# Erich Fromm's Place in the Interpersonal Tradition
## Erich Fromm Lecture 2017

Sandra Buechler

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> »I would compare us with a patient on the critical list. In other words, there is the possibility, and if I let only my thinking speak, perhaps even the probability that we are headed for the megamachine or for the technotronic society, and for the extinction of individuality, and that means for culture as we have known it. But I also believe there is a great probability that we're headed for thermonuclear war. But I think all this is not a necessity. That there is so much in a protest longing for life, awareness of what's going on, that there is a possibility to change our course. And what I mean is, it doesn't matter so much whether we go 10 miles or 100 miles in another direction; what really matters is whether we change the direction. The faster one goes in the wrong direction the faster one gets into catastrophe.« (Fromm 2012b, pp. 9–10.)

Erich Fromm's humanistic message is as pertinent in 2017 as it was in the late 20th century. His voice rang out against a too ready adaptation to society's dictates. He warned us that we must remain alert to the possibility that societies, like individuals, can lose their way. Even his titles are enough to inspire: *The Sane Society* (1955a), *The Revolution of Hope* (1968a), *To Have or To Be?* (1976a), *In the name of life* (1974b), *For the Love of Life* (1983a), and so many others. In many beautiful passages, Fromm articulated his vision of health, which always included concern for others. Here is just one example. »Indeed we must become aware in order to choose the good – but no awareness will help us if we have lost the capacity to be moved by the distress of another human being, by the friendly gaze of another person, by the song of a bird, by the greenness of grass.« (Fromm 1964a, p. 150.)

In this paper I suggest that Fromm's anti-adaptation passion is an important aspect of his contribution to the Interpersonal analytic tradition. It can be seen as a thread that runs through his writing on social character, analytic training and treatment, the nature of love, the role of work in healthy living, and the human values of truth, integrity, freedom, self determination, and self realization. I comment on Fromm's attitude toward adaptation and other issues, as they defined his place among the early Interpersonal analysts. More specifically, I contrast his

approach with some of the writings of H. S. Sullivan and Rollo May, two other major theoreticians. Interestingly, Sullivan, Fromm, and May each sought to fuse analytic theory with another framework. May never lost his religious underpinnings, as he added Adlerian and other analytic disciplines to his orientation. Fromm sought to connect Marxian and Freudian thinking, in a unique blend that honored the emphases of each. Sullivan's theoretical leanings borrowed from American philosophical pragmatism in an interplay with analytic theory.

I think it is fair to say that each formulated a creative solution to the problem of integrating two disciplines. In each case what resulted is a new and innovative treatment method. The disciplinary fusions each attempted called for important deviations from classical technique. I will suggest some of what I think Sullivan, Fromm, and May have in common with each other, as well as some differences.

**Three Outsiders**

I believe that May, Sullivan, and Fromm had important »outsider« experiences, that played a significant role in their personal and professional systems of belief.

May and Sullivan each had what can be called a nervous breakdown which became, arguably, personally and theoretically formative. May's breakdown occurred when he was 23, during his lonely experience as a missionary teacher in Greece. Sullivan's break was in late adolescence. Sullivan, an only child, had an extremely isolated early life, on an upstate farm, and is thought to have been unable to make the transition to an Ivy League college when he was admitted to Cornell at 16. In his second term he failed all his major subjects and was suspended. The only book Sullivan ever published was titled »Personal Psychopathology,« and, though many have argued about the degree to which it is autobiographical, I think all would agree that Sullivan first learned about serious emotional disturbance from his own life experience. As we know, much of that experience was shaped by his being gay, in an analytic culture and a wider culture that pathologized and stigmatized homosexuality.

Fromm, like May, suffered from tuberculosis. In 1931 he left Frieda and made his way to Switzerland for treatment. Aside from the separateness inherent in this experience Fromm faced other kinds of isolation. In his biography of Fromm, Lawrence Friedman (2013, p. 278) described him as marginalized many times over: »As a Jew who often resided in a dominant Gentile culture, as an academic on the outskirts of academia, and a psychoanalyst free of Freudian orthodoxies, Fromm always empathized with marginalized segments of society. Indeed, he often considered himself to be on the outside looking in.«

My point is that I wonder about the role of a personal experience of very severe loneliness in May's, Fromm's and Sullivan's later political and analytic orientations. Sullivan developed a theory of the primacy of interpersonal relations, and said about loneliness, »I, in common, apparently with all denizens of the English-speaking world, feel inadequate to communicate a really clear impression of the experience of loneliness in its quintessential force« (1953, pp. 260–261). Of course our theoretical approaches always have some personal derivations, but can we say that the in the development of the thinking of May, Fromm, and Sullivan personal acquaintance with highly disturbing loneliness played an especially important role?

**Adaptation and the Interpersonal Analyst**

As an introduction to this section, I would like to read a few lines from a poem, that, I believe, captures Fromm's fighting spirit. It is by Dylan Thomas, and titled *Do not go gentle into that good night*.

> »Do not go gentle into that good night,
> Old age should burn and rave at close of day;
> Rage, rage against the dying of the light.«

At the end of the poem, Dylan Thomas makes his demand clearer still.

> »And you, my father, there on the sad height,
> Curse, bless me now with your fierce tears, I pray.
> Do not go gentle into that good night.
> Rage, rage against the dying of the light.«

The poet brings me to a place already familiar to me, from the writings of Erich Fromm. Sometimes it is *rage* that powers the fight against the forces of darkness. Dylan Thomas asks his father for a fierce and unforgettable legacy, a fiery source of inspiration for the rest of his life. I think this is exactly what Fromm left for us, his theoretical heirs.

But it does not give us a clear path. The role of adaptation in health in general, and in treatment in particular, is an extremely complicated issue. Like much else, our own tendencies are lived out with our patients, often outside our awareness. I would like to note that it is very hard to write about these subjects without resorting to binaries. Of course, none of us always adapts or always fights for change. More specifically, no one functions in relationships in a clear cut way that can be captured in a phrase. Yet I have come to believe that there are some fundamental alternatives that recur in many walks of life, and our stance toward adaptation is one that has special relevance clinically.

In my mind it is fortunate that this issue plays out at so many levels in sessions with patients. For example, in a therapeutic relationship, two people may be mainly adapting to each other, to a great degree, and only occasionally fighting for changes in how they operate. Another treatment pair may be negotiating the terms of the relationship on a constant basis. Most often these inclinations are not the result of conscious choices. They are part of our signature styles of coping with the human condition. Products of our personal and cultural life experiences, they are often reinforced in the professional circles we choose.

This gives us countless opportunities to work on one of life's most pervasive dilemmas. Every time we adapt to the circumstance of being in a relationship with each other, and every time we fight for change, we are saying something about the importance of adapting/fighting. Again, I am using a shorthand, since most interactions are at neither extreme. But, overall, I think it is possible to characterize a relationship (treatment or otherwise) as mainly prioritizing harmonizing or clashing. To the extent that the human condition dictates some challenges as unavoidable, we meet them in sessions, just as we do everywhere else. How we meet them can have great impact on both our lives. Whether or not we are aware of it, clinicians are »more simply human than otherwise,« (Sullivan 1954) and, therefore, inevitably tilted toward

or away from adaptation. But how does this affect our ability to offer our patients an open invitation to explore their own inclinations? In other words, what happens to the patient's *self directed* inquiry if our own attitudes about adaptation inevitably shape the treatment exchange?

Elsewhere (Buechler 1999) I have spelled out the belief that, while neutrality corrects for some untoward influence, it can also neuter us. In my view, in order to help patients fight for health, we can't avoid taking passionate and non-neutral positions. Theoretically, it is certainly possible to be passionate while neutral, but, in practice, it is hard to sustain when patients present the ultimate challenges inherent in being human. For example, a patient struggles to bear the death of her life's partner. What vision of the work of mourning, and of my role in facilitating it, do I bring to the session? If I hold myself to a standard of neutrality, how might this affect my ability to help my elderly patient live with indignities, or my traumatized patient carve out a future? On the other hand, without some standard of neutrality, how will treatment differ from indoctrination? I would argue that many ways to understand our roles can be valid, but, whatever we would like to believe we are doing, we still have to contend with patients who see themselves as coming to treatment to get help coping with what is happening in their lives.

Two of my most influential clinical forbears represented somewhat different attitudes about adaptation as a way of coping with life. In much of his work, Erich Fromm (1941a, 1950a, 1955a, 1968a) championed challenging society's dictates. Overall, he brought a skeptical eye to its expectations, and advised others to do the same. In contrast, H. S. Sullivan (1953, 1956) quite frequently struggled to help his patients develop socially sanctioned styles of dealing with »problems in living,« although in some areas, such as the issue of homosexuality, his attitude was harder to characterize. As Wake (2010) delineated, sometimes Sullivan championed questioning society's dictates, especially regarding sexuality, but at other times he seemed willing to support and even implement them.

But I think Fromm left a clearer legacy. In *Psychoanalysis and Religion*, (1950a) Fromm is explicit about the issue of adaptation to society. He describes (pp. 73–74) two basic attitudes clinicians can have: »We find that according to one conception adjustment is the aim of analytic cure. By adjustment is meant a person's ability to act like the majority of people in his culture (p. 73).« Fromm goes on (p. 74) to describe a second view, in which »the aim of therapy is not primarily adjustment but optimal development of a person's potentialities and the realization of his individuality.« Fromm leaves no doubt that the second attitude describes his point of view about healthy living and about the clinician's task.

My understanding is that Fromm's position stems from his conviction that societies can be unhealthy, as well as his humanistic beliefs about the meaning and purpose of life. Adjusting well to a disturbed society could not be healthy. Of course this point of view presupposes that there are universal norms for psychologically healthy living, against which a specific society's mores can be measured. On this point, as well, Fromm couldn't be clearer (1950a, p. 74). »Here the psychoanalyst is not an ›adjustment counselor‹ but, to use Plato's expression, the ›physician of the soul.‹ This view is based on the premise that there are immutable laws inherent in human nature and human functioning which operate in any given culture.« Fromm goes on (p. 76) to name these laws. Human beings must strive to recognize the truth, to become in-

dependent and free, to be an end in themselves, (rather than a means to the purposes of others), to relate lovingly, to distinguish good from evil, and to listen to the voice of their own conscience. It follows that each human being should strive toward the fulfillment of these goals, and that clinicians should help their patients in this process.

Many (Burston 1991; Funk 2002) have commented on the roots of Fromm's viewpoint in his studies of societies that supported the rise of Hitler, as well as his more general religious, philosophical, historical, and other researches. I feel that Fromm's viewpoint has direct implications for how we live the fundamental challenges that face all human beings, such as bearing aloneness, mourning, aging, suffering, uncertainty, humiliation, hardship, and helplessness. While cultures shape meanings that attach to each of these challenges, I believe they exist wherever there are human beings.

Fortunately these challenges also make appearances in clinical sessions. This allows the clinician to live them with patients, rather than merely discuss them when they arise in the content of the material. I believe that frequently they form a subtext of the work, often outside the awareness of both participants. In a sense they constitute a dialogue about what it means to be a human being, and live a human life.

Problems arise when the music is too disparate from the words. That is, if the clinician's words tout the value of individual self expression, but his or her actions pressure patients to adapt, the result is likely to be a confused and ineffective dialogue. The same holds true for supervision, and other forms of communication.

But, while Fromm's voice is probably the strongest in what I call my »internal chorus,« Sullivan's makes frequent appearances. As I have already indicated, Sullivan sometimes privileges adaptation, as a way to avoid the ravages of intense anxiety. Here are his own words: (1954, p. 239). »The brute fact is that man is so extraordinarily adaptive that, given any chance of making a reasonably adequate analysis of the situation, he is quite likely to stumble into a series of experiments which will gradually approximate more successful living.« In treatment we facilitate this process, largely by helping the patient become aware of obstacles to fully grasping his interpersonal situation. At some time, these obstacles, or security operations, were instilled in order to avoid anxiety, but now they are standing in the way. Sullivan's optimism about our fundamental drive toward health leads him to believe that clearing away obstacles is often all that is necessary (1954, p. 239): »[…] work toward uncovering those factors which are concerned in the person's recurrent mistakes, and which lead to his taking ineffective and inappropriate action. There is no necessity to do more.« In my view, while Sullivan's stated beliefs and clinical approaches were complex, and sometimes contradictory, both Fromm and May more consistently took the side of questioning a too-ready adaptation to society's dictates.

Fortunately, the treatment dialogue frequently offers both participants a platform for playing out, learning about, and perhaps modifying our inclinations toward or away from a ready adaptation to expectations. Not only does this subject often play a role in the explicit dialogue, but, I believe, it plays an even greater part in what remains implicit. A session can resemble a seesaw, in which the participants lean toward or away from adapting to each other. For example, I notice that a patient is using a phrase from our previous sessions. Noting that he tended

to dismiss his painful, disappointing experiences I coined the phrase that what happens to him is »no big deal.« In a subsequent session he used that phrase to characterize what happened with his wife. I played with the phrase, exaggerating it, essentially saying that the quality of his life is no big deal. Neither of us may be consciously focused on the ways we are adapting or differing but, from my perspective, he is implicitly adapting to me by using my words, and explicitly adapting to his wife by going along with what she wants. For my part, by highlighting the long term costs of adaptation, I am taking a different position. That is, when he said his compromise with his wife was »no big deal« I could have smoothly *adapted to him* by saying nothing, or by expressing, in some form, the view that adaptations are a necessary part of being in a relationship. When I (somewhat playfully) said that the quality of his life is no big deal I was, in effect, saying that I would not, quietly, go along with his attitude. I was *enacting with him, as well as explicitly expressing, the value of non-adaptation*. While I was not aware of it at the time, in retrospect, it seems to me, my inclination owes Fromm a debt.

**The Role of Anxiety in and Outside Treatment**

I see similarities in the thinking of Fromm and May, in many clinically relevant areas, that are somewhat related to the issue of adaptation. For example, both saw an important role for anxiety in the process of healthy psychic growth. While Sullivan also admitted that learning occurs along what he called a »gradient of anxiety,« he constantly cautioned against allowing the patient to develop too much anxiety. His students taught me to monitor signs of anxiety in the patient, and intervene if it seems to be escalating. The spirit of this seems very different from what I read in Freud, May, and Fromm, who seem more comfortable with the necessity for the patient to experience anxiety, in order for the defensive and resistive processes to occur, and, eventually, for their analysis to take hold. For these writers, efforts to delimit anxiety in the patient would block the analysis of defense, and be therapeutically counter-productive. For example, Fromm wrote (1955a, p. 196), »[…] the psychic task which a person can and must set for himself is *not to feel secure, but to be able to tolerate insecurity, without panic and fear* (italics in original).« I hear May as agreeing with this notion, since, as Robert Abzug suggests, May's personal experience taught him that »with the anxious facing of death came the faith to live«. For me, this is a crucial point. More generally, do we see human beings as profiting from encounters with anxiety, or is it our task to help prevent them, or at least, ameliorate them? Elsewhere (Buechler 2010) in a paper titled »No pain no gain? Suffering and the analysis of defense,« I outline three attitudes toward pain and suffering, and their effect on one's conception of the analyst's role and, more specifically, on the degree of emphasis on the analysis of defense. Briefly, I think Fromm most often votes on the side of questioning defensive maneuvers to avoid anxiety, since, like May, he sees anxiety as unavoidable in any process of change and, more generally, in facing the dilemmas inherent in the human condition.

**The Interpersonal Analyst and Society**

Fromm argued passionately for psychoanalysts' active involvement in politics. In *In the Name of Life: A Portrait Through Dialogue* (1974b, pp. 88–117) he pleads (p.116):

> »[…] if we love our fellow humans, we cannot limit our insight and our love only to others as individuals. That will inevitably lead to mistakes. We have to be political people, I would

> even say passionately involved political people, each of us in the way that best suits our own temperaments, our working lives, and our own capabilities.«

There is clearly a greater emphasis on an ethical dimension in Fromm and May, than in Sullivan. I see Sullivan as the ultimate pragmatist, working to help his patients become better able to fit to society and have successful, secure relationships. He was less focused on what was right and wrong than on what was acceptable interpersonally. Sullivan was much less focused on the potentially negative effects of society on the individual, and the dangers of the need for external approval. Whereas Fromm and May espoused values that are universal and supersede those of any particular society, Sullivan was content to help patients adjust more successfully within society as it is. Fromm was explicitly critical of societal trends that focus us on having rather than being. In what I hear as a similar tone, May (1953) described »other-directedness« as typical of many in modern western culture whose drive for approval can make them into »hollow« people, lacking in inner, guiding, orienting values and strong convictions.

**Erich Fromm's Passionate Legacy**

One of Erich Fromm's books is entitled, *Greatness and Limitation of Freud's Thought* (1979a). A theory's strengths and limitations can be intricately linked. I think Fromm's passion has left us with an extremely valuable but also complicated legacy. I am reminded of T. S. Eliot's great poem, *East Coker*:

> »There is, it seems to us
> At best, only a limited value
> In the knowledge derived from experience.
> The knowledge imposes a pattern, and falsifies,
> For the pattern is new in every moment
> And every moment is a new and shocking
> Valuation of all we have been.«

Theories impose patterns, and therein often lay their strengths and inherent problems.

Erich Fromm epitomizes the strengths of fervently championing one's theories of health. Just as he deftly summarized the greatness and limitations of Freud's thought, his own approach had its invaluable benefits and some challenges for adherents. In my view it is vital to retain his fervor, but integrate it with adequate humility about the limitations inherent in any treatment approach. Elsewhere (Buechler 2004) I discuss the effects on the clinician of practicing with Fromm in mind. Briefly I suggested that, for the clinician, Fromm

> »[…] gives us a strong sense of purpose, hope, courage, and integrity. We feel we are fighting the good fight, on the side of the angels. On the positive side this can contribute to our stamina, holding us steady during periods of treatment stasis or regression. It may help us tolerate the patient's confusion, doubt, skepticism, even contempt. We have conviction in our mission. We can feel centered and whole.« (Buechler 2004. p. 169.)

Every time I re-read Fromm his passion stuns me. Can anyone read his insistent prose without feeling profoundly affected? Here is just a brief sample of Fromm's statements about emotional health and the clinician's task.

1. Fromm was absolutely clear about the goals of treatment: »The aim of the analytic process is to help a patient grasp his hidden total experience.« (Fromm 1992g [1959], p. 100.) In this, I believe he didn't fundamentally differ from other analysts, but his vision of what is »hidden,« or dissociated, was somewhat broader. It includes becoming aware of the »filter« that comes with membership in a particular culture. Thus, for Fromm, health includes an awareness of how society has affected our perceptions.

2. Health also includes an awareness that »everything is inside us – there is no experience of another human being, which is not also an experience we are capable of having« (Funk 2009, p. 22). I see this as similar to Sullivan's one genus postulate, that »[…] everyone is much more simply human than otherwise« (Sullivan 1953, p. 32). It is a profoundly humanistic statement.

3. The analyst forms a conception of who the patient was meant to be if he or she were not distorted by life experiences and resulting defensiveness (quoted in Funk 2009, p. 30). In other words, armed with a theoretical vision of human experience, we can imagine a healthier version of the patient we have before us.

4. Essentially, as I understand it, we help people by relating to them in a very direct way, so that they feel less isolated, and by avoiding intellectualization. »[…] the task of analysis is that the patient *experiences* something and not that he *thinks* more« (Fromm 1992g [1959], p. 118; italics in original). We should not withhold what we see, out of concern that the patient isn't ready to hear it, because that would not fully reach him. In Fromm's words, when you think you see something, you have to »stick your neck out« (quoted in Funk 2009, p. 36) and say it. My way to describe this (Buechler 2004, 2008) has been that the analyst has to have the courage to voice inconvenient truths. Training (including one's personal analysis and supervision) should enable us to become radical truth tellers. Ideally the patient leaves the session with an exhilarated feeling of increased vitality.

5. Fromm ardently championed the value of knowing the truth. For example »[…] this is the hope for the human race, that in fact truth makes us free, as the New Testament says (John 8:32)« (Fromm, 1992g [1959], p. 85).

6. We must fight against alienation, as individuals and as a society. Here is how Fromm (according to Funk 2009, p. 12) defined alienation:

> »By alienation I project an experience, which is potentially in me, to an object outside of me. I alienate myself from my own human experience and project this experience onto something or somebody outside, and then try to get in touch with my own human being, by being in touch with the object to which I have projected my humanity.«

7. For Fromm health is a relative absence of dissociation. He generally preferred to use the term dissociation, rather than repression, for what is not conscious. In his paper, »Dealing with the Unconscious in Psychotherapeutic Practice« (1992g [1959], Fromm explains that the repressed refers to what was conscious and now is not. In contrast, the dissociated can refer to what was conscious and what was never conscious (cf. ibid, p. 83). Thus it is a more inclusive term.

8. Health includes the capacity to embrace life's contradictions, for example, that we are, and,

in another sense, we are not, responsible for others.

9. In health, we experience life directly. We feel our feelings, rather than *look at* our feelings from the outside. We are in our lives, rather than ego invested and worried about our image. This eliminates the problem of anxiety.

> »If a person has really woken up – if a person has really seen the reality of his Self, of his Ego –, then indeed there is no need to compensate for anxiety anymore, because there isn't any.« (Fromm 1992 [1959], p. 98.)

10. Another statement is that we are healthy to the degree that our life oriented passions (passion for love, interest in the world, in people, in nature, in reality, pleasure in thinking, and artistic interest ) prevail against »[…] the archaic passions: intense destructiveness, intense fixation to the mother, and extreme narcissism« (Fromm 1991c [1964], p. 19).

11. Fromm (according to Funk 2009, p. 48) advocates focusing on the conflict between the patient's child like irrational passions and his or her more adult rational strivings. The picture he paints is of the analyst paying great attention to this conflict. Fromm sees other approaches as inadequate if they address only the child or only the adult. In treatment (p. 49) we help the patient more fully inhabit this conflict with vivid, evocative images and experiences in the session. As Fromm put it we »help the patient be unhappy rather than to encourage him« (1991c [1964a], p. 34). That is, since suffering is a part of life, Fromm sees the direction of health as facing it, rather than avoiding it.

12. It is important to Fromm that we have a vision of how our lives could be. We need a dream, to augment our passionate pursuit of health.

**Fromm's Legacy in My Own Work**

Fromm has a permanent place in my own »internal chorus.« That is, he is a kind of professional ego ideal. Particularly when my stamina wavers, thinking of him lifts me.

What my internalized Fromm can do, more than any other theoretician, is inspire me to engage in treatment passionately. Could an author have this powerful effect without his firmly held convictions? Could someone with less conviction about his vision of health nevertheless profoundly move, ballast, deeply inspire? Speaking for myself, I doubt it. But I do believe it is important to be mindful of the complicated challenge of practicing passionately, with devotion to life, yet also with adequate appreciation for the limited impact of any treatment approach.

Human beings share a capacity to respond to the world with wonder and joy, as well as the potential to be overtaken by fear, anger, shame, or guilt. What constitutes successful coping with this legacy? In short, what are some conceptions of psychological health that could inspire a life enhancing treatment?

**My Own Integration of Interpersonal Influences**

Aside from being among the first interpersonal psychoanalysts and founders of the W. A. White Institute in New York, what do May, Fromm, and Sullivan have in common? Like many others in their era, they had the power of believing they understood emotional health and pa-

thology. When they were writing, the wider culture had its heroes and villains, and the rest of us could confidently tell them apart. Good was bound to triumph in the end. American »can do« fostered plucky determination. Growing up in that era, I was profoundly affected by its values. More than I realized at the time, I was primed to be inspired by the legacy of these great clinicians. Many of their students were fiercely committed to an interpersonal tradition. With passionate fervor they sought to spread the word.

My contention is that strong convictions can lend strength to me as a clinician, but also have their dangers. »Knowing« what health is can operate like a compass. An analyst's sure sense of direction often inspires the patient's faith in the process. Clearly the resulting power can be misused, and our field's history is littered with examples. Of course, this is just as true of orientations other than the interpersonal.

I feel that Fromm provided for me, and still provides, a much needed antidote to the more removed aesthetic of the Sullivanian expert. For Fromm we are here, in our profession and, more generally, on this earth, to promote life passionately. I need Fromm. Very often he lends me courage and stamina. He provides a forceful ballast against my becoming too much of a cool, Sullivanian observer. On the other hand, I understand that Fromm can persuade me to be too forceful an advocate for fuller living, perhaps sometimes making it hard for some of my patients to express their depressive, hopeless, regressive urges.

Fromm is so different from Sullivan, that it is hard to integrate them into an interpersonal point of view. And yet, I think it is ultimately very fortunate that we can draw on both Sullivan and Fromm. Where Sullivan warns us to beware of evoking too much anxiety in the patient, Fromm challenges us to challenge our patients. Fromm exhorts us to have the courage to leave our own comfort zones, in order to help patients outgrow constraints that have limited their ability to fully live. He adds a note of urgency. Clinicians should have a sense of purpose about our mission to overcome stagnation. Only honesty and directness are respectful toward the patient. Fromm had a vision of who the patient could become, and a passionate dedication to facilitating growth, as he understood it.

Sullivan's caution can be tempered by Fromm's zeal, and vice versa. Where Sullivan worried about whether a patient was ready to hear something, Fromm confronted, believing the truth really sets us free. I agree with Hirsch (1998, p. 510) when he says that, »Analysis without a touch of Fromm's authenticity and romanticism is a far less rich enterprise.«

I have often played with the idea that Sullivan and Fromm recapitulate the old tension between Apollonian and Dionysian cultures. The cooler, more cognitive Apollonian approach emphasizes achieving greater clarity about one's interpersonal patterns, while the hotter, more passionate Dionysian empowers movement and accelerates change. For me, at least, one without the other is incomplete. Fortunately, we can draw on all of our forbears, as we face the daunting challenges of being a clinician, a citizen, a participant in the human community today.

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