Existential "Psychotherapy": Special Considerations in Working with Young Men

Miles Groth

Existential therapy is a form of treatment provided by clinical psychologists in the tradition of existential psychotherapy. In its modified form as existential therapy, it is an especially effective means of working with young males. The paper discusses current problems facing providers of treatment with young males, the existential tradition in clinical practice, unique features of male disposition and development, and several examples of how the existential approach can meet the needs of young males.

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I. First, I must say a bit about three terms in the title of my presentation today: men, psychotherapy (in scare quotes), and existential. Only the last—existential—might be problematic for a general audience, but all three ideas are in need of interpreting at this time in the cultural history of the States.

Currently, men are experiencing a period of remaking themselves in the wake of important changes in social life, including challenging concepts of gender and masculinity, redefining our relationships with women and other men, and the disappearance of many jobs for uneducated men. Last year, while on sabbatical I addressed these issues in discussions and seminars in Australia, and earlier in Canada and here in the States. I will not have much to say about these matters today, but you will see that the changing contemporary status of being male is related to what I will have to say about working with boys and men in counseling and psychotherapy.

Next comes the term psychotherapy. The field is in the midst of an identity crisis. The public tunes in on television to watch celebrity shrinks (Dr Phil, Dr Drew, like Dr Ruth and Dr Joyce Brothers before them), Christian counselors, life coaches, and "interveners" who do not resemble the formally attired classic psychoanalyst (three-piece suit or simple frock with a string of pearls), the white-coated psychiatrist of *One Flew Over the Cuckoo's Nest* fame, or the indifferent technician in Frederick Wiseman's horrific documentary of a life and "treatments" in a Massachusetts hospital for the criminally insane during the 1960s, *Tititcut Follies*. Even more important than appearances is the move away from the long-term talking cure to the use of prescription drugs (authorized by medical colleagues) to manage the symptoms of any of a bewildering, ever-increasing number of coded diagnoses. You would recognize most of the chemical agents by their brand names (Xanax, Prozac). On television, patients are portrayed and provided with drug treatments on television in advertisements created by sponsoring pharmaceutical companies.
The most popular disorders are OCD, PTSD, ADHD, bi-polar disorder, and schizophrenia. (Letters are easier to pronounce and obscure what that indicate.) Increasingly, the psychotherapist's role is to "support" what the chemical agent is causing to change in the physiology of the patient's brain and nervous system and elsewhere in her body where the person is said to reside. Of course, supporting a chemical process and supporting a person are not the same thing. Where the mind is in all this—well, never mind.

Evidence is conflicting about the effectiveness and efficacy of treating mental illnesses medically or with or without conversation as an adjunct. The precise ways in which so-called psychotropic drugs work (drugs that are supposed to change the mind, the self, or the personality) are not understood. Nor do we understand just how and why certain kinds of conversations are therapeutic.[1]

No matter. Many such conversations go on every day in the consulting rooms of psychotherapists of the many schools or modalities of psychotherapy. Although it began as the invention of an

Austrian neurologist (who predicted that his invention for the treatment of illnesses of the nervous system—psychoanalysis—would be replaced by treatments using drugs), the "talking cure" became the basis of all of the modalities except some (not all) of the purely behavioral sort. Psychiatrists now rarely study psychology and in their four-year residency typically are required to take only a six-week-long course on cognitive-behavioral therapy (CBT) as mandated by the American Psychiatric Association.

Meanwhile, outside of the hospital setting, illness-care insurance provides less and less in the way of compensation for psychotherapists representing any of the several hundred named modalities. But because insurance readily covers visits to physicians (not only those who specialize in psychiatry), nurse practitioners, and other providers overseen by medical professionals (in the broadest sense), most disordered, disabled, suffering people are diagnosed and treated with drugs after a brief interview with their provider. Not to belabor this much longer—but: it is important to bear in mind that the sort of work I want to talk about today is quite different than what is done by most medical doctors and their proxies. Therapy is also quite different from the services provided by social workers, who often coordinate their efforts with medical healthcare providers but are in the business of informing, educating, and advocating for those entrusted to their care. It is interesting that many counselors and psychotherapists today begin with training as social workers. This is likely because the MSW can easily be licensed and find a place in the world of insured healthcare.

Having said a bit about gender (men) and a profession (psychotherapy)—and I expect there will be discussion and questions about what I have already said—I want to move on to my theme proper and say something about that third word—existential—before talking about working with boys and men as an existential therapist. (Notice I have replaced the word psychotherapist with therapist. I'll soon explain why.)

Given the changes in the profession I have mentioned, there continue to be individuals who report experiences that trouble them a lot and a curious bunch of individuals who, oddly enough, are drawn to talking with them, working with them, caring for them—or as we say "treating" them. We call interactions between one of each therapeutic when the distressed person claims she feels better as a result of the interaction. What goes on between them is fundamentally emotional but has a cognitive component. After all, talk is all we see in a therapeutic relationship and using words reflects among other things thinking (the cognitive element). The first group of individuals are said to "have" a psychological disorder (a mental illness, even a disease of the brain) that can be contracted and experienced by anyone—rich or poor, barely out of infancy or in old age, male or female. Following the medical model, they are called patients. Reflecting a business model, they are sometimes called clients. The second group is comprised of those weird folks who gain a certain gratification hanging out with such people but only in certain settings. They are called psychotherapists. They have kept company with psychiatrists and a variety of counselors and social workers.[2]

II. The first patient I saw, in 1976, when I had completed my first master's degree was a late teenage boy brought by his parents to a small town general hospital's outpatient mental health clinic.

For some reason, after interviewing me about interning there as a would-be psychotherapist, the director of the service turned the young man over to me under his supervision. Briefly, I sat alone with the lad in the office provided us while his parents waited in the—well—waiting room just outside. He returned a half-dozen times. A week or so after what turned out to be our last talk, his mother telephoned to say her son was doing much better in school and at home. She was now not worried about him, as she had been. He was not as sullen, she said. He was talking more and seemed to be enjoying school again.

I had *no* idea what I had done to accomplish this miracle, but I reported it to the director of the service and added the mother's comments to the case notes I was required to keep.

Since then, I have spent quite a lot of time working with young men and women in various settings. In the 20 years after I saw my first patient, I sat across from male patients in various settings, institutional and private. For a while I shared office space with a psychiatrist on Washington Square West. In other settings I saw young males (most of them Black and Hispanic) who were inmates from Riker's Island; snobby and wealthy (mostly White) adolescents at a private school in Manhattan; clinic patients seen under supervision at two psychoanalytic institutes where I was in training, and students in counseling services at three other colleges before coming to Wagner in 1994. In my office here and out on campus I have talked informally with many students, male and female, as their teacher and academic advisor but never officially as their counselor or therapist. A lot of that would qualify as counseling though. Much of it was therapeutic.

In short, after forty years I've lost count of the number of young men I have spoken with as their therapist—official or unofficial—but I have learned that working with them (I prefer the term person to patient or client) demands a set of aptitudes, skills and attitudes that are unique to working with that diverse population. And that brings me to the topic of my presentation which is the approach I take and teach.

Let me set the context for talk about existential therapy. General skills are required across the board, no matter whether the therapist is male or female and the other is male or female, regardless of their respective ages, background of experiences, or whether therapy takes place in a semi-rural setting (such as where I began) or in an urban center (like New York City where I have lived and worked since 1980), in a clinic or hospital (such as the one where I taught residents in psychiatry for a year), a private consulting room, or campus counseling center—all places where I have worked. These skills were formalized during the 20th century.

In the brief history of the psychotherapy profession—I prefer to call it a vocation or calling—at first only men practiced it. This quickly changed when very soon after its inception psychoanalysis attracted as many women as men among its practitioners. Today the mental illness-care field is dominated by women psychotherapists, counselors, and social workers. Regardless of sex or theoretical rationale—how psychotherapists explain and justify what they do—all of them are expected to show in their work capacities for practice that reflect certain features of personality: empathy, patience, and an irrevocable respect for the privacy of the other. They are also expected to be fairly well psychologically themselves, no matter how difficult it is to define just what psychological health is, and knowing that such health is acknowledged to be the expected result

of psychotherapy. Freud spoke of mental health as the capacity for loving and working. For our purposes, that will do nicely.

Like psychiatry, popular psychology has from the start advertised the benefits of psychotherapy as the alleviation of symptoms, since symptoms are presumably what bring people (or have them brought to) psychotherapists and counselors of every sort (to treat drug misuse, grief, trauma, evil parents, and so on), much as a sore throat or aching back brings someone to the physician or nurse practitioner's office. Currently, employing unclear ways of thinking is taken by the most popular modality of therapy to be the hidden culprit that leads to most complaints (symptoms). With that in mind the modality known as CBT proceeds to remedy stilted or exaggerated thinking. Changes in behavior are expected to follow changes in ways of thinking. I think this is reductionistic. Other psychotherapists who believe that conflicts within one's private experience of images, feelings and thoughts taken altogether are the source of their confusion and emotional and social misery. For such people, the cure is the longer, more arduous process of psychodynamic psychotherapy.

Modality aside, nearly all practitioners agree that not having family or friends to talk to about emergent or longstanding problems is a common feature of the profile of nearly everyone who seeks the attention of a psychotherapist. Loneliness and isolation are the hallmarks of nearly every prospective patient or client in who seeks out psychotherapy. Most also agree that being a friend is not what a psychotherapist is about. Instead, a professional relationship is required—like the one between a physician and patient, a lawyer and client, a barber and his patron, and student and her teacher—one in which the recipient of a service is protected by legal guidelines for the conduct of the professional. The license inspires trust and insures a person will have recourse to legal protections and can submit malpractice claims. That is the purpose of licensing providers of services that involve contact with the intimacies of the other—physical intimacy in the case of medical care and emotional intimacy in the case of psychotherapy. I also have to trust the barber whose scissors are so close to my neck.

Specific technical practices in psychotherapy range from quiet, inexhaustible listening to exhorting the client to get his act together; from exhuming dormant childhood wishes to assessing realistically what life now demands of someone who is no longer a child or waiting for the person sitting there to accept the bad hand (longstanding or of short term) Fate has apparently dealt him. More exotic practices have also been employed: hypnotism, pressing on the forehead, hiding silently behind the person who is stretched out on a couch talking into thin air so that she will feel less hesitant to say possibly offensive or embarrassing things to the person listening to her, encouraging the person to yell at the top of his lungs ("primal scream therapy"), imagining what the process of being born felt like and going through the moves again ("rebirthing"), and so on. Then there has been the use of chemicals to enhance psychotherapy: for example, taking LSD before a session in order to exorcise one's schizophrenia. In the past, among psychiatric psychotherapists treatments for serious mental illnesses also included such innovations as submerging the sufferer in very hot water or very cold water, extracting teeth, destroying parts of the brain with a tiny icepick-like instrument inserted just under the eyebrow, and passing currents of electricity through the skull on into the brain tissue of the patient. Who is to say what we can expect in the coming years?

l have been led to propose another option, less well known than those I have just described—

CBT, psychoanalysis, pharmacotherapy, leucotomy, electroshock and other procedures I've alluded to—one that I believe will replace them as the calling or vocation known as psychotherapy finally comes into its own, no longer involved with the Church, medicine, social work or education. And that is the *existential approach.* It should become clear by now that I am pretty critical of the other modalities I have described and have pursued another course. Moreover, I have found the existential approach especially effective in my work especially with males. In the remaining time I have, I want to briefly describe that approach and why I recommend it when working with boys and men in therapy. I will briefly discuss six reasons why I do so.

III. The existential approach—or what from here on out I will call existential therapy or ET—can perhaps best be described at first in terms of what it is *not*. Existential therapy is *not* humanistic psychotherapy. Some of you may know of the latter especially in connection with Carl Rogers and his client-centered or person-centered therapy. Humanistic psychology, which came to be known as the Third Force in clinical psychology (following psychoanalysis and behavioral therapies, the first two forces), is still talked about, but as a modality it has all but dropped out of the armamentarium of the clinical psychologist as a uniquely definable modality. A few West-coast institutes and the Chicago School of Psychotherapy still identify with the approach, as does the Blanton-Peale Institute here in New York. It lost a lot of its credibility by being persistently associated with the New Age lifestyle that emerged in the 1960s and '70s. Being supportive and kind—the hallmarks of humanistic psychotherapy—turns out not to be necessarily therapeutic, however, unless the client is disposed to want to change and become a better person. More important, although being nice is nice it is not the point of therapy. Nor are providing unconditional positive regard for the person or accepting her basic goodness missing among the characteristics of the personalities of otherwise tough, no-nonsense therapists like the folks who provide CBT. They are also humanistic.

Nor is ET a form of *psycho*therapy. (I would say the same thing about CBT and the behavioral therapies, which have also disposed of the psyche or mind.) That is why you see scare quotes around the word 'psychotherapy' in the title of my presentation. Many modalities of practice that appear in standard textbooks of psychotherapy have dropped 'psych-' from their names, including rational-emotive therapy, client-centered therapy, cognitive-behavior therapy (CBT), Gestalt therapy, family therapy, and so on. In each case, the omission of 'psych-' implies the disappearance of the mind, "I", or ego, or self made famous by psychoanalysis from the theory of these therapeutic modalities. The modalities that have no need for a mind or ego are not alike, however. The mind was discarded from the approaches I listed while existential therapy never admitted it in the first place. This is an important difference. All but one of the founders of non-'psycho-' therapies began as psychotherapists. In all cases but one (Carl Rogers, of client-centered therapy fame) they were trained as classical psychoanalysts (including Albert Ellis, the founder of rational-emotive behavior therapy [REBT, the precursor of CBT] and Fritz Perls, who founded Gestalt therapy). They were card-carrying Freudians until they became disenchanted with the annoying or superfluous concept of mind in what was becoming a field increasingly devoted to explaining human beings mechanically in purely physiological terms or as a computer-like information-processing machine. For those of you keeping track, you may have noticed I have not mentioned family therapy. Briefly, although family therapy does not focus on the solitary I of the classic patient, it sees the site of a

problem in a network of I's, selves, egos.

So just what makes existential therapy unique and different from the other modalities—the psychotherapies or the so-called psychological?

The human being is not really a thing (a being) like a rock, a plant, a cat, or God (the highest being). Instead, each of us *exists*, and that means we never *are* anything that can be defined once and for all—until we have died. Instead of being a what, the human being comports as a *Who*. Each Who is one of a kind, *sui generis*, unique, an artist and her work of art at one and at the same time. But what about the body? Isn't it a What? Yes, but it is not something the *exister* (Kierkegaard's pioneering term) *has*, as I have a car or a green shirt. Rather, existence is embodied. More important, the *Who* that body embodies is not a thing. As significant as all the following descriptors are in various contetxs, existence is neither a he nor a she, an adolescent or a senior, with racial, class, religious, or political features. No personal pronoun applies to existence. Nor do the standard descriptors that make such a difference in social life. Existence (as the famous phrase goes) precedes (any) essence, and an essence is defined by such things as gender, race, and class. This does not mean that each *Who* is not dropped into a certain body at a certain time and in a certain place on this earth. To be sure, existence is profoundly historical but in the sense that it *makes* history. The point of all this for therapeutic endeavor is that existence is more basic than any social or psychological feature, and it is with existence that ET is concerned and has to do.

For ET, a *Who* walks through the door and sits across from the therapeut, who is also a Who. But, certainly, ET always sees, for example, a young Asian woman, an old White male, an elegantly dressed Black girl, a casually garbed Hispanic boy, and so on. Well, yes and no. ET takes what is termed a phenomenological approach to what he experiences. By that I mean ET attempts to bracket or temporarily suspend all the presuppositions that the language of physical, social, cultural and psychological types (biology, sociology, anthropology, and psychology) encourages us to impose on our fellow human beings in everyday life. The therapeutic setting is not the real world and it is only for this reason that such a daring procedure can be undertaken and that therapy can take place. I would argue that therapy was "invented" to make such a space possible. ET is a real relationship that does not take place in the real world.

Obviously, a practitioner of ET is also embodied: a young White woman, an older Indian male, and so on. But, again, an effort is made to temporarily suspend any and all elements of one's self-identity just as an attempt is made to suspend holding to the presuppositions that are suggested by the appearance of the other *Who* now sitting there before me. What we have, then, in ET is the encounter of two instances of existence, two *Whos*. I regret that I can't say more about this now. I would only add that in this very unusual situation we have two human beings—two instances of existence—facing one another: meeting, waiting, and attempting to see each other. Each existence in its historical uniqueness brings along with it, wherever it goes, a world full of meaning-giving and meaning-making detail. Two such instances encounter each other in ET.

There are some real differences that conspire against the feasibility of such encounter when it occurs in the professionalized, medicalized culture of contemporary psychotherapy as it is conventionally construed. First, a fee is exacted by one for the place occupied and the time spent there together. I

have suggested in a pair of papers published last year in the *International Journal of Psychotherapy* that genuine therapy will eventually be conducted outside the framework of this service model, as it was for the first therapeuts. It is very likely that the limited success of psychotherapy to date is due to its having originated within the medical service model. This means, by the way, that therapists will have to earn a living doing other things—practicing medicine, nursing, teaching undergraduates, writing journalism or novels, serving as clergy—quite apart from their practice as therapeuts. This is a very controversial idea as you can imagine. Again, though, I remind you of the question: Who in the world would want to do this kind of work? To help other people? Alas, therapy is not a helping profession. No one ever "helped" another person with "his" or "her" existence the way a surgeon helps someone with his broken bone or an inflamed appendix or an accountant helps me with my taxes. Nor is this about the care of someone's soul. There is no place for the self, ego or soul in ET.

Another important difference between the two human beings sitting there is that one—the existential therapist—knows what the other assumes is the reason for being is not accurate. The purpose of the encounter is not to accuse one of a diagnosis or to be relieved of symptoms, healed or cured—in short, serviced.

These are important differences but the similarities of the therapeut and the other are more important. The existential therapist knows that both are in the same boat, as it were—the ship of fools we are all onboard together with each other: life, with its imponderable provenance, exigencies, surprises, unanswerable questions, and above all limited life span (mortality)—where, as Heraclitus said, everything is in flux and where change is ongoing. The ultimate concerns of existence that are evoked by existential change (whether conscious or not) are the reasons that bring one to the therapeutic setting. That one will die does not compute; it is not known why we are here or what meaning life has other than to continue it and perhaps procreate; there are no certainties; and absurdities dominate. Major changes (physical, intellectual, cultural) evoke awareness (or an uncanny sense) of these ultimate concerns. One may only know *that* something has changed but not what it is. On the other hand, the first menstrual flow for a young female, a young male's first orgasm with ejaculation while awake, being pregnant, being ordained, the death of one's mother or father—these changes are existentially formidable. When such events occur, existence changes, which is to say that the world and everything in it changes. Minor changes are ongoing and most are not noticed. Difference from moment to moment is "the way things are." Other existential changes deemed social or spiritual can be added to list. One turns 18 and suddenly one is an adult (legally) and responsible for her behavior, or one is licensed to cut into another body and not be accused of assault. I have in mind the surgeon.

A cat that has lost its tail or an eye doesn't know what has changed nor even that something has changed. Only an existing being knows about change. The ultimate concerns just mentioned and others are the source of our situation as human beings and it is one or more of these that has provoked the other to meet face to face with an existential therapist. The so-called patient or client who is there at someone else's behest usually cannot benefit from the therapeutic encounter.

Again, the similarities of the two in this unusual partnership are as significant as the differences. *Both* are only relatively successful at love and work, although one may be for the time less successful

at one, the other, or both. *Both* have decided to meet. Existential therapists are also keenly aware of the mutuality of the relationship that is unfolding before them. Part of the phenomenological "reduction" as it is called (it means, literally, leading back to) compels the therapeut to try to "bracket" or suspend the differences that traditionally require being honored between patient and doctor, professional provider and layperson, adult and childlike other, all relationships in which there is a significant power differential. As Thomas Szasz pointed out as early as the mid-1950s, the major issue that has confounded therapy with medical care is the power dynamic inherent in such relationships. In the therapeutic situation, one does not have power over the other in any sense.

The differences between existential ultimate concerns and medicalized psychological complaints usually referred in discussion of psychotherapy are easy to discern. I may complain that I am sexually attracted to someone who doesn't want anything to do with me (just as I may complain I have a pain behind my eyes). I may complain that I have been unsuccessful in a line of work that I got into because the pay promised to be high (just I may complain that I have a tingling in my fingers). I may complain that I feel like a woman, even though I have a male body (just as I may complain of a buzzing in my ears). I may complain because I am afraid of lizards or speaking in front of groups of people (just as I may complain of crawling sensations in my scalp). I may complain about my height or ravenous appetite or the shape of my nose (just I may complain about a ringing in my ears). I may complain that I cannot rid myself of a recurring worry or preoccupation that I know is unreasonable to concern myself about over and over again, day in and day out (just I may complain about the stiffening of my joints as I age). And so on. Ultimate concerns are not susceptible to complaining. I may *not* complain that I will die or that the meaning of this life is unfathomable and ineffable. I may *not* complain that ultimately I am alone in the cosmos. I may *not* complain that there is no guaranteed, inherent meaningfulness in anything I do or perceive. I may *not* complain that change is continual. I may *not* complain that things change. These are matters of existence. These realizations are not symptoms. They refer to ultimate concerns.

As noted, the existential therapist understands that these givens are the real reasons the other is there. Perhaps the person wishes that things had been different than they were or believes that he is stuck in an unchanging situation—stuck in the past, as it were. We routinely attribute these wishes and beliefs to depression or see them as leading to depression. Or perhaps the person would like to have things her way in the future. This presents routinely as what we call anxiety. But this is the secret, if there is such a thing, of ET: The ultimate concerns of human existence—in fact, the term "human existence" is redundant, since only human beings exist—are the ultimate sources of all suffering and misery that present as the so-called symptoms of mental illness in the recently invented world of psychiatric disorders. To repeat: They are disguised as delusions, phobias, disturbances of affect such as anxiety and depression and the like which have come to be thought of as symptoms comparable to pain, nausea, dizziness in the body—all indications of physical illness and perhaps disease. But physicians know that patterns of symptoms don't necessarily line up as correlated with the presence of a disease process. Malingering aside, that one can feel sick—be *ill*—and not have a disease or one may have a disease that is asymptomatic and therefore not be ill (feel sick). From an existential perspective, the inevitable everyday problems of living are not indications of disease. They may seem to be causes or effects of illness (feelings of lassitude, ennui, anomie, lack of motivation, excitability, impulsiveness), but they are the inexorable indications of suffering through the unavoidable "pains" and "headaches" and even "nausea" (Sartre's term for

awareness of the brute fact of reality) of existence. These are "the facts of life."

The facts of life—existential givens—are simply that: inevitable and unavoidable givens. They may be the stuff of tragedy, but they have mistakenly been given the status of diseases. The "human being"—existence—is the site of mood and disposition, but these should not to be confused with emotions, thoughts, values, wishes, and the like.

Misconceptions about complaints or symptoms versus ultimate concerns—which are always *mine, unique, incomparable to any other existence*—have dominated psychiatry and psychotherapy from the start. On the other hand, depression is, by definition, similar in the many in whom it is experienced. Otherwise, use of this descriptive in making a psychiatric diagnosis would be useless. Ultimate concerns were, however, the excuse for inventing the disorders of various sorts that have been named as if to account for them, clustering around disturbances of various functions of psychological life: consciousness, memory, perception, thinking (cognition), speech, affect (feeling), motivation (will), and the rest. Unlike diseases of the body (diabetes, cancer, syphilis, epilepsy, Alzheimer's dementia, malaria), however, all of which were *discovered* and in principle must be traceable to physical causes, pathogens or lesions, so-called mental illnesses or diseases of the mind (ADHD, schizophrenia, PTSD, bi-polar depressive disorder, and all the sexual dysfunctions) were *invented* by psychiatrists.

For ET, psychological complaints are disguises that hide the existential givens we all sooner or later become aware of by becoming human, but have disavowed. Physicians presumably do not *like* diseases and seeing that people are ill and/or diseased, but they train to learn how to treat malfunctioning bodies knowing that all bodies will "fall ill," "break down" in certain ways. Similarly, therapists do not like distressed, unhappy, anxious, confused fellow human beings. Or do they? But it does not follow that anyone *must* at some point "fall ill" or have a "breakdown" of an emotional kind. In fact, most human beings never do and when they do, they cope—unless they may be encouraged not to cope (malingering, learned helplessness)—precisely in order to become subjects of treatments that might be offered to them. That may well be just what has happened in the age of psychiatry, which began in full force only in the late 19th century in the West in Europe and in spades in the States).

The concept around which existence is to be understood is *meaning* insofar as, unlike any being (embodied or disembodied) we use symbols and make meanings using them. Animals emit and respond to signals and *discover* the meaning of things and respond to those things within the range of their repertoire of instincts and needs. By contrast, existence *creates* meaning.

What, then, is the goal of existential therapy, if not to treat diseases or achieve the classic goal of medical care, the elimination of symptoms? Here, as in much of this presentation, I have to be brief.[3] I will make a series of assertions without much explanation in order to convey a sense of the approach. Then I will turn to the question of the special considerations of existential therapy with boys and men or every age. I expect many puzzled expressions.

IV. To summarize: The ultimate concerns of human life are what bring anyone to therapy. On

the whole and for most, the endless small changes are assimilated and accommodated (to borrow Piaget's language) cognitively and coped with emotionally. We deal (with such changes). Most changes escape me as they happen to me. I don't register them. We may say they are unconscious. But all of them—conscious, or implicit—affect existence. At a certain point, in some instances a person feels a change as a source of chaos or enough disruption occurs that he seeks out a therapeut.

What do all existential changes have in common and why take questions about them or the inkling that something has changed (though one does not know what it is) to someone other than a friend or family member which is what most of us do most of the time?

First, every existential change manifests itself as an alteration in the experience of time. Major or minor, experiences of change are changes in *lived time* (Minkowski), not clock time but time as we make it. Consider 15 minutes of clock time waiting to be seen by your dentist and 15 minutes of clock time before saying good-bye to a lover. The first is a "long" lived time; the second passes in a flash. The former period of waiting seems never to reach its end; the latter should never end. We are in the world of meaning giving and each is an alteration of temporality, of the lived present.

The goal of the therapeut is to provide a situation in which the other may resume "his" or "her" present. Recall again what I have said about the principal "affective" symptoms in the history of psychiatry: depression and anxiety or fear (when the future is relatable to something determinate). But existence is the present. It is not in the present. It makes the present. Rather than searching the past (as if it were something fixed like a series of photographs, a film or a video) for causes of current conflicts (which is the goal of psychoanalysis, the classic psychodynamic psychotherapy) or relearning faulty ways of assessing one's strategies and attitudes about her thoughts and behavior (which is the goal of rational-emotive and other cognitive behavior therapies) and in that way somehow determine how the future will unfold, the approach of ET is to make is possible for existence to resume (better said, to assume or take back and take up) the present and to return fully to it in the presence (though not the present) of the therapist.

There is much more to be said about how this is accomplished, but there is no time for that here and now. Consider only the notion of the here and now and what full involvement in it means. In order to have a sense for the present understood in this way, as a thought experiment, try to capture the present *now*. Ready: 3 – 2 – 1 - ! As you've discovered, it's gone. Before you can capture it, the present has become "the past" and one is "in" the future." The convention of dividing temporality into three dimensions has been misleading. Of the three so-called dimensions of (linear) time, only the present is real. Assuming it to be a *point* that bisects the timeline (∞---|---->) in determining the past and the future -- all that has gone before and what is to come -- has made for much mischief. The ultimate concerns, you will recall, have to do with time, beginning with the moment (my birth) that pitched my life into motion and threw or plunged it into making history, and death, the moment beyond which existence no longer makes something of my life and for the first time someone can say *what* I am, that moment at which it can truthfully be said I *am* something (a What now and no longer a Who). The details can be described and people can now say what I turned out to be. Existential turning points (crises) better described our temporality. They both estrange us from the present and highlight it. How to illustrate this notion of temporality? Nothing borrowed

from geometry will help us here (point, line).[4]

We first recognize this present when the first life experience occurs that brings us face to face with ultimate concerns. Like animals, we might say, children live in that present and remain outside of awareness of it. Animals seem to live in such a state all their lives. Human juveniles, however, gradually come to believe in the reality of "the past" recreated by memory again and again, and "the future" toward one is said to aspire. To become adults who live everyday life in community, it is neither desirable nor feasible to consider attempting to live in such a present. Nor is it possible to do so, once the past and future have become "real." But when either (or both) burden a person to the extent that spontaneity, love and work are handicapped or even crippled, the therapeutic situation can provide an opportunity to appreciate the present again in that unique relationship with the therapeut we are exploring here this afternoon.

Fully detailed discussion of just how the existential therapeut works is again beyond the scope of this presentation, but it is possible to describe why some experiences are therapeutic—restoring lived time to the present-, meaning-making of the existence of the other—and especially so for boys and men when the therapeutic venture is existential. I will do this in a moment by listing a few of the therapeutic tactics used by existential therapists working with boys and men. The term tactics may sound mechanical. It may suggest techniques. But that would be a misunderstanding. In its basic meaning, tactics refers to an art of arranging—from the Greek *techne*—and that is very far indeed from anything to do with manualized treatment (analogous to a surgical technique for correcting a structural problem) or a technology.

Now why does ET work so well with males? Here I must point out some features of males that in general seem distinctive. To what extent they are genetically determined (or expressible), to what extent dispositions are manageable by upbringing remain questions, and how these two factors determine each other remain undecided. On the basis of cross-cultural direct infant and child observations, on the whole, we can say the following: Males are more kinetic than females from birth. They tend to inhabit space in a certain way and exhibit play patterns that are not the result of training or exposure to certain kinds of games. As boys, males engage in rough-and-tumble play more than girls. Play-fighting is not an expression of aggression but rather an outlet for the surplus of energy (perhaps mediated by testosterone, which occurs in much greater quantities in the male body) although it may also express competitiveness that has evolved in relation to mating or defending (or attempting to take over) territory. With respect to the accommodation to and use of space, boys are centrifugal and eccentric (in the sense of moving away from a central point) in the deployment of their bodies, while in general most girls tend to be more centripetal and enclosing of space, both as individuals and in all-female groups. Again, as a result of upbringing any of these tendencies may be discouraged in boys. There are boy-rearing practices in some cultures that limit or promote the expression of random, erratic movement. Swaddling, for example, among some traditional Native American groups affects the range of movement. Boys will react to this more vigorously than girls. Such practices may produce more assertive males. Direct observation of infants since the 1920s has confirmed that boys are also more distractible than girls and follow moving objects with his eyes more eagerly. Consequently, their gaze does not remain settled on objects for as long a time as one observes in infant and young girls. Boys are crankier and more difficult to settle down and console than girl. In this sense, they are "more emotional" than girls

from birth. Later, they are more impulsive.

Boys are also more in need of a *male* second parent than girls, mostly for the purpose of identification with a male as a male. (I am confident that girls are, too, although not for purposes of identification.) American culture has discouraged boys from expressing intimate physical contact with their fathers after late childhood. This is in contrast to the freer expression of especially physical signs of affection among Mediterranean and Middle Eastern fathers and sons (and men in general). Greater physical intimacy can be also be observed everywhere between Jewish fathers and their sons. The consequences of this essentially Anglican-Germanic style of fathering in most American families cannot be underestimated. Such boys experience more "father hunger" than boys raised by a mother and a physically and emotionally demonstrative male.

Boys are about a year behind in overall developmental of higher functions compared with girls until about age 17 when they "catch up" with same-age females. Their poorer performance in school is legendary. See Mark Twain's wonderful books!

At puberty, the boy's earlier discovery of his penis (perhaps as early as the second year of life) is revisited, now in the context of spontaneous erections that can lead to ejaculation, while asleep (wet dreams) or awake (masturbation, which is universal in healthy boys). Early overvaluation of his penis and shame about displaying it together produce in boys a notable ambivalence about the phallus. Focus on strength elsewhere in the boy's body is probably one result of an ambivalent attitude toward the penis. Boys and men are extremely vulnerable to painful feelings if the testicles are bumped or struck while playing or being punished. (Paddling, then, is an assault on the testicles as much as the "behind" in boys.) All this adds up to the boy's overcompensating for the physical and emotional vulnerability of his "testifying" genitals (the *testes* are literally "witnesses" to the phallus). Obscuring visible evidence of the genitals as a feature of male clothing goes in and out of fashion. All this adds up to an experience of shame in the male that is significant. Girls are raised with a sense of shame about other parts and elements of their anatomy.

These are only a few important differences that are related to male development—all of them closely related to male anatomy—that can be adduced in explaining special considerations in doing therapy with males. One further distinguishing feature of males is relevant to our discussion. While we have few words for emotions in American (as is the case in all natural languages), boys have the tendency to say less and express in actions rather than words what they are feeling. For example, to show gratitude to his mother or love for his father, a boy is more likely to make something for the parent and hand it over as a token of love—allowing the gift to speak for itself and for him. A girl is more likely to (also) say something to a parent about how she feels: "Mummy, I love you so much! Here, this if for you!" or "Daddy, I love you! I made this for you!" Are boys discouraged from verbalizing such feelings? Are they less capable of finding words for feelings than girls are—so-called alexithymia—or are they made to believe that talking about feelings is not a manly thing to do? This is a discussion that ranges widely in gender studies, social psychology, and therapy—and one we must pass up now. That most males come to say less than most females is clear, however—the exceptions being college professors and politicians.

Recall now what was said at the beginning of this presentation about the changing status of the male,

the masculine, and manhood in contemporary society; next, that ET is about ultimate concerns and the experience of lived time; and, finally, the developmental singularities about (especially early) male development just discussed. We can then talk briefly about special considerations related to working with males in therapy. I will single out just six. There are others. And I will focus, as promised, for the most part on late adolescent/early adult (that is, young, college-age) males.

V. Now how do the features about (mostly young) males I have selected affect how the existential therapist works with them in contemporary American culture? I invite you to revisit note 2 (below) before continuing. Access to existence is the goal of existential therapy but precisely that is barred by many of the features of a typical young male's life. Getting at his existence means getting past what he is presumed to *be* by virtue of being a young male.

A. Reluctance

The mere fact that a young male is sitting there across from me is something of a miracle, given the learned reluctance of males to admit they are feeling uncertain, afraid, unhappy, or anxious. Historically, access to care by a counselor or psychotherapist has not been encouraged among males after his days with the pediatrician and follows the pattern of relative lack of attention society has given to attending to the health needs of males. Men aren't supposed to get sick. That is a sign of weakness. They are certainly not supposed to have emotional problems. In ET one approach a young male by focusing on what is right about him.

There will always be something to observe about him that is working well, perhaps success in sports concurrent with fair or poor academic performance. He needs to know that being there in the consulting room is not a sign of abnormality. I may offer that I sought out counseling when I was an undergraduate and found it helpful—some of the time. The psychotherapist's self-disclosure (of kind and degree) is a hot topic in theory and practice. I have found that self-disclosure is essential when the therapist is male. As a man working with a young male, this is more important than if the therapist is a woman. It is an open question whether a young man is more likely to be open with a female therapist, even (or even especially) if she is an older woman. Being a young male therapist is not necessarily an advantage when working with young men.

Privacy and shame are related. It is always important up front to assure him that what is said between us remains between us. No notes, no reports to parents or school officials. In fact, after completing institute preparation which required keeping case notes, I never write anything during a session (except to jot down a telephone number or something of that kind) and have do not keep clinical notes. Consequently, I have nothing "in writing" to have to turn over to a third party or discard.

B. Space in Time

I find that sitting directly across from a young man is not advisable. I observe body language closely and am sensitive to the social implications of male-to-male intimacy that most males—straight

or gay—are burdened with in our culture. I generally sit at my desk, my back to the wall with his chair alongside the desk. We are close, but full physical openness, to which males are more sensitive literally and figuratively, is in that way avoided. I always tell him where to sit. I may push my chair back if my client begins to wriggle in his. My consulting rooms are always set up so that the other can easily move to the door (even if it is behind him) and, if possible, look out a window. I may be backed into a corner, but he or she should feel free to get up and leave at any time if need be or look out a window rather than a bare wall or only me. In general, it is more difficult for males to remain in one position and place for long. This is related to the overall greater kineticism mentioned earlier.

The experience of space and lived time are related. Male clients tend to want the consultation to be over as quickly as possible. I often feel the need to say: "This won't take long." On the other hand, that may be contraindicated if I sense that it will take him a while to feel secure with me. I don't want him to feel rushed, but often say something to the effect: "We'll have to stop at (with a half-hour later implied) and note the clock time." In general, the tradition of clearly carved-out periods of time in psychotherapy (the 45-minute "hour") makes this kind of flexibility impossible if more time is needed. On the other hand, clear-cut limits (rules of engagement if you will) and certainties are preferred by males. I am always prepared to stop things sooner than the planned span of time to be together if I sense he is not relating well to me or has become more anxious than when he arrived. In general—and everything I have to say expects exceptions—males want something to be accomplished if they spend some time at it. They want a result. Too much talk is frequently off-putting and a briefer session is often indicated with young men. I always take the lead in the discussion and don't allow too much empty space in the therapeutic situation. Psychoanalytic waiting is not tolerated by most males. They appreciate the idea of innings, quarters, periods (to borrow from sports). While ambiguity is one truth of the matter in life, young males especially want certainties. Even though I know I cannot provide them, I try to end every session with a summing up of what has surfaced or been seen.

C. Present-Orientation

I have suggested that we are all present-making in the everyday world, but I would add that males are more present oriented than females, and that includes the therapeutic setting. I am judicious about asking questions about his past. The exceptions are to learn about siblings or other important persons (I ask for a *first* name of a girlfriend or close friend), or the presence or absence of parents now or at crucial times earlier in life (if this should be relevant, as it is at a time when two out of three boys are likely to have been raised by a single parent—the mother—for a significant period of early life). With little direction to the past, the present becomes critical—in the sense of a crisis, which means literally a turning point.

Many young males are not especially interested in planning for the future. This is another consequence of their present-centeredness. I always bring a session to a close, however, by asking him what he will be doing next—lunch, the gym, a rehearsal ("nothing" is a very common response). In this way, the next present moment is opened up and he can be returned to the real world. Decisions about what to do next may be encouraged. I am therefore more directive with

young males than with female clients. In general males respond well to a direct and even directive attitude.

I assume that the session I am in is the only one I will have had with him. In general, I approach every session with anyone this way. Often, as though an afterthought, I ask: "Are we finished here (implying: "We are finished.") or "Did you want to talk about something else?" I want him to leave with the impression that no one was in control of the situation, only the conventions of the clock. I always shake his hand. This is the customary physical gesture of emotional exchange between males in our culture.

As an existential therapist, as I have said, I know we are each making our own present and therefore do not have direct access to it. Male clients seem to be especially aware of this. For many, there is no tomorrow. Again, many seem not to plan a great deal and are, as we say euphemistically, flexible. It is more a matter of improvising or "seeing what will happen." I like to understand this as reflecting a certain spontaneity that is gender-specific but it also means males are less cautious (and more impulsive) than is in their best interests. Seemingly as an afterthought and after we have shaken hands, I may ask: "Do you want to talk any more?" (meaning, again). I leave that up to him. He will likely be decisive about this. A "Yeah." is not, however, a guarantee—that is, another day.

D. Proactiveness/Reactiveness

Words are the medium of therapy. Males tend to be more terse than women especially in physically and emotionally intimate contexts such as therapy. This is related to their tendency to act before deliberating and discussing. More positively, males are more proactive than reactive. Monosyllabic responses are common. The therapist has to be quick on the uptake and offer a comment observing the rule of avoiding empty aural spaces (silences). The reflective style of so-called person-centered (or client-centered) therapy is therefore not suitable for working with young men. Repeating what they have said is a needless review of the obvious. Hearing "I hear what you are saying." is ludicrous, not reassuring for most young males. Although I am not a therapist who has specialized in working with children, it is always in the back of my mind that children enact what they cannot (or will not) say. For children, play (without chat) is the medium of therapeutic interaction, and with boys play often takes place with little or no comment.

Later in life, men may work side by side for hours without saying much at all. Directions are given with a nod or other gesture or by example. Young males play with words much as they did with toys. Most little boys tend to be playful (ludic) in our culture. Their punning and humor, and the use of idioms, slang and street language must not offend the therapist. Sometimes it is therapeutically useful in working with them to make that clear by using such language with them. That does not mean trying to talk with them "guy-to-guy" or to be "cool." One judicious use of a four-letter word is enough to make the point that any word is acceptable in the therapeutic setting, no matter how offensive it may in fact be to the therapist. Indirect communication—"saying" without naming—is also especially effective with young males. Again, this does not mean attempting to be *like* them in order to suggest we are pals in a conspiracy against parents and authority figures. Blunt candor is appreciated by males. It sanctions the tendency to proactive behavior but without encouraging

impulsiveness. This does not mean I suggest doing something or other. In fact, I am careful to avoid assigning homework or directing the client to act out a given practice after our meeting. I don't give young men advice. The most important therapeutic action of the existential approach occurs in the lived time of the encounter in the therapeutic setting. One existential therapist (Wilfred Bion) described the approach to each session as "without memory, desire or understanding"; another (Ernesto Spinelli) describes it as maintaining an attitude of "unknowing" (openness to what something or someone means).

E. Shame

Given the mysteries of gestation female clients more likely than not have an appreciation for the hidden as well an appreciation for an investment in the future. The secret and private has a positive valence. For males, who have experienced something overvalued turned into something never to be exposed—for shame!—the exposed comes to be experienced with ambivalence and the unspeakable. It is there, but one must not admit it or talk about it, except in jokes, that is, dismissed as funny. This is the background of the male's greater reluctance to expose himself in other ways, especially emotionally to others. A boy's mother may be the exception, but after a certain age she is also deprived of access to his body and feelings. Boys begin to bathe themselves and toilet routines become private. They will not want to appear nude in their mother's presence. Fathers play a different role in the boy's life, and different fathers do this differently. The Eastern European bathhouse in which males of all ages congregate is not known in the West and as central heating and private rooms for sleeping were made available to children, a boy was less likely to see his father's naked body. While in junior high school in the 1950s it was still common practice for boys to have a swimming class without wearing bathing suits. Girls wore swimsuits. Locker rooms remain places where boys undress and dress in each other's presence, but with fewer public schools offering "gym class," the relative disappearance of scouting, and the lack of mandatory military service, boys and young males currently may not have many occasions to see other males' naked bodies except at home if they have brothers or perhaps at the beach. Only male athletes will routinely undress and shower together.

The relevance of this for therapy is the male's attitude toward the anatomically exposed but nonetheless covered and therefore simultaneously hidden in his life, his genitals. Anything that might prove to be embarrassing is associated with these experiences of the sexed body of boyhood. In the consulting room, approaching the discussion of what he has kept to himself is a delicate affair especially. Admission of weaknesses also causes shame and is therefore also discouraged if not forbidden in the world of stoic manliness. Only time and confidence in the therapist can provide the conditions for a young male to talk openly about concerns relating to his emotional life (which echoes his genital life). This also holds for his sexual life, especially its fantasies. How best to respond to what is offered about the unspeakable? Congratulating someone on having revealed something of himself is often seen in media representations of popular psychology. In reality, it is rare with males in the therapeutic setting. It is important to acknowledge what is revealed in confidence, but I do so without fanfare. Generally, I do not explore such admissions and allow the client an opportunity to assess the fact that he has said something he feared was going to be shocking. It is something therapeutic in itself to have one's privacy respected. Having been open

about what was thought to be unheard of to anyone and watching the therapist take it in stride is therapeutic.

F. Alexithymia

Alexithymia refers to the want of words to express emotions and it has been associated with males. I am not sure that boys suffer from this more than girls. Their brevity about what they are feeling may be better accounted for in terms of a tendency to be more laconic than their female counterparts. In general, language does not have an excess of words for the nuances of feeling, even physical sensations such as pain (sharp, burning, searing, dull) or even more so pleasure. A young man's vocabulary of emotions (psychological feelings) is probably as extensive as a girl's, although it may not be used as often and perhaps chiefly for "negative" emotions congruent with masculinity—namely, hostility-- and anger-related feelings. The route from hostility (an affect) to its expression as aggression (behavior) may be shorter and quicker in boys, but that is probably not because of a lack of available words. What, then, of the young man who seems tongue-tied when asked the generic feelings question: "So what's going on?" The expected reply is: "I don't know" or a shrug. Lack of articulate verbal responsiveness in young males may be temporarily disheartening but it should not be discouraging in ET. Here one of the most important considerations about working with males comes up. Generic variations of the classic four-letter words may be all they can find, since their tone is negative and more often related to experiences of anger than affection. As noted earlier, I welcome these and sometimes repeat the word so assure the client that I am not put off by the use of such words in the effort to say something where, in general, words in any case fail most of us much of the time. Uttering one such word may prime the pump for the elaboration of feeling. Sometimes the response to "shitty" (for example) is best: "As in . . .?" There may be some success in evoking an elaboration of affect.

Male clients are not less aware of the consequences of their feelings, including those that may lead to impulsive acts or self- or other-harming acts. If I sense from a change in facial expression, posture or body language that we have hit on a way in to what he is feeling, I may use the opportunity to address an issue that has been close to expression but avoided up to that point. I may take the opportunity to "translate" the slang as a way of clarifying for him what I believe he is feeling, but I am always cautious about wanting to appear to speak *for* him. He knows better than I do (or anyone else does) what he is feeling. In any case, it is always presumptuous to "say" for another person what is on his mind. This is not what Freud meant when he said he "made" an interpretation about the latent content (content not in the awareness of the analysand, the person undergoing psychoanalysis) of a dream, slip of the tongue or joke. We should distinguish such apparent omniscience or "mindreading" from seeking clarification of an image by asking for more details about what someone is describing.

Any verbal expression of a feeling is therapeutic (even if at the same time it increases the volatility of the situation) and often it is important as a way of forestalling or defusing imminent action that could be dangerous to the client or others and that the saying replaces. We may recall the histories reported in the newspapers of boys who had "gone silent" for long periods of time, only to break out of themselves with violent acts against others and typically in the end against themselves.

Their blogs or notebooks, kept private, turn out to have been filled with tragically eloquent verbal expressions of fears, hates and sometimes longings and wishes. They had the words but there was no one to safely utter them to.

Obviously, any of the personality or character features presented as characteristic of young males may be found in young women in therapy, but they are far more common in males. For this reason I have tried to understand how therapeutic *effectiveness* is *affected* by them in working with males, especially young males from the perspective of ET. ET with young American males—and I would add this holds for Canadian, Australian, British and probably most European males—is best suited for them because of its primary goal, which is to make it possible for the person to recove and resume the present. I have argued that, for a variety of reasons—most of them hard-wired—males are present-oriented: proactive and assertive rather than reactive. This temporal positioning often puts them in harm's way because of the resulting impulsiveness. For better or worse, still expected to take the lead in relationships, to be stoical, to control strong urges (especially sexual drives) and yet successfully deploy them on demand, and to express themselves on short notice physically rather than verbally—males respond well, when they allow themselves to seek out ET, an approach that resonates with such present-orientedness. I have not found significant differences in this respect in males whether they are white and well off financially and socially, poor and undereducated (and perhaps having been involved in the juvenile or adult criminal justice system), white or non-white, rural or urban, Christian or Jewish, straight or gay or in between.

The dispositional orientation of females to the future and the dispositional orientation of males to the present turn out to be obstacles, respectively, to gaining access to the present that is the goal of existential therapy. Paradoxically, for males (especially young males) getting to their existent where the present is made—gaining access to the lived present—is hindered by their dispositional investment in the now.

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1 [1] In the world of pharmacotherapy as the use of psychiatric drugs is termed, forms of what is known on the streets of Staten Island as "crystal meth" (methamphetamine) known by their brand names as Ritalin (methylphenidate) and Adderall (dextroamphetamine) are used to treat children with ADHD (Attention Deficit Hyperactivity Disorder). The long-term effects of these drugs on growing bodies and minds may turn out to be as toxic as were the effects of a family of antipsychotics such as Thorazine, Risperdol and Haldol which are known to cause tardive dyskinesia (involuntary twitchings) when used over the long term. The twitchings cannot be cured but may be controlled in part by the use of other drugs. Drugs used to treat ADHD are given to children who are as young as four years of age.

2 [2] A few more preliminary comments are in order. *First*, even though madmen and the insane have been around at least since the earliest parts of the Bible were composed, psychological disorder is a quite recently coined term. Shamans, priests and pastors have also been around for a very long time, but it was only a little over a hundred years ago that psychiatrists staked out a territory of human suffering that would be attributed not to trouble with the gods, but instead to conflict within oneself or between other people and oneself. Wilhelm von Krafft-Ebing coined the term psychotherapy in 1896 and with that the first psychotherapists can be said to have come into being to practice it. However, a curious historical figure called the *therapeut* has been around for quite a while longer, more precisely since the first monastic

orders wandered off into the deserts of the Middle East during the first century Common Era, leaving behind their orthodox Hebrew traditions and trekking as a small party of one of the new Christian sects. The therapeut is the prototype of the existential therapist. It can be said that with Sigmund Freud the therapeut returned on the scene, now no longer wandering through Roman Judea but at the heart of late 19th-century European Romantic culture in Vienna.

Second, today the emotional sufferer is becoming more common. More people are diagnosed as mentally ill than ever before. This should be puzzling and requires reflection. The most common reasons for the trend are said to be the hectic pace of modern life, stress (itself an idea borrowed from metallurgy and engineering on how forged metals respond to weight), and technology. Other reasons include the poor health of the nuclear family in American society, a revolution in the politics of gender, and the "death of God" (Nietzsche's phrase) in our hearts. Keep in mind that outside of grammar, the word gender did not mean what it does today until the mid-1950s thanks to the work of the gay American psychiatrist, Harry Stack Sullivan, the British sociologist, Alex Comfort (best known for his best-selling illustrated book *The Joy of Sex*), and the New Zealand-born sexologist, John Money. Sullivan seems to have first used the word gender in print to refer to the social and emotional dimensions of sex, what Money called the "sexuoerotic" world.

Freud and his followers did not speak of gender but only the unconscious determinants of sexual interest and behavior. A powerful notion, gender has taken its place alongside class, race and religious orientation as a crucial determinant of how people see themselves and others. For many young men and woman, gender is the focus of their social lives to a greater extent and for a longer period of time in their lives than sex was, following puberty, during the decade or so of adolescence. One could argue that making gender the keystone of identity has added at least five years to adolescence.

Whatever the reasons might be for the increasing need for more psychotherapists and even though more and more patients seek help for their emotional problems among the medicine men and women, there is evidence that many individuals who choose conversation over medication are becoming disenchanted with their experience in psychotherapy. An ever greater number of them have had multiple experiences with medical psychologists. Often their subsequent response to one of the modalities of psychotherapy—psychodynamic psychotherapy and cognitive-behavioral therapy are the most popular—is less than satisfying. They may have completed a course of sessions of CBT but must return in a year or two for another series of ten sessions. They may have spent several years in psychoanalytic psychotherapy until what is a called a "rupture" in the therapeutic process has occurred and they abandoned it. Or the process at a "stalemate." It is in response to these problems in psychotherapy itself that existential therapy has something to offer.

3 I invite the interested listener to see my series of papers, *After Psychotherapy* (forthcoming 2016).

4 Perhaps Augustine had it right in his *Confessions* (400 AD): "What then is time? If no one asks me, I know what it is. If I wish to explain it to him who asks, I do not know." Nietzsche followed in a tradition (neither exclusively Western nor Eastern) that thought of time as cyclic, not linear. Perhaps that is the sort of temporality implied by the notion of lived time.

Miles Groth, PhD, Professor of Psychology, Department of Psychology, Wagner College, Staten Island, New York, and the Editor of New Male Studies: An International Journal. He can be reached at mgroth@wagner.edu.

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