gender of her mother and Jerry is a different demographic.

Dr. Melchiode: I now have grandfather transferences.

Abbey: Welcome to casting.

Dr. Jarrett: That is going on and here is this woman who hasn’t learned to assert herself and here is this authority figure who says you are disappointed and you don’t know you are. That has an impact. We have 3 different things going on. We have 2 different treatment modalities, have different genders, and different demographics. I think gender is more important than age. You are telling me about your mother. As a female I have knowledge of what a daughter mother relationship is in a way that Jerry can’t know. I’m not saying you have to have the whatever to treat the whatever. Sometimes it can be an obstacle. I think that is a very important thing in the therapy and in our discussion. I think that I’d be trying to make her assertive. She may have an easier time with me, but may have a harder time as she has to assert herself with her mother.

Dr. Godby: I have another question, which is, Robin knows this better than I do. There are some very well developed manuals for assertiveness training. I’d ask Robin and Jerry would you use a manual like this; say a 10 week assertiveness training. What might it foreclose?

Dr. Melchiode: Spoiler alert. Just because I represent a certain kind of therapy doesn’t mean I’d recommend it. You have picked up a very difficult resistance to
deal with. The patient that needs the approval of the therapist; they will say and do anything to get your approval. That is a very difficult resistance to get through because sometimes when you make an observation to a patient like this they will take it as a horrible criticism. They will feel they are not pleasing you or you are disappointed in them. This is one reason you might not recommend psychodynamic treatment. In terms of assertiveness manuals I don’t know about those. If the patient says they’d like to try it. I’d say I don’t know about them, but if you’d like to try it, and if you’d like to come back and talk with me about it, I’m here for you.

Dr. Brenner: I’m going to stop this line for now. We can get back to it. I want to make sure we get to some of the folks waiting.

Dr. Rathbun: I am still back at part one. I thought that both therapists were trying to help this young woman develop some kind of internal freedom. That was a value both of them had. The difference seemed to me that for Dr. Melchiode helping her become her own woman had to do with helping her understand what made it important for her to renounce that freedom to stay caught up and enmeshed in this relationship with her mother. Maybe this is not fair because I don’t understand CBT so well. I thought that Dr. Jarrett’s approach to helping this patient was a skills acquisition approach. That, that would help this woman grow up.

Dr. Jarrett: I do think that we are trying to teach people skills in a different way of taking a perspective in cognitive therapy. But we don’t really know what the mechanism of change is in cognitive therapy or any other therapy. And honestly, we do not know whether cognition is the mechanism of change or is skill building the mechanism of change. There is very little evidence to help you discover that. I personally believe that the jury is still out. I don’t think we have the right technology to test the theories. I do agree with you I was trying to teach her a skill. But I wasn’t trying to teach her the skill to go to U-Haul and get the boxes. I was teaching her how to look at herself in a different way. But I am hoping she will go to the U-Haul.

Audience: I am wondering if folks could speak to the values of other than individual psychotherapy. Is this someone who could benefit from a process or skills group, family sessions?

Dr. Godby: I think the question goes to the heart of the empirically validated treatment movement. I don’t think we have any good evidence that would help us decide with this specific patient. I do a lot of group therapy and our whole practice offers many groups. Clinical experience and wisdom would tell me that Sherry would do well in group. If we put her in a group, the thing Jerry is talking about, her being a pleaser, she can’t please all eight group members. She would be in there and some people would not be pleased and they would be challenging
her. She would need to come to the fore and learn to be herself without being able to please everyone.

**Dr. Brenner:** So I would like to hear some thoughts from the panelists. How would you think about what to recommend, what evidence base would you appeal to? Dr. Godby gestured to this earlier in his introduction about the question of the research literature on randomized trials with manualized therapies and the evidence base that consists of the accumulated wisdom of the clinician and the wisdom that has to do with the patient's own sense of what might work for her.

**Dr. Godby:** There is also something we have yet to speak about, which is the patient's resources. How would she afford this treatment and what would each of the treatments cost her as far as time and money?

**Dr. Melchiode:** When I think of the appropriateness of therapy there are some factors that are more robust than others. One factor that is very important is the therapeutic alliance or working alliance. Is this patient able to step back with me and begin to wonder about what is going on in her mind? I am not sure because of what one questioner brought up about her resistance of the need for approval. Some patients look like they are going to be excellent patients, they are bright talented, but if this is a major resistance this kind of therapy might not go well in the long run. The other question I have is what is like this kind of therapy in her life? It is a lot of work, requires showing up. She has finished a degree program and is serious about her work as a teacher. I give her a check mark for that. There is an important factor that is missing. What is psychodynamic therapy? It is a very intimate relationship over time. Has she had relationships over time? I'm interested in same gender relationships. Has she had a good girl friend? Does she know what that woman is worried about? Does she share concerns with her? Is that woman a person in her own right? We don't hear anything about that with her. It is absolutely missing. What about her relationships with men? But that might not be an ego function. It may be a sexual inhibition. That is why I go back to same gender relationships as an important factor. I am not sure, I don't think I would recommend an insight oriented treatment for her. There was a psychologist who came to speak to us, Sydney Blatt, Ph.D., who teased out the Menninger work. One group was helped and one wasn't. The group that wasn't helped by psychoanalysis was the one with anaclitic depressions and relationships. The group of patients that were helped were the ones who had intrapsychic conflicts and were struggling with guilt and they seemed to work better in this kind of therapy. You may make the case well maybe she is guilty about her aggressive feeling and this may be a harbinger that this kind of therapy might work. On the other hand she has never been able to separate. She cried her whole week through summer camp, sleepovers, but that is one night. She didn't go away to college. She didn't rebel in her adolescence. So this is a woman in mind who has never been able to separate psychologically. There are
people who have separated and then regressed. But I don’t think she has ever separated psychologically.

Dr. Jarrett: So Jerry what I hear you saying is you can’t help her?

Dr. Melchiode: That’s a good point. I don’t only do insight-oriented psychotherapy. I do supportive therapy that is informed psychoanalytically. I see couples. Although I understand things psychodynamically, I might refer her on to someone else to do treatment or may do a more supportive treatment. The study of Menniger’s patients the patients who were anaclitic or dependent did better in more supportive therapies.

Dr. Brenner: So some of the difficulties that all of us struggle with in terms of reading the studies is while there is some body of literature that shows some disorders respond better to a particular kind of therapy, most of see patients who are more complicated like this patient where there is not much literature to direct us.

Audience: It felt to me that there were values in the first approach to follow the goals she presents. But let’s say the patient has more dysfunctional goal such as she is going with an older married man and is hoping to find some help with getting him to leave his wife.

Dr. Jarrett: I think if the patient has a target, will I accept that target? This is where values come into play. I would want to understand why she wants that. I would tell her I’m concerned about that. And that I think that we might want to define what she works on in a broader way. What she sees for herself in the future. One of the things we didn't mention is that cognitive therapy is collaborative. I get a vote. I don’t think I would sign up for that as the target. I would have to be careful that she didn’t view my concern as a rejection of her or a moral stance. As a female I’d like her to take a look at she got together with a cheater, so what will happen down the line. I’d encourage her to talk to other women.

Dr. Brenner: Let’s sacrifice some depth for getting more audience participation.

Audience: I have a question about the health aspects that neither therapy addressed. It seems everyone is fine with the mom in seclusion and 80 pounds overweight.

Dr. Brenner: I think this is a wonderful question because it gets at the underlying values. How does one define what the actual problem really is.

Dr. Jarrett: So at the end I said two things might seem to be in conflict. Maybe we can figure a way to help your mother and in time figure a way your mother can help herself. I want to bring up the idea that she could stay in relationship
with her mother, but that her mother had some work to do herself. That was also what I was trying to speak to in terms of the dynamic between mother and daughter. Men are taught to leave home women are taught to stay. Women are lifetime caretakers of the family that is in front of them; whether it is the babies or the elders. That’s the difference.

**Audience:** I was curious about the countertransference?

**Dr. Godby:** During the break a couple of therapists told me they just wanted to hug Sherry.

**Dr. Melchiode:** That would be the major countertransference. To take care of her and try to do too much for her and then you have repeated the curse again. She still can’t be her own person because you have taken over that…or being angry with her for being stuck.

**Dr. Godby:** I don’t see Connie here, I do see Neil. I think some of the family therapists might suggest a home visit. Maybe knock on the door, talk outside the door with Sherry and her mother.

**Dr. Jarrett:** I would tell her mom needs to come and she’d say mom can’t come because she is too heavy. I’d say what if we call mom. My hope would be to get mom into the office. There was some conversation about resources, there is family therapy, couples therapy but they are expensive so I would try something less expensive.

**Audience:** I have a question about the investment in the goal of the client. The client has the goal of living her own life, Dr. Jarrett, you said you wanted her to get to the U-Haul boxes. I want to know if that is a difference. Dr. Jarrett has more of a focus getting her to do what she says she wants to do. Dr. Melchiode, your goal seemed to be more about understanding and that even if she stays you don’t have an investment in how that part turns out.

**Dr. Melchiode:** I have an investment in her welfare. I want her to be well. I guess the value that I have that if she can understand the demons that are plaguing her then she will do what is necessary to be her own person and to be well. That is what I believe in, if she can do this. I’m not sure she can do that in the kind of therapy I offer.

**Dr. Jarrett:** With this person we have with us today she doesn’t have a diagnosis. I had her do an inventory, QUIDS, for depressive symptoms. She had a 3. She is more anxious than anything else. Her symptoms are pretty low level. She doesn’t have anything I’d call an illness. What she has is a psychological disturbance, stunted growth for lack of a better word. She is more like a high school student than a college student. I would view the goal as having her become an assertive young woman. Part of assertion is getting what you want
and not hurting other people like her mother. That is what I’d focus on and I’d say I have an evidence base for it and I’d steam ahead.

**Dr. Godby:** You say you have an evidence base to go ahead with the assertiveness.

**Dr. Jarrett:** But I’m not going to give her that manual you’re talking about.

**Dr. Godby:** But I have a question. Often in the context of evidence-based medicine some of us who are categorized as growth-oriented therapists can feel like they are being charlatans, because they are not paying enough attention to the empirical evidence bases, because they feel like they don’t particularly apply. You know David Barlow is predicting that in the future growth oriented therapies will occur outside the health care system and that psychological interventions for specific psychological disorders will occur within the health care system. Could you talk about that? Should we feel like charlatans?

**Dr. Jarrett:** I don’t think you should feel like charlatans. I think that we are all faced with this whether we assert that we practice evidence based medicine or not. I think that you and the patient have to have some identifiable things that are going to change. Ed Bordin talked about the therapeutic alliance being made up the bond, which I think of as chemistry, a task, or a method, and you have to have an agreement on the goal. I think we have talked about all those pieces. If you have all that I think you have a strong alliance. So in defining the goal I think you also have to have something that is measurable. It has to have something that will be different at the end of the therapy compared to the beginning of the therapy. It has to have smaller steps along the way that you are actually measuring, because you have to know when this thing is going to be over. One of the things I am worried about with this patient is that she is going to start depending on me too much and not do all the things in life that she needs to do because she is getting the support from me. And so that is something I am going to be checking on as we go along.

**Dr. Brenner:** We have about 5 minutes and I wanted for you, Dr. Godby and Abbey, to wrap up. I think it would be interesting for both of you to think about that now that the patient has had this experience of the two forms of therapy and heard a little bit of the informed consent of what each would be like and you as the clinic director having both of these available. How should the referrer, how should the patient, what goes into making a decision?

**Dr. Godby:** In my mind and in the way I practice I would have been talking to her about group therapy. Partly in terms of the cost and also because of the modeling that would occur. I was conceptualizing the patient as having a problem with integrating her aggression and not being in touch with her aggression. If she was in group she would watch people being angry; they would get mad at her sometimes. She would have some modeling experience and get a chance to
express some of her own anger at group members and the group could provide a
safe holding environment in which she could learn to express as well as receive
anger from others. That is how I would be thinking about her. I would be
concerned about what Robin has mentioned about measuring progress and
outcome. I would consider it a success if she could start to be frustrated with me
in her therapy. If she could be frustrated with other people in the context in the
group and I would theorize that this would transfer to her being able to
successfully experience and express her anger at her mother, her sister, and her
father. We would hope this would lead her to find productive ways to make use of
her aggression.

**Dr. Brenner:** One of the things you, Dr. Godby, mentioned in your opening
remarks was that you see therapy as an emergent process where there are
surprises. We didn’t plan to have group therapy be one of the major options and
outcomes and I think it is a lovely thing to see how that emerges.

**Dr. Godby:** With me on the panel it may not be that big of a surprise.

**Dr. Brenner:** Let’s close with your thoughts, Abbey. If you might imagine how
things might go or from a patient’s perspective what you think is actually helpful
for patients to learn or hear about the different types of therapy that helps them
decide what to do for themselves.

**Abbey:** I don’t know if I am alone in this but I think there is a sense as a patient
coming in that is like, ‘I know nothing, you know everything.’ The idea that it
could be a decision on my end is kind of mind-blowing. Why don’t you just tell
me what is best? You go to the doctor you don’t know anything about
physiology tell me about my body. Fix it. That is empowering but also a little
scary. I think that it is weird, I am an actor but...it is coming through two different
lenses right now. I think for Sherry, what Robin said, taking into account, and I
didn’t even realize this, but in both the rehearsal interviews and in the interviews
here there was something for Sherry about talking to a woman that perhaps
subconsciously there something more comforting. I didn’t know what that was
about and I am realizing that maybe it is about the mother, maybe like I am
getting to have the communication from the woman therapist that I am not
getting from my mother. To take that into the account is new for me to hear. I
think exposure to other people in a therapy group and breaking up her schedule
that she is used to would be liberating having another appointment in the week
with a group.

**Dr. Godby:** Maybe a group with 3 or 4 other women.

**Abbey:** Expressing anger, like oh what? Sherry is an A student. She is a very
curious student. At the end of the day, she would like to know the foundation
underneath. Why? She is in this place when everything seemed fine. I want all of
it. I don’t know if it is healthier for her to speak to woman that she would have a
mother transference to without her realizing it or healthier to speak to a man. I don’t have any answers for you.

**Dr. Brenner:** I think in terms of my sense of how to measure the outcomes this event. The fact that we have Dr. Melchiode at some point expressing his skepticism about whether insight-oriented therapy would help and we have Dr. Jarrett expressing her interest in the maternal transference and the patient wanting both treatments feels to me like a terrific metric of success for this event. Thank you all very much and thank you to the audience for your wonderful questions and comments. I learned quite a bit from your questions and comments, thank you very much.

**Post-Discussion Reflection and Possible Future Seminar**

**Dr. Godby:** David Orlinsky practiced psychotherapy and conducted research on psychotherapy his entire career. In a paper on why he became and continues to be a psychotherapist, he suggests a topic that might be of interest if we could get some of our senior psychotherapists to present on: “**WHY I BECAME AND CONTINUE TO BE A PSYCHOTHERIST**”. I hope a brief quote from Orlinsky’s paper will be inspiring:

**Apologia pro Scientia Sua**

How much the foregoing helps to explain “why I (really) became a psychotherapist” I really cannot say. It seems to me that a more interesting question than why I became a psychotherapist is why I remain a psychotherapist. I never had a full-time practice of psychotherapy and now have just a little because I travel much and am trying (in however much time I have left) to take several long-term research and writing projects to fruition, but I have always felt a strong desire to remain active as a psychotherapist and have tried to be here for those who want to talk with me in that way. Asking why I want to remain a psychotherapist allows me to question my current self in a way that it isn’t possible to question the younger versions of myself (child and youth and young adult), who are available to me now only as half-veridical, half-recreated memories, and as felt presences within me.

Yet this question, now that I pose it, seems just as difficult to answer in its own right, or at least to answer in a way that will not sound strange to many because it is an ontological statement. However, if pressed, I believe I would have to say that I sense something “sacred” in a person (cf. Durkheim, 1915/1965, bk. 2, chap. 8) that I can be near as a therapist. There is a living, radiant being at the core of an individual’s personality (typically obscured by that personality, which is more or less opaque) with which I recognize and can sometimes realize a deep connection. An enlivening vitality resides in that
personal core, not fully knowable in itself (hence always a source of mystery) but knowable in qualified, refracted ways through the responses of the individual that flow from it. If approached with sensitivity, tact, respect, and well-disciplined “philosophical” love (such as Plato advocated in Socrates’ second speech in the Phaedrus), that personal core of an individual is invited to reveal itself more fully and may be willing to meet in the fundamental way that Buber (1965) described as “interhuman” and Charles Williams (1938/1984) described as “co-inherence.”

I think that the great and complex work of psychotherapy, however approached, is to challenge carefully and to help remove the obstacles in personality that obscure an individual’s vital core and restrict its well-being. All theoretical orientations, in their varied wisdom, offer words and deeds and images that can help in this work. Sensing which will work, when, and for whom—and knowing how to do them—is the essential art of psychotherapy. Providing facts to inform the practicing therapist’s intuition is the part of the science of psychotherapy.

Maybe there is something “religious” about this credo, but if so, I mean it to be religious in the secular, cultural sense defined by Durkheim and the existential, ethical sense defined by Tillich and Buber. In that restricted but important sense, I would even say that doing psychotherapy provides an opportunity to worship, to celebrate our fundamental and energizing interdependence. There are moments in therapy when this energy and human beauty meet (as they do in other forms of creativity and love), and where, when they meet, a healing influence resonates in all directions, into the therapist as well as the patient, and to others closely involved in the patient’s life. That seems reason enough to remain a psychotherapist—even if (as for me) one no longer needs to do so.

Envoi
Surely more could be said, but an end must come; I will just quote some words of Erik Erikson (1950, p. 98) that I didn’t well understand when I was younger. About the challenge of my present age, he wrote:

It is the acceptance of one’s own and only life cycle and of the people who have become significant to it as something that had to be and that, by necessity, permitted of no substitutions. It thus means a new different love of one’s parents, free of the wish that they should have been different, and an acceptance of the fact that one’s life is one’s own responsibility. It is a sense of comradeship with men and women of distant times and of different pursuits, who
have created orders and objects and sayings conveying human dignity and love. . . . Aware of the relativity of all the various life styles which have given meaning to human striving, . . . he knows that an individual life is the accidental coincidence of but one life cycle with but one segment of history; and that for him all human integrity stands and falls with the one style of integrity of which he partakes.