FROM THE PRESIDENT

EVIDENCE BASED PRACTICE (EBP)

In 1973, Congress passed the HMO Act, propelling psychodynamic and psychoanalytic psychotherapists into a thirty-year fight to demonstrate that containing costs by limiting access to mental health services was detrimental to the good of the public. As a result of research findings, litigation, and legislation, health insurers are now curtailing routine utilization review for outpatient treatment and expanding access to providers. Some states have passed legislation to establish parity for mental health treatment and national legislation keeps reappearing in each congressional session. As we emerge from one victory, we are alerted to another fight, about Evidence Based Practice, or more accurately, the misuse and distortion of the term. Ron Levant’s article, which appears in this newsletter, frames the difficulties and weaknesses of a narrow definition of what constitutes evidence.

As psychodynamic therapists, most of whom were trained in the “scientist-clinician” model, we support the idea of sound clinical training based on proven theories and techniques. We support that proof comes through empirical research, clinical competence, and patient satisfaction. We will not accept a false dichotomy between clinicians and researchers or the notion that randomly controlled studies offer the best proof of efficacy. We insist competent therapies factor in issues of race, ethnicity and culture. How odd to be asked on one hand to include multiethnic competencies in our training and in our work, and on the other to only teach and practice therapies whose norms are established by a primarily Caucasian subject pool.

As a Division we have among us top researchers and are resolute about the importance of research. Section VI (Psychoanalytic Research Society), has committed itself to compiling an annotated bibliography of current therapy outcome data to permit us to represent our ongoing role as scientist-clinicians. We have recently become cosponsors of the First Annual New Haven Psychoanalytic Research Training Program. The Anna Freud Centre program at the Yale Child Study Center will run a five-day program for psychoanalytic researchers who will be mentored by major figures in the field including Sidney Blatt, a Division 39 member. An announcement of the program and the application procedure also appear in this issue of the newsletter.

We must recognize the dangers to accreditation of psychodynamic graduate programs and psychodynamic internship and postdoctoral training sites posed by a zealously narrow definition of EBP. We must maintain and defend the programs that will turn out the next generation of psychodynamic therapists. Recruiting graduate students and creating a home for them in the Division was and continues to be a priority.

So what are we to do? I am naming an Ad Hoc Task Force to recommend a multipronged strategy to the Division Board about how to best utilize our resources. We need to continue to disseminate the existing bodies of research, while supporting new research endeavors. We need to gain a voice in the APA accreditation process so our position is heard and represented. We must join with like minded APA Divisions so the voice of many is not drowned out by the voice of a few. We must craft a message for officials who formulate policy and for the public so they understand the complexity and importance of our working in the context of EBP. We need a voice in the public debate.

As psychodynamic clinicians, we must not let our interests in intrapsychic lives take precedence over making ourselves heard in the professional and political worlds in which we also live.

MIAMI SPRING MEETING

I look forward to seeing all of you at the Miami Spring Meeting, March 18–21, 2004. Where else can you have your intellect and your soul cared for at the same time? Think cold and snow in the north, and warmth, collegiality, and intellectual stimulation in Miami.
Transmission of Culture, Class, and Institution

The Conference addresses the unique diversity and overlapping boundaries of both psychoanalysis and American society as exemplified by South Florida. Since its beginnings, psychoanalysis has stood at the crossroads of multiple disciplines and at the divide between science and religion, theory and healing. Its greatest thinkers and practitioners have struggled to find the space where the beauty of theory meets the ordinary needs of people in distress. While psychoanalysis has developed a clear and confident voice, its range has been restricted to those who “speak its language.” In this century, American psychoanalysis must learn to “speak the language” of a more diverse and culturally transformed society. We welcome the participation of clinicians and researchers, healers and thinkers, to reflect on psychoanalysis and its contributions to the development of our discipline, to the mental health movement, and to our evolving culture.

Keynote Speakers

Otto Kernberg
Roy Schafer

Invited Panels

Morris Eagle and Doris Silverman: Authority in Psychoanalysis
Susan Coates, Stephen Seligman, and Arietta Slade: Attachment and Trauma
Muriel Dumen, Jay Greenberg, and Donnell Stern: Conflict Over Conflict
Néstor A. Braunstein, William J. Richardson, and C. Edward Robins: Freud on the Edge: “My Wife Believes in God”
Nancy Hollander, Lucia Villela Kracke, and Waud Kracke: Institutions and the State in a Time of Terror
Virginia Goldner, Spyros Orfanos, Barbara Pizer, Stuart Pizer, and Donnell Stern: Interchanges at the Edge: The Analyst’s Use of Culture and Context in Creating Analytic Space
James Fosshage and Paul Lippmann: Perspectives on Dream Theory and Interpretation
Lewis Aron, Steven Botticelli, Steve Cooper, Adrienne Harris, Karen Maroda, Maureen Murphy, Malcolm Slavin, and Melanie Suchet: Psychoanalytic Journeys: The Education of a Psychoanalyst
Ricardo Ainslie, Neil Altman, Rosemarie Perez-Foster, and Cleonie White: Stretching the Envelope: Psychoanalytic Engagements with Social Trauma.
Harriette W. Kaley, Bertam P. Karon, Oliver J. B. Kerner, Robert C. Lane, Murray Meisels, Arnold Z. Schneider, and Bryant L. Welch: The Coming of Age: Twenty-five Years of the Division of Psychoanalysis

Meeting Cochairs: Andrea Corn (CornPsyD@bellsouth.net) and Antonio Virsida (ARVirsida@aol.com). Information regarding this meeting, including registration materials, is available at the website of the Division of Psychoanalysis (Division 39), www.division39.org. For additional information, contact Natalie Shear Associates, 1730 M Street NW, Suite 801, Washington, DC 20036, phone (800) 833-1354, e-mail Division39FL@natalieshear.com.
LETTERS TO THE EDITOR

Carl Shubs, in his letter in the Spring 2003 edition, cogently raises an issue of real importance for psychoanalytic practitioners. He is right, I believe, that the APA Insurance Trust’s recommended approach to informed consent, if left unanswered, may become the expected standard for all psychologists. This, despite the fact that scarcely any practitioners, psychoanalytic or otherwise, seem inclined to use it. It thus may become the standard of care in the emptiest sense: imposed from on high by a committee of risk managers, instead of growing out of theory, clinical experience, and debate among those engaged in real treatment of real patients. The best response, as he notes, is for clinicians to come out of the shadows and reveal how they handle informed consent in their own practices.

I, for one, despite my agreement with the principles embodied in the doctrine of informed consent, have never felt that a lengthy discussion (much less a canned document) detailing the risks of treatment is a clinically sensible way to start a therapeutic relationship. (One has to credit APAIT with developing the best document available, but it can only be the best of a bad lot.) Moreover, the risk-management intention of these documents is usually unmistakable. The patient is thus implicitly pressured to sign away permanently the right to be dismayed, angry, or, for that matter, litigious, without either party commenting on the nature of the transaction. Concealment begins an endeavor dedicated to uncovering.

The alternative is to help the patient, over time, to know the nature of the therapeutic process and to decide what to do within, through, and beyond that process. This is not a simple matter for either party, but psychoanalytic practitioners have a leg up. We have worked long and hard to find ways to help patients know and speak their minds, thereby developing a kind of autonomy that can never be acquired by signing a form.

I think my wife said it best. When I described the APAIT approach to her, she said, “People don’t really do that, do they? That’s no way to start a trusting relationship.” Indeed, people don’t really do that, so far as I can tell, and they have good reasons for not doing it. But until practitioners start speaking out about what they do do, the risk-management hawks will have the field to themselves.

Bram Fridhandler, PhD

I appreciated the letter from Dr. Carl Shubs in the Spring issue. I am writing as a member of Division 39, and formerly Southeastern Member-at-Large of Division V. In the last month or two, I’ve done a fair amount of reading in the HIPAA materials now available. I plan to re-read this material and to join in whatever counter-currents will occur.

1. We all know that the “cleaner” and less cluttered with variables therapy is, the better. The voluminous “contracts” suggested by HIPAA are contraindicated. Moreover, contrary to some statements made, one cannot guarantee success in therapy.

2. My reading noted an ingenuous assumption that the patient and therapist will be friendly. What happened to negative transferences?

3. Like many, I do psychoanalytic assessments/reports in depth. Unless the results will be protected as “therapy notes” and there is no sign of this, patients will be given these reports when they request them, to the detriment of further therapy. A good solution in the past was to send the reports to other professionals who went over the reports with the patients. I consider these reports as potentially lethal as most clinicians know. Perhaps we should include a “hold harmless” if these reports go out to patients or family.

4. I agree that HIPAA is creating some perceived new standards that have the power of law and fines if not followed. In a recent APAIT conference I recently attended, the APA professional repeatedly referred to, “Falling on your sword” if you did not go along with HIPAA.

5. At first it looked like the classic conflict between the needs of some private practitioners versus the good of society. Now it looks more like a conflict between some early models of psychotherapy and some more sophisticated ones.

6. One suspects that to some extent, we have been lumped with reports from physical medicine.

7. As regards patients’ amending their PHI (Personal Health Information), one can picture an argument between a therapist and patient as to whether the diagnosis is Bipolar or something else. Bills in Congress are passed in one House and then the other, and then referred to a committee, which seeks to reconcile the differences. I am not aware that Psychology was asked to the discussion table.

John J. Mallet, PhD, ABPP
I would like to weigh in on the issue of what has been called, sequentially, “empirically-validated treatments” (APA Division of Clinical Psychology, 1995), “empirically-supported treatments” (Kendall, 1998), and now “evidence-based practice” (Institute of Medicine, 2001).

Empirically-validated treatments is a difficult topic for a practitioner to discuss with clinical scientists. In my attempts to discuss this informally, I have found that some clinical scientists immediately assume that I am anti-science, and others emit a guffaw, asking incredulously: “What, are you for empirically unsupported treatments?” McFall (1991, p. 76) reflects this perspective when he divides the world of clinical psychology into “scientific and pseudoscientific clinical psychology,” and rhetorically asks, “What is the alternative (to scientific clinical psychology)? Unscientific clinical psychology.” (see also Lilienfeld, Lohr, & Morier, 2001).

There are, thus, some ardent clinical scientists (e.g., McFall and Lilienfeld) who appear to subscribe to “scientistic faith,” and believe that the superiority of scientific approach is so marked that other approaches should be excluded. Since this is a matter of faith rather than reason, arguments would seem to be pointless. Nonetheless, clinical psychologists have argued over it, a lot, for the last eight years. Punctuating these interactions from the practitioner perspective, the controversy seems to stem from the attempts of some clinical scientists to dominate the discourse on acceptable practice, and impose very narrow views of both science and practice.

Let’s start with a brief recapitulation of the events. Division 12, under the leadership of then-President David Barlow, formed a Task Force “to consider methods to educate clinical psychologists, third party payers, and the public about effective psychotherapies” (APA Division of Clinical Psychology, 1995, p. 3). The Task Force came up with lists of “Well-Established Treatments” and “Probably Efficacious Treatments.” Not surprisingly, the lists themselves emphasized short-term behavioral and cognitive-behavioral approaches, which lend themselves to manualization. Longer term, more complex approaches (e.g., psychodynamic, systemic, feminist, and narrative) were not well represented.

The empirically-validated treatments movement has had quite an impact on practitioners. It provided ammunition to managed care and insurance companies to use in their efforts to control costs by restricting the practice of psychological health care (Seligman & Levant, 1998). It has also influenced many local, state and federal funding agencies, which now require the use of empirically-validated treatments. Moreover, this movement could have an even greater impact on practitioners in the future. For example, it could create additional hazards for practitioners in the courtroom if empirically-validated treatments are held up as the standard of care in our field. Further, adherence to empirically-validated treatments could become a major criterion in accreditation decisions and approval of CE sponsors, as the Task Force urged (APA Division of Clinical Psychology, 1995, p. 3). Some clinical scientists have gone so far as to call for APA and other professional organizations “to impose stiff sanctions, including...
expulsion if necessary,” against practitioners who do not practice empirically-validated assessments and treatments (Lohr, Fowler & Lilienfeld, 2002, p. 8).

Given all of this fallout, it should be no surprise that the Task Force report was soon steeped in controversy. Critics argued first and foremost that the Task Force used a very narrow definition of empirical research. For example, Koocher (personal communication, 7/20/03), observed that

“empirical” is in the eye of the beholder, and sadly many beholdlers have very narrow lens slits. That is to say, qualitative research (and) case studies… have long been a valuable part of the empirical foundation for psychotherapy, but are demeaned or ignored by many for whom “empirical validation” equates to “randomized clinical trial” (RCT). In addition, a randomized clinical trial demands a treatment manual to assure fidelity and integrity of the intervention; however, the real world of patient care demands that the therapist (outside of the research arena) constantly modify approaches to meet the idiopathic needs of the client… Slavish attention to “the manual” assures empathic failure and poor outcome for many patients.

Furthermore, Seligman and Levant (1998) argued that, efficacy research programs based on RCT’s may have high internal validity, but they lack external or ecological validity. On the other hand, effectiveness research, such as the Consumer Reports study (Seligman, 1995), has much higher external validity and fidelity to the actual treatment situation as it exists in the community. Additional effectiveness studies are needed, and could be conducted by the Practice-Research Networks that have recently appeared (Borkovec, Echemendia, Ragusea, & Ruiz, 2001). Finally, others have pointed out that many treatments have not been studied empirically, and that there is a big difference between a treatment that has not been tested empirically, and one that has not been supported by the empirical evidence.

A few years later, John Norcross, then-President, of Division 29 (Psychotherapy), countered by establishing a Task Force on Empirically Supported Therapy Relationships, which emphasized the person of the therapist, the therapy relationship and the non-diagnostic characteristics of the patient (Norcross, 2001). Lambert and Barley (2001) summarized this research literature, pointing out that specific techniques (namely those that were the focus of the studies underlying the Division 12 Task Force Report) accounted for no more than 15% of the variance in therapy outcomes. On the other hand, the therapy relationship and factors common to different therapies accounted for 30%, patient qualities and extra therapeutic change accounted for 40%, and expectancy and the placebo effect accounted for the remaining 15%.

Westen and Morrison (2001) reported a multidimensional meta-analysis of treatments for depression, panic disorder, and generalized anxiety disorder, in which they found that “the majority of patients were excluded from participating in the average study,” due to the presence of comorbid conditions (p. 880). Approximately 2/3 of the patients in the studies they reviewed were excluded, which seems like a high percentage, but is actually a bit lower than national figures for comorbidity. Meichenbaum (2003) noted that fewer than 20% of mental health patients have only one clearly definable Axis I diagnosis. Thus, the vast majority of cases seen by practitioners do not meet the exact diagnostic criteria used in the RCTs that established efficacy for various treatments.

Furthermore, the empirically-validated treatments on these lists have typically been studied using homogeneous samples of white, middle class clients, and therefore have not often been shown to be efficacious with ethnic minority clients.
So what does this all mean? Suppose we had lists of empirically-validated manualized treatments for all DSM Axis I diagnoses (which we are actually a long ways away from). We would then have treatments for only 20% of the white, middle class, patients who come to our doors, namely those who meet the diagnostic criteria used in studies that validated these treatments. That’s bad enough, but that’s not all. In order to limit services to only these 20% of the white, middle class, patients who come to us, the average practitioner would have to spend many, many hours, perhaps years, in training to learn these manualized treatments. And if we restricted ourselves to use only these manualized treatments, we would be limiting our role to that of a technician. And, in the end, these treatments would only account for 15% of the variance in therapy outcomes in these patients. One can readily see why few practitioners embrace the empirically-validated treatments movement.

In my view, although one of psychology’s strengths is its scientific foundation, the present body of scientific evidence is not sufficiently developed to serve as the sole foundation for practice. Practitioners must be prepared to assess and treat those who seek our services. To be sure, we all get referrals of clients that we decide to refer to others because we don’t think that we are the best clinician for that case, but those who are in general practice have to work with the clients that come to us. Whether we operate from a single theoretical perspective or are more eclectic, we bring to bear all that we know from the empirical literature, the clinical case studies literature, and prior experience, as well as our clinical skills and attitudes, to help the client that is sitting in front of us. This is what is often referred to as clinical judgment. Some condemn clinical judgment as subjective. To them I say that clinical judgment is simply the sum total of the empirical and clinical knowledge and practical experience and skill which clinicians bring to bear when it is our job to understand and treat a particular and very unique person.

Fox (2003) goes even further, pointing out that in many learned fields science and practice are often separate endeavors, and that practice often has to precede science. Physicians were treating cancer long before they had much of an idea of what it was, and were using pharmaceutical agents like aspirin long before the pharmacodynamics were known. To quote Fox (2003):

The fact of the matter is that if clinicians restrict themselves to applying only narrowly validated or known techniques, they will never be of much value to society. Lest you think that statement is an invitation to charlatanism, remember that clinicians do not have the luxury to start from what is known. They must start with the needs of the people who come to them and then apply all the knowledge, information and skill they have to help resolve those problems.

On the other hand, we do have a problem of accountability in health care, one that will surely affect psychology. For example, the current lag between the discovery of more effective forms of treatment in health care and their incorporation into routine patient care is, on the average, 17 years. DeLeon (2003) predicts that health care in the 21st century, abetted by technology, will be characterized by even greater accountability for practitioners, due to the combined effects of the increasingly well-informed health care consumer, who gathers relevant health care information from the Internet, the increasingly well-informed practitioner, who will be able to obtain best practice information from a PDA, and increased monitoring of health care practices, to flush out variation in treatment for specific diagnoses. In this environment we are going to need better ways to evaluate practice. I would suggest that we consider using the broad and inclusive definition of evidence-based practice adopted by the Institute of Medicine.

CONTINUED ON PAGE 16
When Mort Schillinger died unexpectedly after a short illness this summer, Section V lost its President and Division 39 lost one of its stalwarts. And, it is not too much to say, professional psychology in this country lost one of its founders and psychoanalytic psychology lost one of its champions.

Apart from his more than fifty years of private practice, Mort founded and ran the prestigious Lincoln Institute for Psychotherapy on West 57th Street in Manhattan. He was its Executive Director for thirty years where his exacting professionalism helped to set the standard for freestanding mental health clinics nationwide. For several years in the 1970’s he was Executive Director of New York State Psychological Association. Adjunct Professorships at NYU and Yeshiva University and myriad consulting experiences with hospitals and social agencies filled out his resume.

Mort was a man with a lot to be proud of. He was proud of his humble origins, of being a Brooklyn kid who went on to get a Bachelor’s in Philosophy from NYU in 1948, a Master’s in School Psychology at CCNY in 1950, a doctorate from NYU in 1970, and his ABPP in Psychoanalysis. He was proud of the fact that his psychoanalytic training took place in an era before the development of formal institutes—and that he had several analyses and took courses with everybody and anybody in the post-World War II New York psychoanalytic scene who he thought might have something to teach him. His teachers, he liked to recall, included Heinz Hartmann.

Mort was proud of the historical perspective he could bring to the current organizational struggles facing American psychology and psychoanalytic psychology. He was proud too of being contemporary—unafraid of modern technology, at home on the Internet, eagerly at work, when others his age might be thinking of retirement, at establishing a bi-coastal practice. He liked being licensed in both California and New York.

He was proud of other great passions in life: his partner of recent years, Elaine Rich, his four accomplished children—and jazz and playing the saxophone! He had a nearly complete Bachelor in Fine Arts in Music. Indeed, he asked in his last days that those wanting to honor his memory should make donations to the Beacons in Jazz Program at the New School University in New York.

For generations of supervisees and colleagues as well as for those who, lately, worked side by side with Mort (notably in Section V, but also in Section VI and Section I, and at Division Board and Intersection meetings), he was a model of professionalism. His energy was a prod and at times even an embarrassment to the rest of us. His high standards were a continuing lesson. And for all the lofty goals he set and the perfectionism with which he pursued them (which we teased him about), there was no narcissism. He was self-effacing; he didn’t like speaking in public. He didn’t want the credit; he was embarrassed at public praise. He just wanted to see the right thing done.

Two extraordinary letters give the measure of the man. He would forgive me, I hope, for quoting them at length. This is the letter he sent to his patients when he became ill late this spring:

A week ago, literally without warning, acute abdominal pain caused me to call 911. The EMTs deposited me in a local emergency receiving hospital. I subsequently transferred to Cedar-Sinai Medical Center, and am now home once again.

Along the way, it was determined that I have a tumor at the juncture of the esophagus and stomach, which has already metastasized to the liver. Neither surgery nor radiation is a treatment option. When the results of the biopsy are known, a protocol of chemotherapy will be developed and begun. To the extent that it is successful it may extend the time I have. But the prognosis is very poor in any event.

It is clear that I will not be able to return to work. So I am actively exploring referral alternatives that I believe will meet your needs. I hope to get these recommendations to you as quickly as possible so that you will be able to connect with a new therapist, and so that I will have the opportunity to consult with him/her and do whatever I can to facilitate the change. And my wish is that I will be able to hang around on the sidelines for a while to lend a hand if needed.

This obviously is a sad turn of events, and a disruptive one for you. But if we stay objective and focused, we can make the most we can out of the bad hand we've been dealt. You've heard me say, I'm sure, that I have no monopoly on answers. You will now see the proof of that.

Personally, be assured that I am profoundly unhappy that this has occurred, but rather philosophical about it as well. I just celebrated my 76th birthday, and am happy that I've lived a fruitful, productive, interesting, exciting and joyful life. I certainly don't feel cheated. This cancer isn't the product of pathological life style behaviors, so I can't be angry with myself. I gave my physicians no symptoms about which they might have been

Mort Schillinger, 1927-2003
How many of us could be so clear, honest and real about being terminally ill? No denying euphemisms, the straight story, concrete in its detail, yet (amazingly) hopeful. Empathic in its concern for the experience of his patient. Maybe a model of clinical self-revelation for all of us? At such a moment to be at once entirely professional and entirely real!

Concluding, he says, "it’s just one of those things”—a line from the jazz standard that must have been running in the back of his head. Just one of those crazy things. Alas, he never did get to be back in touch, but his patients would know he wanted to.

And, finally, he wanted no memorial service. Just like Mort: no embarrassing public praise, please. Here’s what he said in a letter to his family:

I desire that the following arrangements be made: Don't have a funeral, please, and certainly no religious rites. Try to keep me out of Riverside Memorial Chapel (and like places) unless it proves to be the easiest way to do things. If someone must officiate, get Lenny Bruce. If you all feel it necessary to do something, have a party. A good party with lots of good food, booze, and any other condiments that amuse you. Have pretty music, 32-bar standards variety. If jazz, make it like Bill Evans, Sarah Vaughn, Paul Desmond, Clifford Brown, etc., —you know, pretty stuff that I won't have to think about too much. Make jokes and have a good time.... No eulogies please. Don't let anyone defraud those in attendance with patently creative writing about who I should have been, maybe wished I had been, but in truth wasn't. Personal messages can be sent to http://www.interport.net/~mortlany where I'll pick up my mail.

I hope they’ll play the St. James Infirmary Blues: Put a twenty dollar gold piece on my watch chain so they’ll know I died standing pat....
I am again delighted to serve as editor of a series of short articles for the Psychologist Psychoanalyst. The goal of the series, which first appeared as a number of essays on advances in neuroscience and attachment theory in the 2000 and 2001 issues, is to provide a medium for the rapid integration of very recent interdisciplinary data, research, and concepts into the currently dynamically expanding domain of psychoanalytic knowledge. The articles that will appear over a number of upcoming issues are offerings from members of my ongoing Study Groups in Developmental Affective Neuroscience & Clinical Practice, which have met here in Los Angeles since 1996. These groups continuously process a rather large volume of current data from a spectrum of disciplines in order to appraise the relevance of this information for psychoanalysis. A major focus is on a deeper understanding of the mechanisms of psychopathogenesis and of psychotherapeutic treatment, especially of disorders that have previously been viewed to be refractory to psychoanalytically oriented psychotherapy.

The constant stream of research the groups are studying clearly indicates that the developmental sciences are now offering a rather detailed description of specifically how different types of early relational experiences positively and negatively impact evolving psychic structure, and that the neurosciences are currently delineating the structures and functions of the brain systems that process object relational information, mediate attachment, and underlie the mechanisms of subjectivity and intersubjectivity. I therefore have suggested in my two new books that psychoanalytic conceptions of psychic structure need to be consonant with what we now know about internal structure as it exists in nature, and that no current psychoanalytic theoretical model can be purely psychological, but must rather address both psychic function and biological structure. (Schore, 2003a, b).

These study groups share a common psychoneurobiological perspective, one grounded in the neurobiology of attachment, the nonconscious processing of salient information about object relational experiences and the bodily-based self, the primacy of affective phenomena, and the fundamental tenets of regulation theory. The ongoing discussions within the groups and the dialogues between the groups and numerous visiting researchers and clinicians continue to be a critical source of intellectual challenge, lively clinical discussion, and further elaboration of the psychoneurobiological model. A number of individual members are now applying and expanding this perspective to their own particular interests, and over the upcoming issues will present very brief synopses of their ongoing work.

The call for an integration of “cutting edge” interdisciplinary information into psychoanalysis is usually thought to pertain to recent advances in the natural sciences. However, here the first two pieces also include information from not only neuroscience but also mathematics and philosophy. Victoria Stevens succinctly depicts the right brain mechanism that underlies the state of consciousness of empathic attunement as a “marriage between an active discerning working intellect and free-floating associative drifting combinatory play,” and offers an intriguing two-stage model of creative thinking that operates in the receptive reverie state based on the work of the mathematician Henri Poincaré. Paula Thomson also explores the complex mechanism of the creative process in the therapeutic context, deftly integrating the work of Heidegger with Holt’s psychoanalytic studies, neurobiological studies of the frontal lobes, and chaos theory to again describe a biphasic model.

In the final contribution Aline LaPierre turns to the controversial topic of the role of touch in the therapeutic encounter. She cites the pioneering work of Wilhelm Reich, a student of Freud, and then updates the field of somatic psychology, an outgrowth of classical psychoanalysis. Whatever the nature of the clinical issues, there is now solid evidence for the critical role of touch in human psychology and biology. Recent neurobiological research indicating that critical levels of tactile input of a specific quality and emotional content in early postnatal life are important for normal brain maturation supports Harlow’s classical research that early skin-to-skin contacts are essential for future socioemotional and cognitive development and Taylor’s assertion that the sensations impinging on the infant’s skin regulate aspects of the infant’s behavior and physiology (see Schore, 1994 for references). Furthermore, it is now clear that in cases of tactile-emotional violations of early relational trauma, a common element of borderline histories, “the body keeps the score” (van der Kolk, 1996). Now that psychoanalysis accepts the primacy of attachment and not Oedipal dynamics in the earliest development of the self, it is time to reappraise the central role of the operations of the bodily self in psychopathogenesis and treatment. A number of authors are now addressing the urgent need of bringing the body back into psychoanalysis (Aron & Anderson, 1998; Carroll, 2003; Schore, 2003b).
The discoveries in developmental psychoanalysis and neuropsychoanalysis are solidifying yet also altering and transforming the foundational core of clinical psychoanalysis. This principle will be reflected in the contributions of a number of group members over future issues. The purpose of the series reflects the goals of the groups: to forge tighter linkages between basic science and clinical practice, and to increase the speed of information transfer between the other sciences and psychoanalysis, the science of unconscious processes.

REFERENCES

Reading the Language of the Right Brain: Fine-tuning the Analyst’s Capacity for Creatively Attuned Empathic Resonance
Victoria Stevens, PhD

The importance of a healer’s empathic attunement toward a subject has a long history spanning the shamanistic and mystical traditions of various cultures to psychoanalytic technique where it informs and undergirds many aspects of the analytic relationship including transference, projective identification, “holding,” “containment” and “mutative interpretations.” There is currently intense renewed interest in Freud’s (1912) proposal, “To put it in a formula: he must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone.”

This essential process, fundamental to the psychoanalytic encounter, is generally discussed as an intermediate state of consciousness or a state of consciously active reverie in which the person opens themselves to sensory and emotional input from outside and inside of themselves, as well as to all information stored in implicit memory. Being in this state enables a person to allow whatever emerges from a given interaction to play in that intermediate space and imaginatively project their subjective state of mind into a variety of objects and possible ways of being or thinking. This way of thinking is a kind of marriage between an active discerning working intellect and free-floating associative drifting combinatory play.

The faculty that turned sensations into forms has historically been called “fantasy” and in more modern times “imagination.” The imagination is a dominant activity of the mind while it is in the state of free-floating consciousness. The creative function of imagination involves the ability to analogically discern relations between ideas, objects, feelings or forms; the ability to see patterns within disparate elements; and the ability to unite these linkages into new combinations that include asymmetries, contradictions, condensed symbols linked by contiguity, spatial and temporal arrangement, and emotional and narrative meaning. In the psychoanalytic literature, this state of mind has been called many things, including “evenly suspended attention” (Freud, 1912); “primary maternal preoccupation” and “potential space,” (Winnicott, 1956); “faith” and “reverie” (Bion, 1962, 1967); the “intersubjective analytic third” (Ogden, 2001); and the “transcendent position” (Grotstein, 2000).

Current interdisciplinary research is emphasizing the importance of an analyst’s capacity to enter into and hold this state of mind/body in terms of his or her ability to tune into a patient’s mind/body state and understand the subjective experience communicated by patient. Schore (2002) elucidates the similarities between the early relationship between infant and caregiver and the relationship between therapist and patient by highlighting the importance of the right hemispheres of both participants in both dyads. He states that:

Early preverbal maternal-infant emotional communications that occur before the maturation of the left hemisphere and the onset of verbal-linguistic
capacities represent contingently responsive affective transactions between right hemispheres of the members of the dyad” ...[and] “non-verbal transference-countertransference interactions that take place at preconscious-unconscious levels represent right-hemisphere-to-right-hemisphere communications of fast-acting, automatic, regulated, and unregulated emotional states of patient and therapist” (p. 26, 27).

The capacity for the analyst to receive communications from the patient’s unconscious involves a right hemisphere state of receptivity that allows the analyst to empathically attune to the affective and body states of the patient, which then creates the possibility of resonances or moments of synchrony between the analyst and the patient at an unconscious, preconscious or conscious level.

Current research then calls for a reexamination of the emphasis placed on verbal and historical thinking, understanding and interpretations in analytic technique in light of our growing knowledge of the importance of the ability to receive and “read” the essentially non-verbal language of the right brain. This has important implications for the training and on-going development of analysts and psychotherapists of all theoretical orientations and techniques.

**“In One’s Bones”**

Fine-tuning the analytic “receiver” or instrument begins with two basic stages comparable to Poincaré’s first stage of creative thinking called “preparation.” The first is that knowledge of all aspects of development, theoretical models, differential diagnoses, the history of the patient, the history of the analytic sessions and the analyst’s own history and personality development (including both transference and countertransference tendencies or vulnerabilities and defensive default modes) need to be so well-known to the analyst that they are in “one’s bones” as Winnicott put it.

Once that information is learned and practiced, the analyst can consciously “forget” it in order to be fully present to the patient’s communications at all levels. This involves what Bion (1967) called the “eschewing of memory and desire.” Deliberate “forgetting” allows the analyst to “tune in” to the patient and creates space for the analyst to imaginatively understand the particular language and experience of the patient. Once in this state, the encounter with the patient moment-by-moment will evoke sensations, ideas, fantasies, memories, desires, impulses, daydreams and associations that, if allowed to be stimulated and present, act as important signals that play in the analyst’s preconscious.

This notion about the analytic stance implies ability on the part of the analyst to tolerate frustration, disruption, impulses, not-knowing and ambiguity, as well as the concomitant capacity to play without needing to prematurely “understand” what is going on. These abilities are the result of right hemisphere self-regulatory capacities that allow the analyst to take in, experience and process the preconscious/unconscious cues. This “work” provides essential information for attunement at a non-verbal level and can lead to understanding and the ability to formulate interpretations utilizing language when the timing feels appropriate.

**Tuning In, Being Played and Playing**

Once the receiver is “tuned up,” it becomes an instrument that can serve three main functions. The first is that it can constantly adjust itself to receive and resonate with communications from the patient in all forms. Secondly, it can allow itself to be “played upon” by the patient in the sense of being present to be used by the patient for multiple purposes; transference, a container to hold projections of all kinds, mirroring, thinking, a background object and so forth. Finally, it can play the music, poetry, drama and dance of what is happening moment-by-moment within the analyst’s own body/mind while creatively transforming the many levels of internal and external stimuli into a series of coherent synthesized moments of understanding through interpretation. Underlying these processes, the right brain is far superior to the left in terms of scanning as well as the reception and processing of nonverbal cues such as breathing, rhythm, facial expressions, posture, gesture, movement and the prosodic elements of verbal communication.

All of these kinds of communications have their own affective meaning depending upon where and how they emerge within the ongoing narrative of any given session. They then provide layers of subtext that inform the “story” that the patient’s unconscious is telling and affect how one understands the particular words and sequence of words spoken by the patient. The essentially right brain thinking needed to translate this emotional language corresponds to the “incubation” stage in Poincaré’s theory where the analyst observes, takes in and holds unexplained sensations, feelings and ideas and lets them play until a pattern emerges.

**Conclusion**

Far from being a passive, trance-like state, the state of right brain dominant reverie and empathically attuned play is highly active and takes a great deal of discipline and attention on multiple levels simultaneously. It is a way of “thinking” and a technique that can be learned, practiced and honed, and one that is critical to both the art and the science of therapeutic work.

This interanimation of subjects and consciousness through moment-to-moment attunement opens up dimensions of a lived experience where two separate beings are
united in synthetic moments of imaginatively engendered unity. Self-regulation, self-containment, self-awareness and imagination become vehicles for the empathic opening of the analyst to the experience of others and their interpretations of the world. We cannot underestimate the importance of repeated experiences of being seen and heard by another in terms of the effect these experiences have on the development of a sense of being-in-the-world. The transformations that occur within the dynamically changing interplay in the intersubjective space between human beings, facilitated by creatively attuned empathic resonance occur then at all levels: physiologically, emotionally, psychically and perhaps most importantly, ontologically.

REFERENCES

INSPIRATION: TEARING APART AND JOINING TOGETHER

The act of describing and analyzing creative expression, and in particular, the nature of inspiration, has intrigued psychoanalytic thinkers ever since Freud wrote, “We laymen have always been intensely curious to know from what sources that strange being, the creative writer, draws his material, and how he manages to make such an impression on us with it and to arouse in us emotions of which, perhaps, we had not even thought ourselves capable” (1908, p. 131). During inspirational moments artists are often catapulted into a complex dynamic of internal conflicts, doubts and fears competing against their intrinsic drive to create and to express. These processes, so central to the human experience, are of interest to not only psychoanalysts, but also to philosophers and neuroscientists, and so in this essay I will contend that the problem of creativity can serve as a contact point for the integration of psychoanalysis with both the humanities and the biological sciences.

CREATIVITY - A BI-PHASIC PROCESS
According to Bachelard “The poetic image places us at the origin of the speaking being. … it is at once a becoming of expression and becoming of our being” (1964, p. xix). This becoming of both expression and being is an emergent function of the creative process. Although described and labeled somewhat differently by various theorists, the creative process can be distilled into bi-phasic stages that do not necessarily function in a specific sequence or in a particular time period. One phase, inspiration, is marked by a reduction in cortical arousal, loose associations, divergent thinking, greater physiological variability and primary process systems such as condensation, displacement and disorientations in time and space. In an effort to understand this creative capacity during the inspiration phase, Robert Holt observed that artists used more primary process and more control during their responses on Rorschach tests which allowed them to make more unique interpretations. He concluded that high primary process responses can be differentiated from low primary process responses and further he could discern the difference between high and low control during the primary process experiences.

Holt’s work outlines a clear distinction between the creative artist and the neurotic/psychotic, since both participate in primary process activities; however, the artist is able to maintain some control over these responses (Holt, 2002). Recent research suggests that fantasy-proneness and absorption are diathesis factors for dissociation (Kunzendorf, 1998-1999), and so the inspiration phase often resembles dissociative behaviors such as depersonalization, derealization, fugue-like states and identity diffusion. Creative artists thus may enter nonpathological dissociative states during the inspiration phase (Elzinga, 2002), a condition that replicates the observations of Holt and supports the statement by Ernst Kris that the creative artist regresses in the service of the ego.

The second phase, elaboration, is marked by hyperfrontal cortical activation, with the subsequent executive functioning behavior of interpretation, synthesis, refinement, and detail. Louis Pasteur’s observation that
“Chance favors only the prepared mind,” succinctly captures the two phases of inspiration and elaboration. Both phases draw upon complex neural networks and convergence zones within the brain; however, the inspiration phase evokes the often frightening and yet simultaneously exhilarating state of cortical disinhibition, in which more subcortical regions and more right hemispheric activation dominates (Martindale, 1999). Since these regions are more deeply connected into the affective and autonomic systems, the artist is subject to more intense emotional and physiological state shifts. Because the right hemisphere is deeply involved in maintaining a corporeal sense of self (Schore, 2003a, 2003b), it is during these psycho-neurobiological state shifts in the inspiration phase that the “becoming of expression” and the “becoming of self” are experienced.

**The Threshold, Pain, and Chaos Theory**

The philosopher Martin Heidegger depicted “becoming” as a threshold, a place that dependably bears the between “in which the two, outside and the inside, penetrate each other” (1971, p. 204). Unlike Winnicott’s theory of the potential space where fantasy and reality intertwine, Heidegger argued that the threshold is a place where pain “presences” or reveals itself, and that pain both “tears asunder and separates, and at the same time, it gathers everything to itself.” He defined “logos” in a similar way, as a process of “laying out to gather”: and it also occurs on the threshold. The notion of the threshold and of the pain that exists there captures the therapeutic process of rupture and repair encountered by both therapist and patient, since it too involves a visceral feeling of “being torn asunder in an effort to join” and a “laying out to gather.” For the creative artist, this same dynamic is experienced during the inspiration phase.

Heidegger’s philosophical tenets reverberate in the more recent construction of chaos theory, also known as complexity theory, emergent theory, or self-organization theory. Heidegger’s concept of threshold describes the edge where chaos exists, as well as the realm where implicit and explicit memory merge, the body and environment interface, affect and cognition interact, the unconscious is revealed to consciousness and dissociative and repressed material return. It is in this same place that disorganization occurs in order for more complex reorganization to emerge (Schore, 2003a, b). Paradoxically, the more flexible and adaptive the individual, the more dynamic and chaotic their neural processing, hence they will display greater abilities to shift affective and cognitive states and to tolerate more extreme and prolonged states of high and low intensity. For both the therapist and the artist, the ability to shift affective states and recover from intense periods of potentially dysregulating affective states is critical for maintaining a sense of self-cohesion and self-expansion. Indeed it is this self-regulatory ability that reflects the successful navigation of the inspiration phase of creativity.

This capacity is developed in the earliest maturational periods of human development. Schore has convincingly portrayed the brain as a self-organizing system and the primacy of the mother’s role as the initial regulator and co-creator of her infant’s emergent ability to self-organize. Schore describes the developmental sequence of the infant’s maturing socio-affective systems—over the stages of infancy “the self-organization of the developing brain occurs in the context of a relationship with another self, another brain” (2003, p. 5). Similarly, Stolorow, Atwood, and Orange describe intersubjectivity as “any psychological field formed by interacting worlds of experience, at whatever developmental level these worlds may be organized” (2002, p. 32).

If early maltreatment interferes with this process, the maturational development of the brain may be permanently altered resulting in reduced neural complexity and reduced self-regulation. When this occurs for a creative artist, the entrance into the inspiration phase, where the earlier forming subcortical and right hemispheric processes operate without the later forming regulation of the prefrontal cortex and the language centers of the left hemisphere, the individual will be vulnerable to potential fragmentation and massive self-disorganization, since it is the subcortical and right hemispheric regions that encode early traumatic events (Schore, 2002a, 2003b). The “basic fault” (Balint) of the personality will be exposed and a fear of being subsumed by the “primitive agonies” leading to a breakdown (Winnicott) may overwhelm the artist during creativity. For an artist with early relational traumas, entering the inspiration phase will reveal these early deficits, and just as we recognize patterns of re-enactments and concretization in our pre-verbally traumatized patients, we will see similar behaviors in the traumatized artist.

Successful engagement in the inspiration phase demands a robust ability to regulate and shift affective and cognitive states. Early maturational events not only shape self-organization but they also shape the capacity for creative expression and the flexible resilience needed for a sustained career as a creative artist. Helping our patients regulate the affective intensity of the “threshold that tears apart and joins together” is what we do as clinicians and it is also what we need to provide in the training and treatment of young artists.

**References**


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FROM FELT-SENSE TO FELT-SELF: NEUROAFFECTIVE TOUCH AND THE RELATIONAL MATRIX

As a result of the current interdisciplinary rapprochement, a new-found interest in the use of touch in clinical treatment is challenging the classical view that physical contact always represents an intrusive and detrimental violation of neutrality. Basic research conducted by Tiffany Field (1995), director of the Touch Research Institutes at the University of Miami School of Medicine shows that touch is at the foundation of relational experience and, in parallel to dyadic gaze, is a fundamental mode of interaction in the infant–caregiver relationship. There is now widespread evidence that the basic nonverbal mechanisms of the infant-caregiver relationship are activated in the patient–therapist transference–countertransference relationship (Schore, 2003). This principle has been incorporated into somatically oriented clinical contexts; and, so, touch as a therapeutic intervention is emerging as a valuable tool to address breaches in the development of the relational matrix which cannot be reached by verbal means alone.

When we consider the somatic experiences of the preverbal infant for whom language links are yet unformed, or the neuronal and biochemical infraverbal processes that underlie verbal thought throughout the life span, we realize that tending to the inner life of the body—to the lifelong relationship between bodily experience and mental states—is experiential territory only beginning to find its rightful status in our psychotherapeutic treatment approaches which have privileged reason over affect and somatic states (Harris, 1998).

Clinical interventions that favor psychobiological unity are being developed in Somatic Psychology, a field with innovative contributions to add to the soma-psyche dialogue (Aposhyan, 1999; Caldwell, 1997; Chaitow, 1997). The fundamental principles of Somatic Psychology were initiated by Freud who stated that the ego is first and foremost a body ego and believed that somatic processes located in organs or body parts were the source not only of instinctual drives, but of one’s very sense of self (Aron, 1998). Freud’s student and collaborator Wilhelm Reich went on to link the functional identity of the psychic level to its corresponding physical muscular attitude. Since Reich, Somatic Psychology has evolved to address the perceptual experience of the sensory channels to prepare patients to self-regulate their own physiological activation. Somatic techniques guide a patient’s attention inward to the proprioceptive sensations—body heat, involuntary and voluntary muscular contractions, organ vibrations, skin sensitivity—to bring awareness to these invisible, usually unconscious, hard to perceive internal activities. As a patient learns to increase conscious receptivity to internal visceral–affective experiences, a somatically trained psychotherapist often uses touch and/or movement to stimulate, guide, stabilize, or regulate impulses. The intent is to help a patient enter into a sensory-focused internal dialogue that nurtures neurobiological development, encourages new neurological connections, elicits dormant impulses, stabilizes hyperactivation, and releases dysfunctional patterns in order to organize and facilitate neural interconnectivity and engage the body’s regulatory mechanisms in new ways.

TOUCH AND THE RELATIONAL MATRIX

Most authors who address issues of somatization agree that they are rooted in early developmental failures of infant–caregiver attunement that are imprinted into implicit-procedural memory (Levenson & Droga 1997; Schore, 2003). Lyons-Ruth concludes that developmental change is based on unconscious, implicit representations rather than on
symbolized meaning, and argues that “procedural systems of relational knowing develop in parallel with symbolic systems, as separate systems with separate governing principles” (1999, p. 579, italics added). To assist the construction of new possibilities for adaptive regulation, Lyons-Ruth points out the need to extend the transactional space of treatment to include implicit forms of knowing and problem solving that become manifest in action, what Beebe (2003) calls an action–dialogue, rather than a symbolized conscious recall and recount. Touch interventions are such an action–dialogue. Touch uses highly developed palpation skills to contact sensory impulses and bodily states as they arise bottom up to interact with top down cognitive and verbal narratives, forming a reciprocal, interpenetrating exchange between soma and psyche. Bainbridge Cohen (1993) articulates how through placing attention within specific layers of the body, through varied qualities and rhythms of contact, and through following existing lines of force and suggesting new ones, the somatically trained psychotherapist can synchronize to the patient’s tissues in order to affect their harmony and associated qualities of mind.

**PALPATORY LITERACY**

Beyond social interactions such as handshakes or hugs, there is a dimension to touch that leads deep into the inner experience of the body, into the *soma*, the terrain wherein perception, affect, and nonverbal cognition take place. The fine articulation of touch as a direct, intentional, therapeutic dialogue with the patient’s *felt-sense* can lead to a *felt-self* organizing experience in the soma–psyche. Such use of touch requires a specific focus of intention and attention and this in-depth, therapeutic and psychologically significant touch could be referred to as *neuroaffective touch*. Through the use of neuroaffective touch, a therapist initiates a soma-to-soma conversation—an *intersomatic dialogue*—a direct, in-action intersubjective communication that opens a window into unconscious, unrecognized, and unarticulated energy patterns and their representations, into the somatic substratum of conflicts, defenses, and resistances.

Neuroaffective touch relies on palpatory literacy—the ability within the psychotherapist to experience and make sense of the patient’s fine neural signaling—the development and refinement of which should be a primary objective for anyone working therapeutically with touch (Chaitow, 1997). Informed by current neurobiological, emotion, and developmental theories, a psychotherapist using neuroaffective touch focuses on tracking signals in the different physiological systems (skeletal, ligamentous, muscular, visceral, endocrine, and central and autonomic nervous) as they operate to keep the soma–psyche in dynamic balance. A somatically-trained psychotherapist can become a new kind of partner in the therapeutic endeavor, “speaking” directly with these physiological systems individually and/or addressing the relationships between them.

**ETHICAL CONSIDERATIONS**

Touch is a complex therapeutic intervention imbued with layers of cultural and psychological meaning. Somatic Psychology is currently addressing concerns about the ethical use of touch and setting up guidelines for therapeutic advisability and contraindication (Caldwell, 1997; Phillips, 2002). We must however be aware that some of our prohibitions may reveal our illiteracy about touch as an *implicit language*. Our fears speak to the pervasive dysfunctions of touch that make us suspicious of and uncomfortable with the covert nonverbal messages which may be embedded within them. They speak to the untold suffering that physical and sexual abuse, both touch dysfunctions, have visited upon so many, and to the deep yearnings and disappointments that the lack of loving touch leaves in our lives. Since it is known that parents who physically and sexually abuse their children were themselves victims of touch violations, the question arises whether we can afford to remain touch illiterate. For patients who require a real reparative object relationship to rework harmful internalized objects, it could be argued that avoiding contact could reenact the physical neglect or rejection these patients experienced as children.

**FROM FELT-SENSE TO FELT-SELF**

Schore (2003) writes: “There is an intense interest in non-conscious processes, fundamental operations of the brain–mind-body that occur rapidly and automatically, beneath levels of conscious awareness…and particularly emotional processes that mediate the fundamental capacity for self-regulation” (p. xiv). Because neuroaffective touch speaks to the sensory aspects of emotion, it can intervene at the physiological level in the unfolding and regulation of affective states and directly address neurological deficits, dissociation, dysregulation, and chronic bracing and collapse patterns present in states of self-fragmentation. In the work of the repair of the self, which spans infant, child, and adult psychotherapy, neuroaffective touch can facilitate the emergence of the preverbal and infraverbal self (Shaw, 1996). By somatically encouraging and regulating the bodily-based self, early experiences can be cognized, thereby promoting self-organization. From this perspective, the touch taboo and resulting touch illiteracy limit our psychotherapeutic horizons and rob us of effective, perhaps critical, forms of clinical reparative interventions and interactive couple and caregiver education.
References


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(2001). This definition consists of three components: best research evidence, clinical expertise, and patient values. The definition does not imply that one component is privileged over another, and provides a broad perspective that allows the integration of the research (including that on empirically-validated treatments and that on empirically supported therapy relationships) with clinical expertise and, finally, brings the topic of patient values into the equation. Such a model, which values all three components equally, will better advance knowledge related to best treatment, and provide better accountability.

References


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The Anna Freud Centre Program at the Yale Child Study Center & The Western New England Institute For Psychoanalysis

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Announce

THE FIRST ANNUAL NEW HAVEN PSYCHOANALYTIC RESEARCH TRAINING PROGRAM
New Haven, Connecticut • April 22-24, 2004

The Anna Freud Centre program at the Yale Child Study Center in collaboration with the Western New England Institute for Psychoanalysis is pleased to announce the 1st New Haven Psychoanalytic Research Training Program. The program is focused around consultations with faculty of psychoanalytic scholars with considerable experience in empirical perspectives. Modeled on the successful summer Research Training Program at University College London sponsored by the International Psychoanalytic Association, the New Haven program is offered as another opportunity for scholars interested in psychoanalytic perspectives to meet with experienced investigators around issues of study design and implementation. The program will begin on the evening of April 22nd through the morning of April 24th at New Haven, CT, at the Yale Child Study Center.

The aim of the program is to provide an intensive seminar in empirical approaches to psychoanalytic research. The faculty participating in the first New Haven session have particular expertise in socio-cognitive/attachment perspectives on normal and psychopathological development and on the study and measurement of psychotherapeutic process and outcomes. Faculty members include: Peter Fonagy, Ph.D., University College London; Mary Target, Ph.D., University College London; Sidney Blatt, Ph.D., Yale University, John Clarkin, Ph.D., Connell; Semy Buss, Ph.D., Yale University; Stuart Harris, M.D., Ph.D., Harvard University, and Linda Mayes, M.D., Yale Child Study Center. Additional faculty from Yale University and the Yale School of Medicine will participate as invited speakers.
Continuing Education Programs at the 24th Spring Meeting of the Division of Psychoanalysis Fontainebleau Hilton Resort Miami Beach, FL, March 17, 2004

Psychoanalysis at the Edge

From Reactivity To Self-Reflection: Affect Based Couple Therapy
Gerald Stechler, PhD, founder and Chairman of the Psychoanalytic Couple and Family Institute of New England

Description: This course has two major aims: The first is to learn to recognize, understand, and ultimately rework the intense spoken and unspoken affects that are at the heart of marital conflict. The second is to expand the therapist’s horizon so that what has been learned as an individual therapist can be modified and used to meet the demands of the more complex triadic dynamic.

9:00 AM TO 4:30 PM  6 CE HOURS  $120

Psychotherapy Under Duress: Treating Difficult Clients Under Difficult Conditions
Nancy McWilliams, PhD, professor at the Graduate School of Applied and Professional Psychology at Rutgers University

Description: Dr. McWilliams will apply contemporary psychoanalytic scholarship to groups of patients who are famously hard to treat even under optimal circumstances, most notably those with borderline psychologies, psychotic tendencies, and severe disorders of personality. McWilliams will discuss both theory and practice, including some of her own work with difficult clients. Participants in the workshop are encouraged to contribute their current clinical problems and solutions; case vignettes are invited.

9:00 AM TO 4:30 PM  6 CE HOURS  $120

Keeping the Baby in Mind: Attachment, Reflective Functioning, and Clinical Intervention
Arietta Slade, PhD, professor of clinical and developmental psychology at City University of New York and associate research scientist at Yale Child Study Center.

Description: The purpose of this continuing education workshop is first to review the central constructs of attachment theory and research, as these have been developed by Bowlby, Ainsworth, Main and their colleagues. These constructs then will be used as a basis for introducing and reviewing the notion of reflective functioning, a term introduced by Fonagy and his colleagues to describe the mechanisms that allow for interpersonal understanding, and the capacity to hold other’s, as well as one’s own experience, “in mind.”

1:00 PM to 4:15 PM  3 CE HOURS  $60

Contextualized Therapies with Latino Immigrants: The Dance of Identity, Relatedness, and Trauma
Margarita Alvarez, PhD, Mauricia Alvarez, LICSW, PsyD, Silvia Halperin, PhD, Raquel Limonic, LMHC, members of a multidisciplinary team of the Latino Mental Health Program at Cambridge Hospital, Harvard Medical School

Description: This program will present relevant aspects of clinical work with Latino immigrants. The workshop includes a focus on essential interrelated processes of the psychodynamics of immigration, the mother-daughter relationships and the shifting loyalties precipitated by the immigration process, and specific clinical challenges presented by this population

1:00 PM TO 4:15 PM  3 CE HOURS  $60

A Workshop On Supervision of the Psychoanalytic Process
Clemens Loew, PhD, cofounder and Codirector of the Supervisory Training Program at the National Institute for the Psychotherapies

Description: This seminar will provide a collaborative forum for supervisors to enhance their understanding of the supervisory process, sharpen their skills, and organize a clearer framework for their work. Participants are invited to present a supervisory issue from their work. Some advanced readings will be encouraged. Workshop is limited to 15 participants.

5:00 PM TO 8:15 PM  3 CE HOURS  $60

The Division of Psychoanalysis is approved by the American Psychological Association to offer continuing education for psychologists. Division 39 maintains responsibility for the program. Participants will need to attend the entire program and complete evaluation form, to receive certificate of attendance. Please review and complete the registration form included on this brochure.

For a full description of the goals and objectives of the Workshops, please go to our website, www.Division39.org, where you will also find registration materials. You will also receive these materials in the mail. You may address questions and concerns to Natalie P. Shear Associates, 800-833-1354 or Division39FL@natalieshear.com or to CE Chair for Spring Meeting, Bill MacGillivray at 865-558-5675 or DrMacG@bellsouth.net
When I was in graduate school (1947-51) I was fascinated reading Freud. As was typical in those days no one was teaching psychoanalytic theory. So a group of us organized a class, talked a professor into being our mentor (he didn’t know much about the subject nor did he show up in class very often) but we read Fenichel’s *Psychoanalytic Theory of Neurosis* and I was hooked. As a class we began to think of the patients we were seeing in the University Counseling Center in psychoanalytic terms, which was exciting. I knew then I wanted to be an analyst but mostly I think, I wanted to be analyzed. My first job upon graduation was Chief Psychologist in the VA Mental Hygiene Clinic in Omaha, Nebraska. I immediately began analysis and spent four years in Omaha learning to be a psychotherapist by working with veterans from World War II. A friend of mine, a psychiatrist who worked in the clinic with me, referred a patient and offered the temporary use of his home office to see the patient privately. I was eager to develop a part time practice but my analyst (a medical analyst) interpreted my wishes to enter private practice as acting out. I don’t think I was being fully understood. What may have been missed was my identification with my Russian immigrant father who struggled to make his way in a new land and was in private practice of medicine. The Medical Practices Act of 1905 in Nebraska laid “ownership” to psychotherapy for physicians alone. Thus my desire to enter private practice was seen as acting out of Oedipal wishes in competition with my Father.

I helped organize the Nebraska Psychological Association and served on its first Board of Directors. Getting a license to practice was uppermost in my mind as we went about the business of creating an organization to serve the needs of psychologists. I looked to see where training was available for psychologists to become analysts and discovered NPAP in New York. Reluctantly transferred to the VA Hospital in East Orange N.J. so that I could enroll and begin analytic training. The reluctance was because there was much unfinished business in establishing the profession in Nebraska but I couldn’t wait to begin training. Thus began a new journey for me that was to be the road map for the rest of my life. I began a second analysis as I entered NPAP. Within a year, I started a part time practice and within another year I left the VA for full time private practice. My training at the analytic institute lasted 7 years (beyond the doctorate) and I completed my second analysis in 4 years. My current non-medical analyst did not interpret becoming a private practitioner as acting out although there was much work done on Oedipal issues.

Fulfilling my dream of becoming a psychoanalyst was momentous in my life. By now, my wife, a practicing psychologist–family therapist, and I had settled in New Jersey and were raising our 4 children. But Psychology had a long way to go to become a recognized profession and I turned my energies into gaining recognition for us. In 1967 we finally became licensed and the following year we became the first state to enact a Freedom of Choice Law. That meant we cracked the insurance industry discrimination against psychologists as well as the medical monopoly, which influenced the insurance industry. I was active in APA as well as New Jersey and served on the APA Committee on State Legislation. We worked to help the remaining states enact licensing laws and started the ball rolling getting other states to enact freedom of choice laws. We were learning to be political and work with state legislators. This was something new to me. When I started to study psychology I didn’t know anything about the political realities and thought this was already a profession. It turned out I had embarked on a second career, namely profession-building. Recognition by the states and the federal government was a long process.

It took 20 years to achieve licensure in NJ. Learning to lobby, to raise money for the political process became necessary activities. It took 20 years of work before we were recognized by Medicare. It was always my sense that to have psychologists fully licensed and recognized by the insurance industry and the federal government was the way to proceed. Psychologists practice using the APA Ethics Code as a guide. The code stated that we practice what we have been trained to do. As a licensed psychologist, trained in psychoanalysis, we practice psychoanalysis ethically.

I also saw that we needed to make APA more practice friendly so that the resources of APA could be utilized in support of practice. Psychology had been an academic domain exclusively for many years and making APA responsive to the needs of practicing psychologists was no small achievement. It meant broadening APA’s mission and influencing it to include practice as an important resource. I served as Chair of the APA Board of Professional Affairs in 1978 and on the APA Board of Directors in 1982-85. There were many victories in those years helping APA develop the infrastructure to support practice. The creation of the Practice Directorate was an important development spearheaded by Bryant Welch and Ron Fox and many Council members. There were many heroes in our ranks such as Rogers Wright, Nick Cummings, Gene Shapiro, Jack Wig-
gins, Herb Dorken, Stanley Graham, Art Kovacs, and Tommy Stigall to name just a few. I’m omitting many who toiled to make psychology a diverse profession that was inclusive of practice.

For me, this was the necessary first step toward establishing ourselves as psychologist–psychoanalysts. Building on these achievements, the next logical step was to create the Division of Psychoanalysis, which was realized in 1980. That took political work within Council of Representatives, which has the power to create Divisions. There were many council representatives who thought we should be a section of Division 29 (Psychotherapy), since psychoanalysis was a special form of psychotherapy. There were others who were opposed to proliferation of new divisions especially since they would all be practice divisions. This was a residual of the academic vs. practice skirmishes, which were still active. As a Council member I spent much time arguing that we needed our own home within APA.

We were successful and Division 39 was born. Reuben Fine, Gordon Derner, George Goldman were among those instrumental in bringing the division to life. Reuben became our first President and I was elected to the Board. I remained on the Board for the first 6 years of its existence as we went about further establishing psychoanalysis in the world of academia and practice. APA members flocked to join us who had shown no interest in APA because psychoanalysis had always been in the wings rather than center stage. I was one of the board members who felt it was important and necessary for our survival to remain strongly connected to APA.

Those first meetings were fun for me. Our first Midwinter meeting (which I chaired) was held in Ixtapa, Mexico; and prominent psychoanalysts took part in the rich presentations. Going to a meeting and hearing papers on clinical work and theory, which had been sparse at APA meetings but was now expansive was exciting and in an atmosphere of conviviality, was very pleasurable. Stephen Applebaum brought his tenor sax and he and I played jazz in one of the restaurants in Zihuatanejo. Roy Shafer, Ernie Lawrence, and Rita Frankiel joined us for the celebratory evening. I recall sitting around a table with a number of colleagues just gossiping when I commented that I recall my analyst never used the word “why” when he spoke to me. The word “why” evokes defensiveness and rationalizations. I have always tried to emulate that. “Yes,” said Donald Kaplan, who was sitting with us, “my analyst never asked why either. Instead she would say “what.” Like I would tell her something I was doing and she would exclaim “WHAT”!!! We all howled.

Networking had become natural in this setting. People from all over America were developing analytic contacts for referrals, etc. There was a great sense of comaraderie and confidence that we were accomplishing a long-range goal of making psychoanalysis part of American Psychology. We had arrived and were having fun.

To fill out the story with another relevant development: in 1969 a group of private practitioners gathered at my home (invited by Morris Goodman and myself) to discuss creating a Psychological Service Center much like the one that had been started in New York City. We invited Milt Theaman, who directed the NY Center to come and tell us all about his experience. The
upshot of that meeting was the group (20 of us) decided to create a Professional School of Psychology. We spent 5 years of regular meetings and political work with the Board of Higher Education that culminated in the creation of the Rutgers University Graduate School of Applied and Professional Psychology. This is a story in its own right but I won’t go into all the details here. I was appointed a Visiting Professor and we created an “analytic track.” I taught a yearlong course on psychoanalytic theory and therapy. Strangely, some of the most famous behaviorists taught at Rutgers on our faculty but the students signed up for the analytic courses. In fact 80% of them in the first few years were studying in the analytic track. All of my students entered analytic therapy although it wasn’t a requirement. (I think they knew that was the only way to stay on my good side.) After a number of years, the faculty decided to do away with tracking because of the complaints from the behavioral faculty.

I discovered that the internship centers in the New York area were not interested in our students because for many previous years, prior to the setting up of the Professional School, they didn’t know the Rorschach and in fact had been taught that it was invalid and unreliable. We taught it at the new professional school. I spent many hours on the phone contacting internship directors working to convince them that we had just the kind of students they were looking for and our students had a good grounding in psychodynamic theory and practices. Some arm-twisting occurred and some of our students were accepted for internships. They led the way and changed the minds of the directors, essentially overcoming their prejudices. I stayed at Rutgers for 14 years on a one day a week basis until I opted for 3-day weekends and resurrected Mondays for myself. That has evolved into a 3-day workweek, Tuesday through Thursday, and the rest of my time is spent either on my lake sailing, or at APA, or just hanging out.

About a dozen years ago, IPPNJ (Institute for Psychoanalysis and Psychotherapy of NJ) became an independent analytic training institute. It had been an affiliate of NYCPT, an institute in New York started by Reuben Fine and it existed as the New Jersey branch. We broke our affiliation and have been independent since 1988. I teach on its faculty and have served on its board. Many of the Rutgers folks have gone through our training program as well as others from social work. Admission requires a license to practice as a psychologist, a social worker, or nurse practitioner. Psychoanalysis is alive and well in New Jersey.

Our next task is to help those forces who recognize that managed care is a dismal failure to create health care system in America that gives people choice of practitioner and choice of treatment including psychoanalysis. It seems there is no end to the political problems we face as non-medical practitioners and psychoanalysts. But if there is anything I have learned in these many years of practice, teaching, and politicking, we will not accomplish our goals without a political agenda and a willingness to fight for what we believe is good for us and our public. I suppose if I had listened to my first analyst, and believed that I was acting out instead of pioneering in our field, others would have been the ones to take up the challenges and I would have retreated. Viewing it all as a reflection of Oedipal issues needed to be changed as well. Much in the theory has evolved so that identifications are seen as developmentally organizing and not as seen earlier in strictly Oedipal terms. Staying abreast of all the new developments in psychoanalysis is a life long project. The theory has grown and matured and teaching is one good way of keeping the intellect fresh.

The challenge that managed care has presented is one that emanates from the greed of corporate America. They own sports, entertainment, and now medical care. They want profits. But what people need is connection and relationship. Psychoanalysis is needed more than ever today. Psychoanalysis is under attack inadvertently by the “evidence-based treatment” protagonists. It is gaining a foothold in medicine and is touted by experimental clinicians in psychology, not by practitioners. It is based on data collected in laboratories using manuals and subjects who manifest only one symptom. This is not the real world of patients who are complex and manifest many symptoms and problems in attachment. Flexible therapists practicing “real” therapy, not manualized therapy, are in the majority; but the propaganda that emerges from the EBT folks is vicious. They send letters to the Accreditation Committee urging them to accredit only programs that teach empirically validated treatments (this is the older expression which is out of style now). They encourage managed care companies to promote EBT because it will cut their costs. Real therapy takes time and commitment from patients and therapists. To be effective, a connection, a relationship, must be established between a patient and therapist, which requires time. Insurance companies are not big on allowing time.

The mentality in America is that someone else pays for our health care and people expect insurance companies to pick up the tab. Insurance companies need to make a profit so they will support whatever takes less time and money. Band-Aid therapy, in other words. I mention this latest challenge as one of the things we as psychoanalysts have to deal with. What I have also learned is that when you solve one problem there is another waiting in the wings. The price of success is eternal vigilance. So, fellow analysts, my message is an old one. When danger strikes, circle the wagons but be sure the guns are pointed out. We need each other.
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Dialectical Behavior Therapy
March, 2004
Psychoanalytic Profiles is a new series in the newsletter in which graduate students write about and interview Division 39 members who have been influential in their intellectual development and have spurred their enthusiasm for psychoanalytic work. A unique aspect of this section is a personal interview in which the featured member is asked to reflect on his or her psychoanalytic “journey” and to speak about relevant issues such as the role of research and the future of psychoanalytic practice. The purpose of this series is twofold: for readers to become acquainted with the contributions of notable Division 39 members, from a variety of psychoanalytic perspectives, and for graduate students to directly engage psychoanalytic scholars who have been important to their own professional and personal development. Graduate students who are interested in contributing can contact the editor of this series, David Kemmerer, at kemmerer@utk.edu.

Jessica Benjamin, Ph.D., psychoanalyst, feminist, and writer, is a practicing analyst in New York City. She is on the faculty of the New York University Postdoctoral Psychology Program in Psychotherapy and Psychoanalysis and the New School for Social Research graduate program in Psychoanalytic Studies. She is involved with and has been instrumental in the development of the International Association for Relational Psychoanalysis and Psychotherapy (IARPP), which had its inaugural conference in January of 2002. Her writing includes: The Bonds of Love: Psychoanalysis, Feminism and the Problem of Domination (1988), Like Subjects, Love Objects: Essays on Recognition and Sexual Difference (1995), and Shadow of the Other: Intersubjectivity and Gender in Psychoanalysis (1998), as well as several papers published in, among other journals, Psychoanalytic Dialogues, Psychoanalytic Inquiry and Psychoanalytic Psychology. From these titles, it is clear that Dr. Benjamin’s analytic writing is integrative around topics of gender, feminism, intersubjectivity, sexuality, domination and submission.

As a beginning psychologist in the field, I was immediately drawn to Dr. Benjamin’s ability to incorporate into her psychoanalytic theory, research on infant development, philosophy, feminist thought, and psychoanalysis. I want to add here, that my first exposure to Dr. Benjamin and to her work was through listening to her speak at the first annual IARPP conference. Her presence was strong and intentional, her words passionate and direct, and her ideas stimulating and thought provoking. As a woman in this field, and as a woman in today’s society, I had the experience of immediately admiring her assertiveness, persistence, and curiosity about these theoretical and clinical concepts. What I have learned both through listening to her and reading some of her work, is that her writing is extremely articulate and thorough. I have the dual experience of hearing synthesis and fluidity in her writing as well as complexity of thought and a desire to be quite specific.

Dr. Benjamin articulates that there is a tendency in psychoanalysis (as is true in other fields and in American society in general) to split—that is, to make something be this or that, rather than both. She voices the possibilities and the likelihood that human experience is often about balancing processes, rather than processes that are mutually exclusive.

Dr. Benjamin’s thinking and writing move into spaces that extend beyond the linear to capture the depth of human development, intersubjectivity, relational theory and clinical practice. In essence, she has made significant contributions to the notion of a two-person psychology, which expands upon the one-person, drive model of psychoanalytic thought. Throughout Benjamin’s writing, one can hear that she is not proposing that practitioners and theorists replace the one-person, intrapsychic model of psychoanalytic understanding, with a two-person, intersubjective model of understanding, but that the two are parts of a larger understanding of psychic life and can co-exist. In other words, she emphasizes the profound impact of relationships upon individual psychological development as well as the ways that individuals, as objects to the other, create the structure of intrapsychic life.

So much of what I have heard in Dr. Benjamin’s writing is the issue of what is happening in the space between people. She thoroughly examines the complexity of human relatedness, especially through the existence of two subjectivities and in the dynamics of domination, submission, omnipotence, and mutual recognition. For mutual recognition to exist, Benjamin describes a need for the “third.” This is a mechanism through which two subjectivities are able to recognize each other’s experiences and differences, and not feel the need to have power and control over a situation—that one’s feelings of omnipotence can evolve into a place of recognizing the subjectivity of the other without feeling one’s own subjectivity threatened or destroyed by the other. This process can occur through what she describes as a process of surrender—not giving in to the other, but of giving over to the possibility for mutual recognition. It is the idea of being with another person, of being open to the idea of seeing what is happening between two people, rather than feeling pulled into the perspective of one person or the other.
As a young practitioner, I recognize that Dr. Benjamin has much to offer the field of psychoanalysis, feminist thought and our larger social world. Specifically, in my view, her work has particular relevance to students and practitioners in training as she strives to locate the subjectivity of the therapist/analyst in the room. Her work emphasizes the existence of two subjectivities in the room and questions the notion of therapist neutrality. From my fellow graduate students, I often hear a concern about how much of ourselves ought to be in the room and how to negotiate the balance of voice and subjectivity between both participants. Dr. Benjamin speaks to how the recognition and actions of both participants in this relational field can truly deepen the treatment as well as how the denial and quieting of the therapist’s subjectivity can impede the work. For all clinical practitioners, Dr. Benjamin’s contribution to the field of psychoanalysis is remarkable and facilitates an expansion of awareness about the space between therapist and patient.

**INTERVIEW**

**KS:** How do you understand your “double identity” as a psychologist and psychoanalyst? Is there a tension or a conflict that you have had to reconcile?

**JB:** My double identity is really as a social theorist and psychoanalyst. And in the one side there’s a tension between viewing things in a larger perspective and looking at the individual, but in the deepest sense, those are not really conflicting perspectives, especially if you take psychoanalysis seriously because you see the interpenetration of those areas. What was difficult to reconcile was the authoritarian relations in the psychoanalytic establishment when I got started in my training as compared to graduate school and life in academia in the social theory field. The relationships of hierarchy and seniority in the psychoanalytic world were just appalling by comparison with the probably-not-so-terrific democracy in graduate school in other fields. I remember going to talk to graduate students in psychology, and really getting a sense of how much more dependent they felt and how much more—as the candidates at my institute also felt—how much more compliant they had to be. I just bided my time until I could “get even,” as it were, both theoretically and professionally, by trying to change that.

**KS:** How do you view, understand and value the role of and practice of psychological research as part of your work and identity?

**JB:** Well, I did do a postdoctoral fellowship in infancy research with Beatrice Beebe on her research project and I find infancy research incredibly important in my thinking about psychoanalysis—that is clear from the get go in terms of my work in *The Bonds of Love.*

**KS:** What experience, discipline, or interest outside of psychology has influenced the way that you think about and work with patients?

**JB:** Well, I have already talked about how I have been influenced by social theory and philosophy. Again, as I have shown in my work, there is a significant overlap between the issues that certain philosophers have raised and the issues that psychoanalysts raise. The idea that psychoanalysis is a discipline that simply intersects with one field, psychology, would be inimical to my thinking in any event. Obviously, I think that these disciplinary strategies are somewhat arbitrary. They rely on having to establish borders. Sometimes borders of states are formed naturally, for instance, through rivers, but even when they are formed naturally through rivers, very often people on both sides of the river are using the river. It is problematic to imagine that the river really only belongs to one side or the other. So that is how I see this issue except that there are more than two disciplines or countries on the sides of this river.

**KS:** What thinker/theoretician has been the greatest influence on you and why?

**JB:** Well, I would never like to just say one, but I think that when I first did my work with *The Bonds of Love* and I wrote about the intersection of Hegel and Winnicott, that was certainly very important when establishing a matrix of two very different—but both very dialectical—thinkers. But you know, probably Marx had as much influence on how I think as anybody, because I studied Marxism for a long time when I was a graduate student. Marx was very big in the early 70s and late 60s and the whole process of thinking through Frankfurt’s critical theory, which is based on Marxist (Hegelian Marxist) perspective (dialectics) was what really determined my mode of thought; but it determined it because that’s how I like to think, because that is my sensibility. So, I still think in that way, even though Marx, per se, is no longer so very interesting.

**KS:** Other than managed care problems, what do you feel is the greatest obstacle to successful treatment?

**JB:** (chuckles) People don’t have enough time and money to come often enough. We don’t really provide enough safety for people. People are under too much work pres
expressing and hiding their pain. So that is a very succinct
tive responses to various ways that the patient has of both
ment in the field, I would say it’s the therapist’s dissocia-
which makes it hard for people to feel that they can take
their own growth and development seriously. The external
pressures to perform are such that I see a significant decline
in people’s ability to focus on their internal life and to see
their internal growth or relief from psychic suffering as
significant, so that the materialism and the emphasis on
money and on selfishness in the last 20 years have been
really pernicious for psychoanalysis. That said, for any one
given individual, those may not interfere so much. What
interferes for any individual?—you cannot answer that
question, because it is always different. What interferes on
the side of analysts?—I think that the obstacles that we can
remove are those that come from our own fears—our fears
of being not good-enough according to some ideal that may
have been formulated very unrealistically in an era when
people were constructing the notion of the analyst (and
certainly the notion of the professional psychologist-as-ana-
lyst or the professional doctor-as-analyst) so as to sharply
differentiate the practitioner from the patient, so that the
practitioner could feel sane or solid while dealing with the
craziness of the patient. That method of self-defense was
ultimately destructive and lead to a great deal of dissocia-
tion on the part of the practitioner—dissociating their own
anxiety in the face of the patient, so that, in many ways,
that stance was iatrogenic… And that level of dissocia-
tion, of being professional and separating yourself from the
patient’s pain was seemingly the only alternative to being
immersed or submerged, or overtaken or overwhelmed by
the pain of the other. And I think that because of all the
work we have done in the field, starting with self psychol-
ogy, and then moving on into certain parts of the relational
turn, we are not so helpless—we have many other possible
ways of keeping ourselves, shall we say, sufficiently in
tact, while not dissociating as much from the other person’s
pain and anxiety. And I think that has been a huge change.
If we want to talk about the obstacle to successful treat-
ment in the field, I would say it’s the therapist’s dissocia-
tive responses to various ways that the patient has of both
expressing and hiding their pain. So that is a very succinct
was of putting it.

KS: Looking back on your experience, what advice do
you have for graduate students who are just beginning
their careers?

JB: I certainly can’t give people very practical advice
about being a psychologist, but as far as beginning their life
trajectory as therapists, people should be aware of what it
means to develop compassion for themselves and their fail-
ings so that they can have that attitude toward others in a
sincere way. That’s my advice.

KS: For me as a student, there is this question that
I have about the tension, insecurity, and imbalance
between how much I should be in the room versus being
more neutral, and so when I listen to you and read your
work, I think that your ideas, observations and research
can be really helpful for students.

JB: Well, the question of how much you should be in the
room, how do you relate what I have written or said to that
particular issue?

KS: In terms of the intersubjective space—the fact that I
have a subjectivity and the patient has a subjectivity. And
how do those intersect and how are both people partici-
pants. You speak about the third and what is happening that
is not you, not me, but what I hear you saying is that it is
like a chemical reaction, a reaction…and I see it as a means
of, a mechanism of… a space, a means, it is not a thing. I
remember your differentiating it from a thing, such as the
theory that it is not a concrete thing.

JB: I am starting to define it in terms of the idea that the
third is the principle and the thirdness is the function or
capacity or experience that develops in alignment with cer-
tain principles. So let’s say you have the principle of rhyth-
micity, then you and I are having a particular kind of turn
taking that gives us a space of thirdness. Now, let’s say we
become angry at each other and we start interrupting and
we are not respecting the rules of communication, then we
stop being aligned with the third, which is the principle of
rhythmicity, the principle of turn-taking, or the principle of
mutual accommodation, and instead, our thirdness breaks
down into twoness. So that’s how I now tend to express it.
Another way to think of that is the third is like the music
and the thirdness is like the dance that you do to the music.
And of course, if you are making music, then the music is
both the third and the thirdness. I would see the third as the
thing to which you align and the thirdness is the interaction
you create when you are doing that alignment. Thirdness
is the interaction that comes about when we are oriented to
the third.
KS: Given what you are currently talking about, I want to ask what you are currently working on?

JB: I am still working on thinking through this idea of the third and its clinical applications, but right now, I am spending a lot of my energy thinking about peace, reconciliation, what is going to happen to this country. I am spending a lot of my extracurricular time on that, and working with this group, Psychotherapists for Social Responsibility. I am really very concerned with the social world now and the crisis that we are in. I am always trying to develop my ideas and the next thing I write will probably try to make a bridge between these ideas and what is happening socially.

KS: Where do you think that psychoanalysis is headed?

JB: I think that we are working more and more toward trying to create an honest practice that allows us to be much more aware of how deeply our anxieties and feelings as human beings do interpenetrate our work on both sides, so that the principle of reciprocal influence and bi-directionality isn’t just an abstraction, so that we really understand what we bring to this work—because as we understand better what we bring to the work—(not only as specific individuals, but what as analysts is demanded of us and therefore what we all, to one degree or another, experience in trying to do this work and to generalize apart from our own specific histories)—as we become more honest about those demands and honest about how our psyches carry those demands, I think that we really improve our work. I feel like that has been the new emphasis for a while and it will continue to be. Now, what theoretical models we use to bring to that may vary. From my point of view, the more eclectic we can be right now, the better, because there is something to learn from a number of different schools and we can’t use all of them all the time or mix them all together, but there is really something to be gained from looking at different parts of the elephant. I want to make one statement about how my work has been consistently misunderstood. People think that I am saying that the patient needs to recognize the analyst’s subjectivity as though that were parallel to the idea of the analyst recognizing the patient’s subjectivity, that is, really getting to explore with the patient, their internal life. I have never said this and I don’t think it. I think that what the patient comes to recognize is the fact that the analyst has a separate subjectivity and that therefore, when the analyst is empathic, for instance, this empathy is coming from an outside other. As Winnicott said, that it is “not me” nutriment, it is real—the milk is coming from an outside breast, not from something that is under my omnipotent control. This is what makes it valuable to the patient because it means that there is somebody out there whom I can get something from and whom I can lean on—and then, gradually, that also comes to mean that there is somebody out there whom I could connect to. There is somebody out there—how interesting that there is somebody out there who sees the world differently. Maybe there are different things in the world than I knew about. So the outsideness of the analyst becomes a vehicle first for the most precious thing, which is love coming from another person—there is actually recognition coming from another person, not just from my fantasy world, but it also begins to extend to the value and the lovability of the world and to the patient’s sense that they have the capacity to love. So if I can love this outside other, then I could actually love the outside world, as opposed to just finding the outside world disturbing, frightening, or empty. And that is a fabulous experience, and it is not about the caricature in which the analyst needs to be recognized, you know, god forbid, out of their own narcissism; not about a hyper-differentiation where you are trying to get the patient to finally shape up and recognize outside reality, or where you are trying to help them to finally be a separate person who can stop being so narcissistic. It is really not about that. It is about them developing the capacity to love the world, and I think that this has been so incredibly misunderstood.
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Perhaps one of the most relevant controversies facing psychoanalysis is the issue of countertransference. Although there are many schools of thought regarding its value, utilization, and conceptualization, there are few works that thoroughly examine its history and theoretical development. Looking for Ground: Countertransference and the Problem of Value in Psychoanalysis is an important book, not only because it provides a thorough history of countertransference, but also because it allows the reader to decide for him/herself their position regarding its value. Although the author is clearly advocating the active utilization of countertransference in psychoanalysis, he successfully provides a critical overview that provides ample space for the reader to choose his/her own course of action (or inaction). This review considers Carnochan’s description of Freud’s position on countertransference, followed by shifts in psychoanalytic thought regarding the use of countertransference, and the various ways in which we may effectively and appropriately utilize countertransference in the analytic setting.

Carnochan states that analysts always participate in the analytic dyad, as even remaining silent is to be active! Therefore, “objectivism is an unworkable epistemology for psychoanalytic practice” (p. 15). This has become increasingly clear as many theories propose that relationships are the principal motivators in human beings. In this way, countertransference becomes an ally, or an additional medium through which we may know our patients. It must remain clear, however, that to think relationally requires analysts to relinquish claims of absolute knowledge of another.

When we begin to understand that therapeutic action depends on a tangible connection between the analyst and the analysand, countertransference becomes an important source of the analyst’s affective participation. The utilization of the countertransference becomes an important model for the analysand, whose goal is to experience a wide range of emotions with freedom. The author argues that it is impossible for the analyst to treat the patient successfully if they are unwilling to utilize countertransference: “…the countertransference offers a kind of proof to the analysand that the relationship matters to the analyst. For the analytic relationship to become a transformative experience, a place where the unimagined becomes actual, the analyst must be willing to bring emotion forward. Only in this way can the analysand’s limiting beliefs about relationship be challenged” (p. 28). In other words, the analyst must be willing to take the same risks as the analysand in acknowledging their emotions.

It must remain clear that to actively utilize the countertransference does not mean to become undisciplined. One must remain patient with the feelings arising in the countertransference, contain it, and separate it from its underlying emotion before “acting” on it. This will allow the analyst to remain genuinely connected to the patient.
Carnochan argues that if we do not acknowledge the countertransference, we run the risk that it will be repressed, which will eventually prevent us from accessing all potentially available information regarding our patients.

Carnochan then examines countertransference throughout the history of psychoanalysis. In the days of Freud, in which strong proscriptions against countertransference existed, Ferenczi began looking at countertransference in radical experiments on the limits of the analytic relationship. He eventually came to believe that in order for “cure” to occur, warmth and responsiveness were necessary. One may infer that this required the acknowledgement and use of countertransference, although Ferenczi undoubtedly engaged in behavior some may now consider breaking the analytic frame. Nevertheless, this information helps us understand that controversy has surrounded the issue of countertransference since the early days of psychoanalysis.

The author provides a sound overview of various theories and their conceptualization of countertransference, including ego psychology, Klein, Winnicott, and the interpersonalists. We have already discussed Freud’s proscriptions against countertransference. Ego psychology similarly speaks against it, characterizing it as a distorter of the analyst’s behavior and perception. Klein sees countertransference as diagnostic in object relations but argues that it must be contained in order to prevent further damage to the analyst’s ability to perceive reality. Winnicott said that countertransference can serve as a way of knowing the patient and is not particularly threatening because human activity is relational. The interpersonalists are the most active with countertransference and believe it forms a part of our empathic knowing of the patient.

Carnochan provides detailed passages that further explain these ideas, which are helpful in providing a well-rounded theoretical understanding of countertransference. It is also advantageous to understand countertransference from traditions that may differ from our primary orientation, as it helps inform us of other ways in which countertransference may be conceptualized. Although the field has not reached a unanimous decision regarding utilization of the countertransference, there is an increasingly popular trend to consider its applicability in treatment.

Carnochan makes it clear that the conceptualization and utilization of countertransference is undoubtedly influenced by the analyst’s theoretical beliefs. We must be clear not only in what to do with countertransference, but also in what type of countertransference we strive for, as there are many potential ways of understanding this aspect of the analytic situation. The author suggests that countertransference can be used as a source of further discovery and that disclosing it does not entail abandoning the analytic method. However, we must be cautious in disclosure of the countertransference, as we can easily move from silence to self-disclosure, but less easily from self-disclosure to silence. As the author makes clear, “…I believe that speaking about the countertransference, at some point in the process, is an essential part of an analysis. To avoid this type of speech is to preserve a division between the analyst and analysand that prevents the analysand from becoming a full epistemological peer. Through a willingness to explore the analysand’s perception of our countertransference and a willingness at times to speak of our affectivity, we offer assistance to the analysand in learning how to make use of his own affectivity as part of his ability to know” (p. 290).

We must never fail to consider if our understanding of the countertransference helps us move toward understanding the analysand.

Affect is inherently important in the move toward accepting the role of countertransference in psychoanalysis. Although the field is not unified in its account of affect, there are many who argue it is critical for understanding the patient. Without acknowledging affect, the author warns, we may only superficially understand the analysand. Carnochan declares that psychoanalysis must specify the parameters for affective engagement, making sure to include countertransference. He states that, “for analysis to remain vibrant and coherent we must be willing to risk speaking and acting from the countertransference” (p. 390).

We have seen from this modest review that Carnochan provides a thorough historical account of the countertransference. It is clear that the field is not unified on its position of the value or utilization of countertransference, but it is becoming increasingly commonplace to consider its utility in treatment. Although the author is clearly advocating the thoughtful use and consideration of countertransference in analysis, he does so from a grounded understanding of past and present theoretical positions within the field. The work serves as a solid text by which we may gain perspective on the controversial nature of countertransference, allowing us to understand the multitude of issues involved in order to make a grounded decision regarding its utility.

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THE VIOLENCE OF INTERPRETATION: FROM PICTOGRAM TO STATEMENT, BY PIERA AULAGNIER. PHILADELPHIA: BRUNNER-ROUTLEDGE, 2001, 336 PAGES, $32.95

Marilyn Nissim-Sabat, PhD, MSW

Although in France Piera Aulagnier’s work in psychoanalytic theory is regarded as of the highest importance (she is viewed as both psychoanalytic theorist and philosopher, as numerous online entries attest), in the United States her work is virtually unknown. Beginning in the 1950’s, Aulagnier (1923-1991), authored numerous articles and several books. Published in France in 1968, The Violence of Interpretation: from Pictogram to Statement has been translated into English (2001) and provided with an excellent “preface,” actually a lengthy introduction, by Joyce MacDougall and Nathalie Zaltzman. In this review I will intersperse interpretive and critical comments within an outline of some of Aulagnier’s key ideas and insights.

According to the publisher’s blurb, the author puts forth “a theory of psychosis based on children’s early experiences.” This is accurate, but nevertheless distorts the character of Aulagnier’s ideas. Aulagnier indeed was inspired to develop her theories by her desire to understand her psychotic patients. In her view, psychosis results from a derailment of normal processes caused by parental, especially maternal, failure to respond in a meaningful way to the infant from birth. Thus, Aulagnier presents a highly developed theory of normal or optimal development on the basis of which she derives psychotic processes as deviations from the norm. MacDougall and Zaltzman provide the correct emphasis when they say that, “We believe that the prime importance of Aulagnier’s research into the genesis of psychotic thought lay in the exceptional interest and respect she consistently maintained towards the construction of all human thought process” (p. xvi).

The Violence of Interpretation is quite simply a masterpiece. Though Aulagnier rarely refers to other thinkers, grounding in the history of, and current trends in, psychoanalytic thought is essential for comprehension. Additionally, basic knowledge of epistemology, i.e., theories of truth; ontology, i.e., theories of the nature of reality and being; discourse theory and logic; philosophy of science, i.e., realism vs. anti-realism; Kant; phenomenology; etc.,—are very helpful in understanding and evaluating Aulagnier’s compelling ideas. Even though Aulagnier does not discourse at length on any of these topics, her work comprises a unique blending of psychoanalytic and philosophical themes. Moreover, her intricate and cool intellectual style notwithstanding, Aulagnier rivals Alice Miller in the intensity of her sense of and concern for inadequately nurtured infants.

At the heart of Aulagnier’s view of both optimal normal and psychotic processes are her notions of 1) primal process; 2) the violence of interpretation; 3) primary delusional thinking and psychosis.

1. THE PRIMAL PROCESS

Aulagnier postulates a primal process that is prior to the primary process (in Freud’s sense of the latter). The most salient differentiating factor is that in the primal process, the representation of psychic experience occurs in the form of “pictograms” rather than as primary process fantasies. Pictograms are formed when, prior to awareness of separate psychic spaces of mother, or other, and self, the primal psyche represents to itself a sensory encounter with an object, e.g., mouth-breast. Aulagnier seems to understand “representation,” one of the linch-pins of her theory, as degree of awareness—the primal psyche is aware of, has consciousness of, its sensory experience of mouth-breast. This is a pictogram. Most importantly, the primal process does not construe these experiences in terms of an inner-outer duality: the “I,” a term Aulagnier uses to indicate awareness in the sense of the activity of the psyche, construes the pictographic representation as itself presented to itself and created by itself. Moreover, “every act of representation is coextensive with an act of cathexis, and every act of cathexis is motivated by the psyche’s tendency to preserve or rediscover an experience of pleasure” (p. 7). Where the mouth-breast relation is satisfactory, both mouth, which Aulagnier refers to as a “zone,” and breast, an object, are metabolized, i.e., represented as providing pleasure. This is the pictogram of conjunction. Where the relation is unsatisfactory, the pictogram of rejection is represented. For Aulagnier, all perceptual zones are erogenous zones. However,

The zone-object complementarity and its corollary—that is, the illusion that every zone produces for itself the object that corresponds to it—means that the unpleasure resulting from the absence of the object or of its inadequacy, by excess or by shortcoming, will present itself as the absence, excess or shortcoming of the zone itself. At this stage “the bad object” is inseparable from a “bad zone.” The bad breast from the bad mouth... (p. 27)
Where what is in question is a visual representation of a visual object,

...the object seen may be rejected only by abandoning the visual zone and the activity proper to it. In this mutilation of a zone-function as source of pleasure, we find the archaic prototype of the castration that the primary will have to reshape. In the primal, any organ of pleasure may become what is cut off in order to undo the displeasure for which it suddenly seems to be responsible. (p. 28)

Aulagnier claims, then, that castration anxiety cannot be understood unless it is related to processes that reflect the embeddedness of the human person in the world in the sense of a primal activity (orig. Fr. processus originaire) of the psyche. Thus, we may say that while primal experiences of absent objects and lack of satisfaction, which give rise to pictograms of rejection, are not the proximal causes of castration anxiety, such experiences, and, even more, the capacity of the human psyche to have such experiences, are a necessary precondition for the formation of castration anxiety and any of its possible harmful effects. In this, we see the immense significance of the primal in Aulagnier’s formulations. We also see that, if Aulagnier is right, then the entire problematic of psychoanalysis needs to be recast through comprehension of the originary processes of the human psyche.

In addition to this, Aulagnier’s uncovering of the primal process and her extensive analysis and understanding of it shows that human existence consists in a prehistorical and history of continuous development that occurs in layers that are built upon one another and are always in interaction with one another. Moreover, Aulagnier views human existence as a continuous active creation of a meaningful existence through progressive stages of development that bring about the historical constitution of a stable identity. That is, the three levels of representation that comprise psychic activity—1) primal pictogram; 2) primary process fantasy; and 3) secondary process ideation, are all stages in the continuous creation of a meaningful existence. A meaningful existence is one such that the person’s psychic process is not met with elements that cannot be “metabolized” or assimilated.

Aulagnier’s emphasis on the representational activity of the psyche and the psyche-world complementarity is directly relevant to philosophical considerations of the relation between psyche and world. What is clear is that Aulagnier has neither a representational theory of mind nor a correspondence theory of truth. Rather, Aulagnier’s epistemology is closer to the model of Kant, including a coherence theory of truth. Like Kant, she maintains that the belief that one knows objects-in-themselves is an illusion. However, Aulagnier does not discuss these ideas at length (nor does she mention Kant); rather, she shows through her analysis of the primal process that, “Psyche and world meet and are born with one another and by one another; and they are the result of a state of encounter that is coextensive with the state of living being” (p. 8). In other words, the only world we can know, the only reality we can know, is the phenomenal world of experience (Kant). For Aulagnier, however, the phenomenal world is affectively experienced as pleasurable or painful on every level and in every process from the inception of life.

2. THE VIOLENCE OF INTERPRETATION For Aulagnier, the “violence of interpretation” does not refer only to failures of maternal interpretations of infant behavior and interactions. Rather, “violence” is endemic to interpretations as such. To show this, Aulagnier discusses interpretive violence in two forms: primary violence and secondary violence.

a. Primary Violence Aulagnier views the mother speaking to the infant as the “word-bearer” and as the “speaking I” who is subjected to three preconditions: “the kinship system; the linguistic structure; the effects imposed
upon discourse by the affects at work on ‘the other stage’ [Freud]” (p. 11). Owing to these preconditions, primary violence refers to “the difference separating one psychical space, that of the mother…and the psychical organization proper to the infant”(p. 11). Thus, primary violence “denotes what is imposed from the outside on the psychical field at the cost of an initial violence of a space and of an activity that obeys laws heterogeneous to the I…”(p. 12). (Here we see the influence on Aulagnier, who was at one time a member of Lacan’s school but who broke with him, of Lacan’s notion that the unconscious is structured like the language of the other).

Aulagnier discusses in intricate detail (p. 72ff) the process whereby, through the activity of the primal psyche, the heterogeneous aspects of the word-bearer’s expressions, marked by repression and the reality principle, and interpretations in the form of expectations and anticipations, are metabolized into that which is homogenous to the primal psyche, itself governed by the pleasure principle and prior to repression. In this process whereby the heterogeneous is converted into the homogeneous, an essential misconstrual takes place that renders the primary violence impossible to unmask in that it “achieves its aim, which is to make the fulfillment of the desire of him who exerts it what will become the object demanded by him who undergoes it” (p. 13). In this way, the infant I begins to form an identity by appropriating meaning from the word-bearer. Aulagnier is clear that primary violence is “to the benefit of the future constitution of the agency called I” (p. 12). This is not so in the case of secondary violence.

b. Secondary Violence Aulagnier states that secondary violence,

…makes its way in the wake of its predecessor of which it represents an excess, usually harmful and never necessary to the functioning of the I, despite its proliferation and diffusion…. [secondary violence] is a question of conflict between I’s or of conflict between an I and the diktat of a social discourse…[secondary violence] succeeds in abusively appropriating the qualifications of necessary and natural, the very same that after the event the subject recognizes as proper to the primary violence from which it has emerged (p. 12).

For,

…in the register of the I there exists a threshold below which the I finds it impossible to acquire, in the register of meaning, that degree of autonomy that is indispensable if he is to appropriate an activity of thinking that allows between subjects a relation-

ship based on linguistic heritage and knowledge of meaning, in which one recognizes that one has equal rights, without which will always be imposed the will and the words of a third party, subject or institution...

(p. 13)

Thus, just as castration anxiety has a necessary prehistory on the level of primal process, so, too, does secondary violence, a function of parental failure to be attuned to the infant, have a prehistory in the necessary primary violence on the level of the primal process. In other words, pathological formations are deformed versions of normal and necessary developmental processes.

Aulagnier’s notions of primary and secondary violence have vast implications for the relation of the individual to society on every level of development, and equally vast implications for theories of child development and the practice of child rearing. Moreover, these ideas have implications for philosophical theories of interpretation as well. The point is that cultural transmission is not just a matter of the content of what is transmitted; equally significant is the manner in which cultural practices and ideas are imposed on
infants. As Aulagnier points out in the quote above, secondary violence appropriates for itself the meaning of necessary and natural, but it does not have these characteristics in the sense of communications that nurture rather than destroy the independence and equality of the child. Thus, not all interpretations are equal. Aulagnier was not a hermeneutic relativist; rather, she sought to create a scientific foundation for her views based on observation and nearness to experience.

3. Primary Delusional Thinking and Psychosis.

a. Primary Delusional Thinking Aulagnier maintains that her concept of primary process “remains more or less faithful to the one that we owe to Freud.” In her view, the primary process is activated to deal with recognition of the existence of another body, and therefore another psychical space, separate from one’s own. This recognition is stimulated by the experience of presence and absence; thus, it conflicts with the primal process for which all representations are created by itself and which recognizes only one psychical space. The function of primary process fantasy, is to resolve this conflict. (pp. 40-42). Primary delusional thinking arises when the I is presented with “the discourse of the other” which “has confronted it with a meaningless or inadequate statement”; when, that is, the word-bearer and the father have both “turned out to have failed in their tasks,” i.e., when the I has been subjected to secondary violence. Primary delusional thinking forms, then, when, in order to maintain access to the field of signification, the I creates “a cause that makes sense” of its existence, of its origin and of its history (pp. 134-136).

b. Psychosis Aulagnier places great emphasis on the child’s, the subject’s, need to know of its origin and of the origin of its history. When the answers to these questions are “contradictory with his affective and actual experience...to accept the commentary, to take it over as his own, would entail appropriating a history without a subject and a discourse that would deny all truth to sense experience.” For Aulagnier, then, the subject has psychotic potential in that “he must first invent an interpretation that makes a meaning imposed upon him, which he cannot reject, conform to reason, without endangering the foundation of his statements” (p. 136). Aulagnier does not maintain that all subjects with psychotic potential become psychotic, but that the converse is the case. A consequence of the psychotic potential, or primary delusional thinking, is that, in the words of MacDougall and Zaltzman, “because every attempt...fantasy on the child’s part fails lamentably to deal with its painful experiences...the child is thrown back to primal process thinking—that of the pictogram of rejection which the primary processes will now attempt to relibidinise in order to make the experience livable for the child” (p. xxiii).

Concluding Remarks Despite the extensive quotations, this review cannot convey the extraordinarily detailed discussions, including case material that Aulagnier provides for all of her formulations. These discussions show a masterful command of the material and make reading and studying the book a powerful learning experience.

My only caveat regarding this book is that almost all of Aulagnier’s descriptions of mother-infant interactions are linguistic. This is in conformity with the Lacanian perspective, though Aulagnier was hardly an orthodox Lacanian. Though Aulagnier died in 1991, I am not aware that her subsequent research was informed by the great advances in non-linguistic infant research made, for example, by Colwyn Trevarthen and Daniel Stern. Since, in my view, Aulagnier’s discovery of the primal process and pictographic representation is one of the greatest discoveries made in psychoanalysis, it would be of great importance to integrate into our understanding of it the findings of recent infant research.

Finally, it seems to me that Aulagnier’s ideas regarding the relation of primal psyche and world and of zone-object correlation invite advancing philosophically beyond Kant to philosophies of intentionality, especially the phenomenology of Edmund Husserl. As one trained in both psychoanalysis and Husserlian phenomenology, I hope to develop this relation in future work. Husserl would have loved the discovery of the primal process, for it correlates well with his own ideas regarding the primordial level of lived experience.

References


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From a new viewpoint a familiar landscape can sometimes look very different. (Bowlby, 1969, p. xi)

To suppose that Freud would not have wished to integrate the findings of attachment studies within his psychoanalytic theory is rather like supposing that Galileo would have rejected the discovery of supernovae or black holes (and to reject recent research findings as incompatible with Freud is not unlike rejecting later astronomical findings as incompatible with Galileo). (Hurry, 1998, p. 41)

Bowlby’s attachment theory and research, and more recently the elegant works of Main and Stern and their respective associates, has led to a rich and extensive literature. It has influenced the perception and understanding of infants and their development, and parent-infant relations and its effects on later development. Stern (1985) discussed in detail the contrast between the “observed infant” of attachment theory and the “psychoanalytic infant” of traditional psychoanalysis. The latter has been characterized as a retrospective and pathognomic reconstruction based on analyses of adults (Peterfreund, 1978). In contrast, the “observed infant” of attachment theory is based on detailed, elegant, longitudinal studies of infants and parent-infant interactions. These compelling studies have steadily continued to provide a very different view of infant and human development, and of adult patterns of relationship, than that of traditional psychoanalysis. The influence of these studies and ongoing theoretical writing can be found in a variety of psychoanalytic approaches, as Fonagy (2001) describes. Attachment theory has also been used to understand the origin of dissociative disorders (Barach, 1991; Liotti, 1995), and the origin and treatment of serious mental disorders (Allen, 2001). It is puzzling and unfortunate therefore that many psychoanalysts still dismiss or reject attachment theory and research findings, and teach as if neither existed.

Bowlby’s theories arose initially from his clinical experiences with maladjusted children and adolescents who were in residential treatment. He was deeply impressed by the role of relationship loss and deprivation (particularly of the mother) in the origins of maladjustment. Though a combination of clinical practice and careful research driven by his clinical work, he developed a model of psychic development and treatment that addresses the role of life experiences and relationships, particularly the quality of parent-child relationships. Bowlby’s underlying explanatory model relates to a biological drive, present throughout the life cycle, to form attachments as a “secure base” for exploring oneself, the world, and life’s potentials. He developed the construct of “inner working models” — internal representations of relationships formed with early caregivers (although they also can be formed in later relationships) — that influence adjustment, personality and the capacity to form secure relationships throughout life.

A psychiatrist, he was also a member of the British Psychoanalytical Society, was analyzed by Riviere, and became an analyst in 1937. From 1946-1968 he was head of the Tavistock Clinic’s Children’s Department (which he renamed the Department of Children and Parents, in line with his developing theories). He was therefore well placed to test and develop his model and theories through the use of detailed long-term clinical studies and the extensive research studies that he and some of his colleagues undertook. In his commitment to both clinical work and research he was quite unusual (Fonagy, 2001). While he was influenced by other psychoanalytic thinkers, particularly Balint, Fairbairn, Guntrip and Winnicot, and stated that his work had its origin as a variant of object relations theory (Bowlby, 1988), his theories developed independently (Bretherton, 1991). Bowlby was unafraid of exploring and integrating findings and theories from domains outside of psychoanalysis (developmental psychology, cognitive science, systems theory, and ethology) in his search to understand patients and to effectively treat them. Bowlby was also motivated by his experience and research findings to seek to change the way children are understood and treated in schools, hospitals and other settings.

In 1940, Bowlby published a paper that contains many of the core concepts of his theory. Over the next thirty years he wrote numerous articles developing and clarifying his groundbreaking ideas; his first presentation of attachment theory was in 1957 and, undeterred by the disapproving and critical responses this paper evoked in his psychoanalytic community, he published the first of his three major treatises on attachment theory in 1969. Nearly twenty years later in 1988 Bowlby wrote “It is a little unexpected that, whereas attachment theory was formulated by a clinician for use in diagnosis and treatment of emotionally disturbed patients and families, its usage hitherto has been mainly to promote research in developmental psychology.” (p. ix). Fourteen years after this, as Köhler (2002) com-
ments in her Forward to Brisch’s book, despite the vast published literature on attachment research and theory, there is still very little written on clinical applications. It is this dearth that Brisch redresses by describing a selection of cases across the entire age range, in which treatment was informed by attachment theory.

Brisch’s book, with a Forward by Lotte Köhler and an Afterword by Inge Bretherton, is a translation from the original German edition. Brisch’s presentation of his case material at a convention in Germany came just after the original was published in 1999. His presentation was so well received that all 300 copies of his book at the convention were swiftly taken, and Bretherton was so impressed by his presentation and the book, that she felt an English version would be well received.

Like Bowlby, Brisch is that rare combination of clinician and researcher. As a clinician concerned to give effective help to his patients, he realizes that it is necessary to conduct research to test the usefulness of his psychotherapeutic interventions and the theories that lead to them. As a clinician, he is especially concerned to be involved in research precisely because there has been so little work on the clinical applications of attachment theory. Like Bowlby, Brisch is a psychiatrist and therapist who is unafraid of seeking information from, and cooperation with, professionals from various disciplines “pediatrics, obstetrics, prenatal medicine, psychotherapy psychosomatic medicine, child and adolescent psychiatry” (Brisch, 2002, p. xxiv).

Indeed he is enthusiastic and assured in describing collaborations with such colleagues, and comfortable in integrating concepts from various domains of study. He finds it essential to work in this way if he is to help his patients.

His book is certainly worth reading. For those unfamiliar with attachment theory, Brisch provides brief but clear summaries of its core aspects. His detailed, up-to-date descriptions of research on the theory and its applications are written in a style that is rich and human rather than dry and technical. In addition he presents case histories that are absorbing and varied; both the research and clinical work speak clearly to the need and effectiveness of integrating awareness of attachment theory into analytic practice. Indeed, Brisch makes a cogent argument for education in attachment theory and work for providers of any kind of therapy, education, or work with people in residential institutions—including prisons.

For those familiar with attachment theory the book provides a descriptive list of attachment disorders that goes beyond the four usually associated with Ainsworth/Main’s work. There are engaging treatment accounts of both brief and long-term therapies. These accounts are refreshingly peppered with helpful, honest descriptions of the sometimes-raw countertransference feelings that arise with patients. Brisch is humble enough and assured enough that he does not pretend to be invulnerable to countertransference nor on top of it all the time, and nor does he blame the patient for it. While he describes ways he is able to reflect on and use his countertransference to help the patient, he also reports that this can take quite some time. This openness is reassuring for readers familiar with the vicissitudes of countertransference experiences.

Brisch is also at ease describing some of the major adjustments he makes to the traditional frame, particularly around the timing, length, and location of sessions, adjustments made for thoughtful clinical, theoretical and practical reasons which are in service of the patient and which prove effective. A particular gift in these case histories is Brisch’s frank descriptions of working in the less-than-ideal conditions of clinic and hospital settings, where adaptations frequently have to be made to the therapy for purely administrative or practical reasons. Regarding research, Brisch describes and cites several studies from the Europe which are rarely referred to in American writings.

Brisch describes attachment-oriented therapy as a crucial complement to other clinical approaches, and he demonstrates this in his case material. Throughout the text he compares differences in diagnosis and treatment between various psychoanalytic approaches, and refers to areas of congruity between various analytic theories and attachment theory. He makes it quite clear that he does not intend to propose a new metapsychology, nor does he want to start a new school of therapy. Further, as he unequivocally states: “...attachment theory and its therapeutic applications should not be seen as a panacea, nor can attachment theory serve to explain the origins of all symptoms (Brisch, 2002. p. 248), He adds: “Attachment should, however, be seen as a fundamental human motivation that is well documented in the research literature and that is reflected in all therapeutic processes” (2002, p. 248).

The book is divided into five sections, each containing many references to significant papers and books on attachment theory, research and treatment. The first section gives a brief historical introduction to Bowlby and the development of his theory, and a clear and concise description of attachment theory and its core concepts, with a summary of the ways a range of other analysts have addressed “attachment and separation.” The second section gives descriptive summaries of attachment disorders, with numerous references to the research that has supported and helped to form and refine their categorization and understanding. The third section addresses attachment therapy. It begins by reviewing the therapeutic theory underlying attachment treatment and then describes treatment techniques, drawing both from Bowlby’s (1988) recommendations, and Brisch’s own experience and explorations. The fourth section, which
represents well over half the text, is devoted to treatment cases from Brisch’s clinical practice. He presents examples of attachment oriented psychotherapy with cases that cover the entire range of the life-cycle from pre-conception, through infancy, childhood, adolescence, adulthood and old age; treatment lengths vary from a few weeks to several years. The fifth section addresses “prospects for further application” of attachment theory. Brisch suggests nine distinct areas where attachment theory could be applied for both the prevention and treatment of attachment disorders.

This is a very well-structured book, the sequencing of material is well thought out and effective, and the book is written in a style and language that makes the content comfortable to read and accessible. At times the clarity of writing appears to have been achieved by over-generalizing and oversimplifying concepts whose richness and usefulness lies in their details. This is particularly evident in section two when Brisch summarizes other analysts’ understanding of the concepts of attachment and loss, and in section four when he compares and contrasts attachment theory and practice with other analytic theories and approaches.

In some places, notably unfortunately, in some of the earlier cases in section four, his descriptions are sketchy and barely give the reader enough content to be able to understand, think about, or use the material. For a reader familiar with attachment theory this is disappointing and frustrating; one can imagine that for readers who are not familiar with attachment theory this could also be baffling. Such places give the reader an impression of a paragraph written in haste, perhaps impatiently. As an example, Brisch often refers in a general way to having used “attachment theory” to guide his thinking or treatment. It would be more useful to be told which aspect of this multi-dimensional theory he is using, and how it applies—which he does in the later case-discussions.

These would be serious flaws had this book been intended for analysts as a casebook or as an in-depth review of attachment theory and its applications. But this is not that kind of book. Brisch only intended to write “a selective snapshot of the state of research in this area, my own thinking, and my current perspective on the topic” (2002, p. xxvi). This is a very modest description of his book, especially given the breadth of topics within attachment theory that he covers in his “snapshot”: historical, theoretical, comparative, clinical casework, research, and prospective suggestions.

Brisch has been convinced by clinical experience and by the extensive research on attachment, that education in attachment principles and theory can make a profound difference to parents and children, adult patients in therapy and institutions, schools and education, and to society at large. He wants to share an understanding of attachment theory with providers in a range settings and occupations: teachers, nurses, physicians, institutional administrators, parents, families, social workers, as well as therapists. He writes in such a way so as to be accessible to a wide range of readers. In this context, and particularly since the remainder of the case-material is so descriptive, thought-provoking and practical, the flaws while disappointing are less problematic.

This is a useful, unpretentious, and eminently readable book. The theory, research, and case material addressed in it are crucial to consider for those interested in reflective, honest, and effective clinical practice. Attachment theory and therapy challenge some traditional analytical concepts, but it was not the first or only challenge; it is one of the few theories that has repeated, repeatable, and multi-cultural research findings in support of its concepts. Attachment theory is changing the face of parent-infant, child, family, and adult therapy, and it is changing the way development and adult behavior are understood. It is to be hoped that Brisch will write more about his experience of therapy informed by attachment theory.

REFERENCES
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Freud himself, as is well known, was ultimately not much of an optimist regarding the therapeutic efficacy of psychoanalysis. In “Analysis Terminable and Interminable” he catalogued the many obstacles to full, lasting psychoanalytic change, and lamented the difficulties of overcoming them. As analytic theorizing has developed, there has been a gradual emergence of theoretical rationales for greater optimism. The fuller development of ego psychology and the advent of object relations theory have resulted in views of the way the mind works that allow for the possibility of achieving more—and more lasting—change. Alongside these theories have grown clinical theories of technique that aim to explain, and find ways to overcome, the obstacles enumerated by Freud (as well as obstacles that Freud did not foresee).

Nevertheless, inevitably there continue to be analyses that fall far short of their goals, disappointing both analyst and patient. While outside of psychoanalysis we may find many willing to talk about the inadequacies of the treatment, in our literature there is an avoidance of this topic that is understandable but counterproductive. Not only is failure a painful topic, but in the context of psychoanalysis, it is a very complicated topic. What constitutes the failure of an analytic treatment? For that matter, what constitutes success? Certainly, we do not take the relief of symptoms in itself as a sign of analytic success. But is the absence of such relief a sign of failure? If only one member of the dyad is satisfied with the outcome, has the treatment failed? What if both are satisfied but third parties continue to find the patient unbearable? What does it mean to be unanalyzable? Any practicing clinician can no doubt think of numerous other questions. Failures in Psychoanalytic Treatment represents an admirable attempt to take an honest look at the problem of analytic failure, and to explore its causes and uses, but ultimately this book falls short of giving the topic proper consideration.

The thirteen contributors to this volume are a richly international sampling, representing a variety of schools of psychoanalytic thought, including Kohutian, Kleinian-Bionian, American ego-psychology and relational thinking. Nevertheless, with a few interesting exceptions, their thoughts on the topic of failures in psychoanalysis converge on a few main ideas. The role of severe character pathology in the patient, and the role of countertransference enactments by the analyst (the former often eliciting, and therefore co-occurring with the latter) are mentioned by most as the factors that lead to an unsatisfactory result. In addition to this tendency to sound a single note, the volume suffers from unevenness in the quality of the contributions and from inadequate editing. In fact, several of the papers read like early drafts, stimulating the question of whether the writing on this topic may suffer from the same causes that give rise to the treatment failures reported in it—that is, the difficulty of thinking clearly around the clinical problem may manifest in a difficulty in writing clearly about it. The editors’ introduction does little to guide the reader to an understanding of overall organization (say, into subtopics), nor is there any attempt at comprehensiveness in addressing the complex issues involved in defining, explaining and addressing failure in psychoanalysis. That said, there are several very good essays here, and even some of the weaker ones raise interesting points.

While almost all of the authors acknowledge the central difficulty of defining failure in the immensely complicated context of psychoanalysis, only a few take up this problem seriously. Among these, Marvin Hyman’s opening essay—presumably intended to be provocative—takes a turn toward the absurd, calling failure in analysis an “oxymoron.” If analyzing takes place, Hyman asserts, the analysis has not failed. No particular therapeutic outcome is required. This perverse literalism leaves unaddressed the question of why anyone would make the required substantial investment in such a process. Hyman defines analysis as a process of insight-collection, and argues that to make a recommendation of analysis is simply to communicate a “value judgment that it is advantageous to know one’s hidden motives so that one is not taken unawares when these motives make their appearance…” (p. 14). Beyond this goal of avoiding surprises, he seems not to recognize any other possible advantages to such insight, nor does he consider other possible products or by-products of the analytic process. Hyman proceeds to set up an oddly idealized straw man in medicine, which he paints as a field in which a “linear” schema “characterizes the relationships between diagnosis and treatment, treatment and cure…and cause and effect,” and argues that it is only a misguided identification with the medical model that leads analysts to attempt to cure at all. Recognition that analysis is “non-medical,” he argues, entails liberation from the expectation of cure, and therefore from the possibility of failure to cure. Unfortunately, as most practicing clinicians do not share Hyman’s definition of analysis, they may be less than reassured by this exemption from responsibility to help the patient.
In contrast, Alan Skolnikoff’s thoughtful piece, centering on two of his own cases, acknowledges that the definition of failure in analysis is tricky, but does not attempt to sidestep the difficulty. Indeed, he focuses on the fact that “different clinical theoretical frameworks offer different perceptions of outcome.” He presents a variety of hypotheses about his two cases, demonstrating how by using different theories one could see the cases as either successes or failures, and even within these categories one could explain the results in a variety of ways. He points out that the evaluation of outcome depends on when and by whom the evaluation takes place, and observes that subjective assessments by analyst or patient can be distorted in either direction.

Robert Wallerstein’s reflective essay, focusing on several of his own early cases, also recognizes the complexity of the issue, by pointing out the historically shifting nature of the scope of analysis and the criteria for recommending analysis rather than psychotherapy. Many outcomes that were seen as failures in analysis might have been considered successes in more supportive forms of psychoanalytic psychotherapy, he suggests, partly because expectations are lower and partly because the patients’ severe pathology makes the analytic process impossible or intolerable.

Indeed, the attempted analysis of patients with severe psychopathology is the most frequently represented category of failure in this book. Many of the contributors present extensive descriptions of failed cases in which the patient’s inability to work within the analytic frame is offered as the primary cause of failure. Stuart Twemlow, Judith Vida, and Cecilio Paniagua describe cases of severe character pathology, and the difficult countertransference experiences that accompany them. Impasses, interminable treatments, and premature terminations result. The authors console themselves and the reader with the thought that failures are also opportunities for learning. Certainly this is true, but what was learned is not always clear, and one cannot help wondering whether another opportunity—perhaps supervision and consultation with colleagues—was overlooked. The initial presentations of many of these patients make even the attempt at formal analysis seem a surprising choice, one that these authors do not explicitly justify by reference to clinical theory.

Johanna Kraut Tabin’s essay sheds a new light on the issue of failure, by arguing that a single failed analysis may be a step in a successful series of analyses, particularly with certain borderline patients. She observes that while any one of these treatments might be considered a failure, eventually such patients, by “taking attachment and separation into their own hands,” are able to build on the earlier treatments, each analysis constituting a separate developmental step.

Augusto Escribens writes about a specific aspect of transference and countertransference in his essay on “fantasies of cure.” He argues that there is an optimal balance of convergence and divergence in the unconscious fantasies of the two analytic partners about the way that cure will occur. Too much similarity leads to blind spots that can impede the treatment, while too much difference can destroy the potential for necessary identifications.

The volume contains a few essays that do not seem to fit in, although they are interesting in themselves. Ann-Louise Silver’s poignant account of the decline of Chestnut Lodge, once a unique holding environment for severely disturbed patients and their therapists, cannot really be said to be about failure in psychoanalysis. It is more about a failure of psychoanalytic ideals to withstand the ascendance of other treatment ideals, in a particular historical/political moment.

In sum, this volume would have benefited from a stronger editorial presence. An introductory essay providing a firm historical and theoretical framework, and a concluding essay tying the contributions together, would have made this a more valuable volume for psychoanalytic teaching. It is unfortunate that such an important topic was given such a cursory treatment, but perhaps the book will stimulate other thinkers to contribute to the much-needed exploration of the very complex problem of psychoanalytic failures.

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In this provocative text, Richard House suggests that the greatest danger with much of contemporary therapy is not the occasional rogue therapist but professional therapy’s “regime of truth” (p. 12). The therapy discourse creates and reinforces power imbalances and identities—therapist and client—that can engender infantilization and dependency and ultimately produce its own iatrogenic illness. In many ways he follows the spirit of Ivan Illich, indicating the danger inherent in “the disabling of the citizenry through professional dominance” (cited in House, p. 34). This results in individuals unwittingly giving their power away to those in culturally legitimated professions. His attempt in this book is to “rescue the soul of therapy” from the professionalizing tendency of modernity; and in so doing reclaim those essential values and ways of being that are in the genuine service of helping.

His well-reasoned argument is against “the grossly naïve pretense that psychotherapy become a valid science” (p. 212). He suggests that current modernist practice is more about making sense of people through various theories, than actually about helping them. He challenges the modernist notion of objective truth and the privileged position of knowledge that emerges from an interpretive dependent style of therapy, whether in classic psychoanalysis or in cognitive-behavior theory. The therapist’s use of interpretative frames can be abusive, resulting in an enculturation of clients (and therapists) into a worldview that they must adhere to in order to be “cured.”

As an alternative, the author advocates a deconstructive psychotherapy, one that is always in process … “rather than a stabilized set of teaching” (p. 46). The work of therapy may be best served in the borderland of order and chaos rather than from behind an orderly theoretical construct (p. 40). He argues against psychotherapy becoming an efficiency-based “scientized,” and/or “medicalized” practice in favor of a meaning-based, even artistic, activity, wrestling with questions of living. Post-professional therapy emphasizes human potential development and diversity in the face of a hegemonic professionalism.

In chapters 3 and 4, the author deconstructs what he refers to as self-serving categories. He treads on untouchable, or at least taken-for-granted, givens of therapeutic discourse. For example, is resistance “acting out” the client’s neurosis, or is it the patient’s unconscious commentary on an infantilized discourse? Is the therapeutic relationship understood as an emergent dialectical encounter, or is it an ordered systematized meeting obsessed with lines and “boundary-speak” (i.e., the assumption of professional distance and role definition)? Does the emphasis on boundaries have more to do with protecting the therapist from vulnerability than it have to do with client needs? Is the therapeutic container (the notion of “holding”) a safe transitional space for clients, or is it a narcissistic mutual identification, infantilizing the client and fostering the notion of omnipotent therapist? Does supreme emphasis on confidentiality offer client safety or a “privatization of distress” (p. 65) reinforcing an individualizing, isolated, modernist approach to difficulty?

Following this potent deconstruction, in part II (chapters 5, 6, 7) the author highlights the experience of three former clients and authors who have described their own therapy: Rosie Alexander’s Folie a Deux, Ann France’s Consuming Psychotherapy, and Anna Sands’ Falling for Therapy. This brings many of the abstractions of part I down to earth in a compelling way. What is conveyed is not overt client abuse but the iatrogenic abusiveness that is inherent in the “professionalized” therapy described. As Rosie Alexander explained, “I did not suffer from the aberrant condition described in the book and have not done so since recovering from the experience (of therapy)” (cited in House, p. 125). House paints a picture of an unconsciously insidious practice through which healing is achieved only through conforming to the therapeutic worldview, and thereby the therapist’s definition of client’s pathology. Helpful therapy is often about finding and creating fresh stories through which to understand our lives, but the problem, House implies, is in the imperialism of the therapist’s story as imposed upon the client. Anna Sands asks, “Whose truths do we investigate during therapy? The client’s, or that of the therapist, or of the particular school of thought which the therapists follows?” (cited in House, p. 160).

When and how is theory useful, and when does it serve as a “substitute for, and a defence against, the existential ‘terror’ of being fully in the here and now of immediate lived experience?” (p. 204). Perhaps his case against theory is a little one-sided. Theory can help us look in ways that we may not have considered before. Theory can serve to expand perspective as well as to limit it. But its utility, as he understands very well, is as a transitional object of sorts. The problem is not theory per se but the reification of it as
a closed system of truth. He reminds us that length of training one has, and the school of thought one adheres to, have a low correlation with success in therapy—something else seems to make the difference.

A post-conventional ontology and a more improvisational therapeutic approach may rescue the therapy project. He draws the epistemic and ontological ground for this revision from what he describes as “New Paradigm” thinking including that of Krishnamurti, Bohm, Steiner, and also the kind of science that Goethe pointed to. He suggests that this “explicitly and unashamedly spiritual worldview (is) absolutely central to the philosophy and authenticity of psychotherapy and counseling” (201).

The author also draws from the fascinating German poet-turned-physician, Georg Groddeck, a contemporary of Freud, whose remarkable vision of, and success in, therapy offered a view of therapy ahead of his time. He anticipated psychosomatic medicine, holistic treatment of disorders, and the healing power of relationship and love: “Without the arrow of Eros no wound can heal, no operation succeed” (cited in House, p. 181). Groddeck eschewed theory in favor of immersing himself in clients’ experiences and understanding their meanings.

Like Groddeck, House understands therapy not as an assemblage of techniques or theory, but a rich encounter and exchange between persons. This post-modern, post-conventional approach seems to come near the spirit of Carl Rogers and Rollo May—the direction of the human potential development blended with the power of post-modern deconstruction and the challenge of Lacan.

This therapeutic stance is grounded in an ontology that recognizes that human life is better considered a mystery than a series of problems to solve. It challenges the basic assumptions of modernity, the expectation for objective knowledge, certainty and control. As Groddeck wrote, “It is absurd to suppose that one can ever understand life, but luckily one does not need to understand in order to be able to live or help others who want to live” (cited in House, p. 195).

What we are left with from Therapy Beyond Modernity is a notion that the authority of therapy needs to be fundamentally reconsidered. Instead of standing on a well-crafted theoretical orientation, therapy is more authentically grounded in the authority of the embodied experience of being, an organic ethic geared toward intersubjective exchange. This is risky territory, one requiring capacity for constant deconstruction, authenticity, deep reflection, maturity, an ethic of care, and the Eros that Groddeck mentions. In the end this remains fluid, hard to pin down, and certainly hard to train for. This is not an easy, convenient or prefabricated solution (or profession). Instead, it is one that is precisely congruent with the fluid nature and mystery of life.

Richard House has succeeded in forming an erudite and passionate argument against “profession-centred,” modernist approach to therapy. This is equally a challenge to what constitutes valid knowledge; they are inextricably bound to one another. He has also pointed in the direction of a reorientation in therapeutic premise and practice that will require a shift beyond the modernist constitution of being and knowing. Regardless of the theoretical orientation one takes, this book is a powerful contribution to the dialogue of what therapy is and does, for better or worse. It provides just the kind of dissonance that forces a reconsideration of assumptions and actions. And it does so without a club, but with the skill and knowledge of an astute and authentic guide. For aspiring and practicing therapists, this book offers a provocative pause, inviting a radical reconsideration of our assumptions about knowing and helping. It is an important and articulate contribution to the dialogue on what therapy should and shall become.

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Contemporary Psychoanalysis is published by the William Alanson White Institute and the William Alanson White Psychoanalytic Society Donnel B. Stern, PhD, Editor
A Primer for Handling the Negative Therapeutic Reaction, by Jeffrey Seinfeld. Northvale, NJ: Jason Aronson, 2002, 253 Pages, $45.00

This deceptively titled “Primer” can be used by students and experienced clinicians alike, for as the author states in his introduction: “The negative therapeutic reaction is one of the most pernicious problems among therapists of all levels of experience. Beginning clinicians are likely to feel that the patient’s worsening condition is the result of their inexperience, inadequacy, and lack of skill. Experienced clinicians are likely to feel that their training and previous treatment encounters offer little help or guidance” (p. vii).

The problem addressed in this book is that some patients react adversely to what should have been, or appeared to have been, appropriate therapeutic interventions; such patients may also react adversely to the experience of their own progress or successes. This can be frustrating and confusing for the therapist, who may start to feel inadequate or thwarted, or at an impasse with no idea of how to proceed. Seinfeld presents a way to think about what is happening, to understand it, and from that understanding to work with and through the impasse. He offers a way to see the opportunities within the challenges of working with this problem. While his understanding is firmly grounded in classical object-relational theory, he describes his approach as akin to Tai Chi Chuan:

In managing the negative therapeutic reaction the clinician should not attempt to thwart or block it, but instead invite its full expression and make use of it as an opportunity to enable the patient to separate from bad internal objects (p. vii).

Throughout this book, the author uses a dialogue format to present his material; the book is written in the form of question and answer, as Seinfeld responds one by one to questions his students have asked him. Rather than providing an extensive, sequential, or in-depth explanation of his understanding, he provides succinct descriptive summaries of core object-relational concepts, using spare references to the work of classical theorists. Each chapter addresses a different aspect of this problematic dynamic; and he makes frequent use of detailed case examples to illustrate, clarify, and reiterate the central ideas that inform his approach.

This combination of dialogue, succinct presentation, clinical example, and recapitulation renders the complex concepts underlying Seinfeld’s approach more digestible for the reader. It also makes these ideas easier to think about, and to apply clinically. The reader can find possibilities in this text for handling the frustrating and often confusing transference/countertransference dynamics that lie at the heart of the negative therapeutic reaction.

The first two chapters are densely packed with theoretical material and core concepts that form the basis of Seinfeld’s understanding. He provides an historical summary of perspectives on the negative therapeutic reaction, outlining contributions of several major theorists, and he begins to give an implicit impression of his own perspective, which draws on the insights of others, while adhering to none exclusively. His summaries of other theorists serve to introduce ideas that he later uses in explaining his own approach to treatment. He describes how Freud first observed that some patients’ conditions paradoxically worsened following his expressions of hopefulness or satisfaction with their progress. Freud initially interpreted this reaction as defiance, and later as arising from an unconscious need for self-punishment related to guilt and sadomasochism; he believed these were derived from the death instinct.

Seinfeld describes how later theorists such as Abraham, Klein, and Grotstein developed and added to this conceptualization, while retaining the idea that the death instinct was responsible for this reaction. Abraham observed the role of unconscious envy and narcissism in the negative therapeutic reaction, while Klein focused on early object relations and the primitive defenses of splitting, idealization, devaluation, and projective identification. “The split-off envy manifests itself clinically as an inability to accept with gratitude interpretations that are perceived in some part of the patient’s mind as helpful” (Seinfeld, pp. 5-6).

Seinfeld states that the negative therapeutic reaction may occur across diagnoses, though the more pernicious form is usually found in more severe diagnoses, such as the psychoses, borderline personality disorder, and with trauma. He finds it useful to think of this reaction as occurring in the psychotic part of the personality, and draws on Bion’s concepts to describe his meaning: as a result of frustrated instinctual drives, the psychotic part of the personality hates and attacks both reality and the mental functions that relate to reality. This accounts for the patient’s periodic inability to think or to learn from experience—a typical and frustrating aspect of the negative therapeutic reaction.

Seinfeld then introduces Ferenczi’s theories, which specifically describe and address the traumatic origin of the negative therapeutic reaction, in contrast to the intrapsychic interpretations of classical theorists. Seinfeld also
uses Ferenczi’s ideas in order to introduce ideas about the importance of the need for attachment, the real relationship with the therapist and with early caregivers, and the potential for the therapist to contribute to the negative therapeutic reaction. Although he agrees with Ferenczi that the therapist may provoke or exacerbate a negative therapeutic reaction, Seinfeld believes that the therapist cannot cause such a reaction unless the patient has some pre-existing vulnerability. He asserts that a negative response to a therapist’s mistake is different from the negative therapeutic reaction.

In the second chapter, Seinfeld presents some of the key theoretical constructs from object relations theory that inform his understanding. Here he answers questions such as “What is an internal object?” (p. 16), “How does the endopsychic theory relate to the negative therapeutic reaction?” (p. 21), and “What are the motives for the antilibidinal self identifying with the rejecting object?” (p. 22). He answers these questions in the language of object relations theory, but also gives examples from everyday life. He describes the crucial concepts of good and bad internal objects, and their relationship to the external other. Internal objects do not accurately reflect the external other, but are distorted versions of the external other. This is due to splitting but also to the patient’s emotional and cognitive limits. The patient may react to the external other as though they were the distorted bad internal object. The patient may react to the therapist as if he/she were a bad (and therefore threatening) object.

Seinfeld draws on Fairbairn, Guntrip and Winnicott to describe the intrapsychic struggle that arises when the patient’s need for contact with an object coexists with a fear of vulnerability and intimacy. For Seinfeld, it is this struggle that underlies the negative therapeutic reaction. The patient’s uses of idealization, splitting, projective identification, attacks on linking, and identification with bad objects are all in service of this struggle. It is the use of these primitive defenses that leads to the baffling and frustrating interactions characteristic of the negative therapeutic reaction.

Seinfeld expands on these ideas and clarifies them through the use of case examples. He allows a chapter each to describe his approach with an “out of contact patient,” a borderline patient, a schizoid patient, and, in addition, its applicability to children. His case material includes brief sections of dialogue that offer concrete examples of some of his interventions.

Throughout the remaining chapters, Seinfeld gives many examples of common types of therapeutic situations, which he describes and interprets using more everyday, experience-near language—yet still drawing on object relations theory and concepts. The case descriptions make it easier to understand the object relational concepts he uses, and also help the reader to learn how to recognize object relational dynamics as they manifest in clinical work.

In a beginning chapter, Seinfeld describes the four manifestations of the negative therapeutic reaction, and how he works with them. Each manifestation—“out of contact,” “ambivalent symbiosis,” “therapeutic symbiosis,” and “resolution of the symbiosis,” corresponds to Searles’s stages of progressive work with severely disturbed patients. In his case presentations, Seinfeld gives examples of each phase and describes briefly how he works towards helping the patient move through the stages.

Seinfeld devotes a chapter to “the dynamics of the bad object,” which are central to understanding his approach. In this context he presents more explicit examples of the ways in which he allows patients to express themselves fully, while keeping his own focus firmly on their internal object relations. He writes, “I never argued with her about reality. I empathized that the external objects often did reject her….I empathized but then shifted the focus to what she was doing in her mind with the experience” (p. 126-127).

Once a patient has become aware of the difference between internal and external objects he may ask them about the internal image they have of him, in order to help them understand splitting in the transference. Once a patient begins to respond less destructively to disappointment, he feels they may be ready to address their fears of abandonment rather than splitting them off, another critical developmental capacity. At this point he may, after acknowledging and empathizing with the real situation, also interpret the patient’s dread of abandonment. He cautions however “the therapist should not be overly interpretive. The patient needs to experience the rejecting transference as a way of establishing autonomy” (p. 138).

These themes receive further expression as Seinfeld gives a full chapter each to presentations of his method of “interpreting the tie to the bad internal object,” and “interpreting splitting in the transference.” Again, he uses case examples to illustrate his points, and describes how he invites patients to attend to their internal dialogues so that they can notice their internal object relations. He writes, “I told Marilyn that I was interested not only with how she dealt with her husband in reality, but also with how she dealt with him in her mind” (p. 177).

Seinfeld ends with a chapter on “internalizing a containing object,” and he uses his clinical work with a schizoid patient to clarify his meaning. He describes his method of focusing on “the deficit of a good containing object,” and reports that he spent the first year of treatment using interpretations that held and recognized what was missing in the patient’s object relations, while using language that reflected the patient’s inner experience. This included comments that described and addressed the patient’s projective
identifications: “you are putting into me that part of yourself that wants you to be more social” (p. 232). As Seinfeld describes it, the patient initially appeared unable to identify with such interpretations, but eventually became curious. After working for some time in this way, the patient came to sessions with questions both about his way of relating, and how he had become like that. He slowly developed the capacity to allow himself to experience and express a greater range of feelings. Seinfeld describes a way of working that recognizes and allows the patient their freedom of expression and experience, but adds to that some commentary on their internal object relations. Even when the therapist chooses not to interpret, the therapist’s attention remains with the patient’s internal object relations and with the ways that these are expressed in the transference/counter-transference dynamics. This is the foundation of Seinfeld’s approach.

As Seinfeld presents it, there are actually at least two kinds of problems. The first is that the patient does not respond as the therapist expected or intended, but “worsens.” The second is that the therapist does not know what to make of this. Seinfeld’s resolution of both problems is to provide a particular way for the therapist to think about and understand what is occurring both within the patient, as well as between the patient and therapist. This understanding then leads to different interventions that, over time, lead to different results with the patient.

While he devotes several chapters to what may be going on in the patient, he gives little attention to what happens in the therapist, or how the therapist may be contributing to the patient’s response to treatment. Since he frequently states that it is important to attend to countertransference, and refers to the possibilities for the therapist to contribute to the negative therapeutic reaction, this paucity of attention is noticeable. At one point he gives a brief description of projective identification as unconscious interpersonal communication, and states that “projective identification can originate from the therapist as well as the patient, and the intensity of the patient’s positive and negative transferences can be affected by the therapist’s projections” (p. 27). Unfortunately, this is where he leaves the matter. Surprisingly, he does not devote any more space to this profoundly important observation.

At several points he makes reference to his own countertransference, but it is always in the context of countertransference that he notices it and uses it to guide the therapy. What is problematic, and all too common in the “negative therapeutic reaction,” is that both patient and therapist inevitably become caught up in unconscious reactions and re-enactments. In such situations the countertransference cannot be used therapeutically because it is out of awareness, which is part of the problem.

At this point it may help to briefly consider the influence of language and theory in treatment. The capacity to think, and to think reflectively rather than just react, is a crucial therapeutic ability. Theoretical concepts and language provide a way to organize and frame reflective thinking, which supports the skillful use of this ability. However, as Westen (2002) so eloquently argues, the use of some psychoanalytic words and terms can unfortunately restrict clinical thinking and work.

The process that Seinfeld terms “the negative therapeutic reaction” seems to be what Rosenfeld (1992) describes in his work on the psychotic aspect of the personality. It may resemble what Elkind (1992) might think of as an impasse related to vulnerabilities within both therapist and patient. Davies and Frawley (1994) see this process as a dissociative relational enactment of prior trauma, which affects both patient and therapist. Each perspective on this therapist-patient interaction suggests different ways of understanding and handling the dynamic, which might be different as well from some of the interventions that Seinfeld suggests. However, each of these other approaches emphasizes unconscious processes in the therapist as well as in the patient. Accordingly, the other authors take considerable space in their books to discuss how to understand the therapist’s unconscious reactions and their impact, both on the patient and on the course of the therapy.

Seinfeld uses the term “negative therapeutic reaction,” to describe what is happening in the therapy. This use of the term originally suggested that the therapist had been providing proper treatment that the patient rejected due to his or her unconscious intrapsychic processes. Seinfeld’s treatment focuses firmly on the patient’s intrapsychic process. Perhaps an unfortunate side effect of the use of the term “negative therapeutic reaction” and of such a strong intra-psychic focus, is that the therapist’s role may be neglected or underestimated.

References


Cress Forester is a licensed psychologist in private practice in San Francisco. She also provides psychotherapy and supervision at Richmond Area MultiServices. She specializes in working with adults with disrupted early attachment, trauma, and dissociative states.
This work provides a personally courageous and introspective assessment of the interactions between therapist and patient when confronting trauma and sexual abuse. Perlman is forthright in discussing the thoughts, emotions, and self-revelations of repressed trauma that may arise for the therapist when encountering countertransference with patients. For the seasoned therapist, this work provides self-validation in managing the stress and ethical dilemmas associated with the treatment of traumatized patients. For the student and novice, it provides guidelines and preparation for what he or she will likely encounter as a therapist.

The text is presented in three major sections. Part I begins with an overview of dissociation and countertransference from theoretical writings and clinical findings of psychodynamic and psychoanalytic pioneers. The importance of dissociation as a prominent coping mechanism is explored through both historical writings and modern considerations. Early on, Freud and Janet, through their studies with Charcot, observed the dissociation of trauma patients manifesting symptoms of conversion hysteria. Perlman summarizes these and subsequent writings by Ferenczi, the British School, and those of American, self and interpersonal psychologists.

From here, Perlman describes the initiation of therapy and the progression of the process. This primer provides a backdrop for sparking self-assessment by the reader when processing feelings and reactions to uncovered traumatic revealed by the patient. Perlman’s descriptions of the therapeutic process with his case examples resounded memories for this reader regarding the symbolism, behavioral manifestations derived from trauma during pre-verbal development, and the roles of the therapist elicited by the patient (i.e., “the rescuer,” “the deputy,” “the aggressor,” etc.) during play therapy. The text also provides a thought-provoking discussion of how the therapist’s own childhood trauma and his or her former role of calming a dysfunctional parent leads to the making of a therapist. This is another reason why the opening of trauma states in the patient can simultaneously engage the therapist’s own repressed trauma. The importance of analysis or ongoing collegial consultation cannot be over-emphasized when is engaged in long-term therapy with trauma victims. Perlman eloquently and openly discusses his own process of self-exploration in tandem with his treatment of difficult cases. He points out that often the therapist and patient are reliving their respective traumas at the same time. The needs of the patient accompanied with intense emotions can interact with the trauma experiences of the therapist.

Trauma patients can present with a plethora of challenging symptoms: repetitive memories, flashbacks, emotional numbing, omens of trauma, misperceptions of re-experience, denial, self-hypnosis, dissociation and rage. Co-occurring and self-defeating coping behaviors may include substance abuse, self-mutilation, sexual and emotional enslavement, withdrawal, masturbation, adrenaline addiction, suicide attempts, and clinging to other people. Perlman notes that some patients may attempt to use therapy as another maladaptive coping strategy. Often the therapist must perform the role of emotional soundboard for the patient’s transference and manage his or her own emotional roller coaster through countertransference.

Part II addresses the emergence of recovered trauma material during the therapy process following initial rapport building. Perlman emphasizes the importance of safety and connection for the patient as preparation for delving into repressed painful material. “Here the patient needs a deep, close experience of the therapist as a good containing other, and even a sense of positive merger or connection” (p. 76). Perlman indicates how these observations are synonymous with the concepts of traditional preoedipal transference and those proposed by the self psychologists. The necessity of achieving this goal for therapy is underscored in order for deeper trauma work to occur. Procedural memory (nonverbal memory) also plays an important role in providing openings to the unconscious, more dissociated self of the patient. These experiences occur prior to the child’s development of stable language. The adult patient may initially recall these experiences in bodily sensations such as pain, prior to being able to recapitulate them into concrete memories with verbal descriptions. These volatile emotional displays can be harrowing for the therapist and may trigger the therapist’s procedural memories or dissociated parts. During these times, the therapist is vulnerable to contributions determined by his or her own past and not by the treatment needs of the patient.

Questions that the traumatized patient typically needs answered during the early stages of therapy include: Will you hurt, ignore, or help me? Can I have power over myself? and Can you hear me? Perlman guides the reader through each of these questions one by one. He vividly illustrates the associated delicate and often emotionally draining process encountered by the therapist. An emphasis is placed on the role of countertransferences. The patient often requires soothing from the therapist in order to develop independent coping for the painful material unleashed through
procedural memory. “Also, other people usually have been unwilling to listen and provide support after the trauma, creating a secondary traumatization” (p. 84).

These steps may elicit self-doubt for the therapist as the risk of suicide and the emergence of dissociated ego states can bring further challenges. Additional concerns may include violent aggressive behaviors and child abuse. Perlman recommends limiting the number of traumatized patients for the therapist’s self-preservation. Case examples illustrate the ethical frustrations which can arise in the form of delinquent payments and/or reduced fees for therapy services and the patient’s sense of entitlement that the therapist owes special allowances for their victimization. These issues may also entail crisis calls to the therapist at all hours, which can strain the family relations of the therapist. Patients need to develop self-management skills to contain unpleasant emotional or physical symptoms. Without attention to emotional and physical regulation, the therapist can actually contribute to an overwhelming therapy process for the patient.

Sexualized behaviors by the patient and the therapist’s vulnerabilities to emotional and physical attraction are explored. The reader is provided with examples of internal dialogue that the therapist must process during the sessions. Steps for maintaining ethical boundaries while exploring the latent meaning of the transference and countertransferences are also suggested for patient-sexualized behavior. This book is an excellent resource for guidelines in managing these potential pitfalls.

Limit setting by therapists is necessary when they feel overwhelmed by the patient’s material. This can prevent retaliatory acting out which may endanger the relationship. Therapists must also manage their potential rescue fantasies, which can inhibit the therapeutic process. Consultations and vacations prevent burnout and other emotional or physical impairments for the therapist.

Second-stage therapy questions include: Can you listen to the trauma and validate me? Am I lovable? – Feeling deep love and bonding. Can you see me? – Discontinuous and shattered existence. Who is bad and who is the abuser? Is this my body? – Touch. Can you believe in ritual abuse? Perlman addresses these questions in individual chapters.

Trauma patients need to express their trauma experiences and be believed by the therapist. As sexual abuse and trauma memories are painful, disturbing, and often family secrets, the patient needs to validate that these events actually occurred. It is sometimes easier for patients to think of themselves as crazy, deny the reality of the abuse, or cope with dissociative states than to accept that someone abused them. The patient must also learn to accept that they were victimized and did not deserve what happened to them. This is often made more difficult when the perpetrator was a parent or family member from whom the patient expected love and acceptance. Lawson (2002) reports that the trauma patient’s mother may have a personality disorder, be in denial, and/or may possess neurologically-derived memory deficits regarding her abuses of the patient. The therapist must validate the trauma experience and show acceptance of the patient in the midst of graphic and often disturbing recollections.

Perlman illustrates how the therapist may have to acknowledge dissociative ego states or alternate personalities that emerge during later stages of therapy. The therapist must help the patient achieve a “contained” and reality-oriented state prior to leaving sessions. Perlman cites cases of car accidents by patients leaving sessions in states preoccupied with childhood memories. Perlman describes ways the therapist can help the patient to re-focus on the “here-and-now” at the 5, 10, or 15-minute marks prior to closing a session. He tells patients that it is “time to begin putting away the difficult material for now” and to reorient themselves to the outside world.

Part III concludes the text with chapters that provide guidelines for assessing false memories and final comments on therapist survival. Perlman presents a communication model and relevant research on criteria for the believability of repressed traumatic memories uncovered in treatment. Analysis of the event itself is presented first, followed by an examination of declarative vs. procedural memories. Research and clinical literature regarding false memory assessment is explored and possible patient behaviors and characteristics typical of genuine vs. false memories are described and compared. Risk management strategies for the therapist are also discussed for the legal and ethical dilemmas accompanying recovered trauma memories.

This is an excellent book for graduate students and clinicians with limited trauma therapy experience. It provides guidelines and lessons learned by a seasoned clinician and may help to alleviate some of the fears and frustrations encountered by the novice. For the experienced therapist, this text provides self-validation and some degree of comfort in knowing that others are encountering similar transfers and countertransfers. It resounds with the classical wisdom of the Oracle of Delphi, “Know Thyself,” and underscores the importance of analysis and collegial consultation as survival tools for the therapist.

References

Gregg A. Johns is Internship Training Director of the Mississippi State Hospital. He is an experienced child and adolescent therapist and currently supervises psychological services for intermediate and chronic inpatient adult males.
Freud once remarked that psychoanalysis is like the game of chess, in that the opening moves and the closing moves can be taught, but the middle game is difficult to learn. Martha Stark teaches the middle-game in a book of extraordinary depth that is marked by disarmingly simple and remarkably understandable principles and moves.

Taking the position that the central project of psychoanalytic psychotherapy revolves around the resistive forces that oppose the work of treatment, Stark speaks to all those resistive forces within the patient that interfere with the analytic progress toward mental health, i.e., toward developing the capacity to experience one’s love objects as they really are, uncontaminated by the need to have them be other than they are. The patient defends against accepting reality by clinging to illusions and distortions that constitute the resistance. While Stark does not directly address countertransference and counter-resistance, she writes in a direct, no-nonsense style about how two people can work together to cut through forces that limit the lives of both in the relationship of the treatment process.

The patient experiences a tension between “his recognition of the reality that his therapist is not as good as he had hoped and his need to see his therapist as the good parent he never had, [as well as a tension between] his recognition of the reality that his therapist is not as bad as he had feared and his need to see his therapist as the bad parent he did have” (p. 8). In working with these tensions, Stark sees the patient’s knowledge of the therapist informed by the present and his experience of the therapist informed by the past.

The central tenet of Stark’s approach to studying resistance is the patient’s refusal to grieve. Drawing upon classical, object-relations, self-psychology, and relational theories, she presents a model of the mind that “takes into consideration the relationship between unmourned losses and how such losses are internally recorded—as both the absence of good (structural deficit) and the presence of bad (structural conflict)” (p. xi). Maintaining these internalized records in personality functioning allows the illusions and distortions resulting from traumatic childhood disappointment to interfere with the movement toward mental health in adulthood and constitutes the resistance to treatment. The patient feels the tension between what he should let himself feel or do and what he actually feels and does instead. Both sets of forces must be named so that the patient can come to appreciate his investment in his defenses and the price he pays for holding on to them. “Ultimately, the force defended against is that healthy (but anxiety-provoking) force within each of us that wills us to change, that force that wills us to let go of the old and to get on with the new, that force that wills us to get better” (p. 3). The compulsive repetitions of childhood traumas fuel the resistance and transference, but they are also the forces that make possible belated mastery of the early environmental failures—the working through of resistances and transferences. Intrinsic to the relentless pursuit of childhood gratifications is the wish to be contained, the wish to be able to repeat in the here-and-now of the therapeutic relationship the traumatic failures with the hope that this time the outcomes will be better.

Building on Sheldon Kopp’s thesis that in genuine grief we express with sobbing and wailing the acceptance of our helplessness to do anything about our losses—while in denial we whine and complain, insist that this cannot be, and demand compensation for our pain—Stark maintains that defensive pathology or resistance arises from our refusal and/or our failure to fully mourn the past and to live realistically in the present. When patients sustain depression, feel sorry for themselves, blame oneself or others, or feel victimized and accusatory, they are not accepting present reality. They are “not confronting reality and doing what they must do to come to terms with it. They are refusing to grieve” (p. 122).

Genuine grief involves confronting the reality of just how bad it really was and is; and it means accepting that, knowing that there is nothing now that can be done to make it any different. It means coming to terms with the fact that neither the objects in one’s world nor one’s self will ever be exactly the way one would have wanted them to be. Nor will life ever be exactly the way one would have wanted it to be. It means knowing that one may well be psychically scarred in the here and now because of things that happened early on but that one must live with that, knowing that there is no way to undo the original damage done...Grieving means being able to sit with the horror of it all, the outrage, the pain, the despair, the hurt, the sense of betrayal, the woundedness; it means accepting one’s ultimate powerlessness in the face of all of this; and it means deciding to move on as best one can with what one has—sadder, perhaps, but wiser too. There is a kind of peace that comes with recognizing that things were as they were and are as they are. (p. 123)

Stark reviews Freud’s five types of resistance:
1. Repression resistance designates the barrier erected by ego to keep out of consciousness the forbidden libidinal and aggressive drives threatening to break through.

2. Transference resistance involves enactments that are repetitions of the past, a re-experiencing without conscious recall.

3. Secondary gain resistance includes gratification of dependency needs, needs for attention, needs to be taken care of, and the need not to have to take responsibility for one’s life.

4. Id resistance occurs when the libido unswervingly adheres to its objects, so that the person is reluctant to give up internalized attachments to infantile objects—regardless of their quality.

5. Superego resistance arises from the person’s sense of unconscious guilt that the ego experiences as it is failing to perform as it should by keeping id instincts successfully out of consciousness or from constantly threatening the repressive barrier. The harsher the superego, the more formidable the guilt and the need for punishment to assuage that guilt.

Stark deals with two-person forms of guilt that derive from the interpersonal perspective: depressive guilt that the person’s aggression is hurting someone loved; and Arnold Modell’s separating and individuating guilt, in which the person is reluctant to achieve emotional distance from the internalized parental objects, hesitant to become a person in one’s own right and unable to carve out an existence for oneself. Suggested interventions include: “You want desperately to find a wonderful woman with whom you can have a close relationship, but you are not sure that you have the right to such happiness” and “You want to be able to excel in your work, but you tell yourself that you are not entitled to find such success” (p. 101).

The most extraordinary feature of the book is the number of rich suggestions for actual clinical interventions—something rarely found in psychoanalytic texts. Stark’s many suggestions revolve around various categories of conflict statements, in which both desire and resistance are highlighted. In order to capture the unusual technical venue of this book, I have chosen a rather extensive sampling of suggested clinical interventions to demonstrate how very helpful and thought provoking this book truly is at a practical level.

When we go with the patient’s resistance, we are careful not to challenge it. We are not interpreting the patient’s defensive posture; we are naming it, highlighting it, defining it. It is his way of constructing his world, and we are respectful of it. We frame our interventions in such a fashion that the patient will feel understood and may even gain further understanding as well. We do what we can to use verbs that emphasize the element of choice in what the patient is doing/feeling; we want the patient, over time, to recognize and to own the power he has to decide how he wants to experience his world. When we suggest, for example, that the patient is determined not to be angry, or when we suggest that the patient does not want to be someone who is dependent, we are attempting to name the power he has and to make him aware of the choices he is making....When the therapist names the defense, the therapist is encouraging the patient to articulate some of the basic assumptions he has about himself and his objects...in an effort to get the patient to be ever more aware of how he structures his world. (p. 23)

Examples of statements supporting defenses are: “You feel that you must have guarantees” and “You are not entirely sure that it feels safe in here” (p. 24). Examples of damaged-for-life statements that uncover underlying distortions are: “Deep down inside you feel so damaged, because of
things that happened to you early on, that you cannot really imagine being able to do anything now to correct it” and “You feel so incapacitated, so impaired, so handicapped, that you have trouble imagining how things could ever be any different” (p. 28). Compensation statements include: “You wish that I could do something to make the pain go away” and “Because you feel so confused and so lacking, you find yourself looking to people on the outside for direction and guidance” (p. 29). Entitlement statements read: “Because you feel that it was so unfair, what your father did to you, deep down inside you are convinced that the world now owes you” and “Your sisters treated you terribly, and now you’re not interested in maintaining a relationship with them unless they are willing to go more than halfway.”

Conflict statements as illustrated by Stark are often framed with constructions that include: “although…nevertheless…”; a part of you…while another part of you…”; “on some level…but on another level…”; “on the one hand…but on the other…” (p. 40). A conflict intervention might be: “Although there must be times when you wonder why you don’t just leave her, you can’t bear the thought of not having her in your life because she makes you feel special and loved in a way that you have never before felt” (p. 41). A path-of-least-resistance conflict statement might be: “Although on some level you know that there are some things you could choose to do, you tell yourself that none of those things would make a real difference” (p. 43). A price-paid conflict statement might be: “You recognize that as long as you refuse to deal with just how disappointed you are with your marriage, you will continue to feel depressed, but it is easier for you to feel depressed than to think about the terror of being alone again” (p. 46). A confrontation conflict statement might be: “Even though you know that someday you will need to deal with these issues before you can have the quality of life that you seek, for now you are feeling that you have done the work that you set out to do and are therefore looking ahead to termination in the near future” (p. 47).

Stark contrasts conflict statements as those that first direct attention elsewhere and then resonate with where the patient actually is in the present with containing statements that first resonate with where the patient is now (in order to engage) and then direct attention to something that will serve to deter acting out. Examples of containing statements might be: “You just can’t get rid of this conviction that if you feel hurt by me, then you get to do anything you want, including breaking the rules, which you and I both know we need to have in order for our relationship to continue” and “I know you’re hating me right now…and I know you want to walk out this minute; but you and I both know that someday you’re going to have to figure out why it’s so much easier for you to get rid of people in your life, even people who care about you, than to forgive them” (p. 78).

Stark borrows heavily from the work of Kohut and self psychology for her understanding of how good gets internalized through non-traumatic frustrations. She relies heavily on Fairbairn and object-relations theorists to understand how bad becomes internalized through traumatic frustrations. Stark calls upon a two-person relational or intersubjective model for understanding how personality integration is achieved through encouraging the patient to look outward in order to experience the reality of who the therapist actually is in the here-and-now—namely, that he is a new good object, not the old bad one.

Working With Resistance demonstrates through theory and extended case illustration how structural deficits give rise to illusion and positive transference and how structural conflicts give rise to distortion and negative transference. Further, it shows how the patient’s transferential need to experience love objects as other than they are can be systematically worked through so that the structural configurations of the patient’s internal world are gradually altered. If something good is missing inside, the goal of therapy is to add it; if something bad is already there inside, the goal is to change it. In the deficit-compensation model, the therapist is experienced as the new good object (i.e.,
through the positive transference); while in the relational-conflict model, the therapist is experienced as the old bad object (i.e., through the negative transference).

Stark devotes considerable attention to the defense of affective non-relatedness to the therapist: “You are determined not to let me matter that much”; “It feels safer, somehow, not to let anyone get that close”; “Perhaps it feels safer right now to be keeping parts of yourself hidden” (p. 189). In the facilitation-conflict statement, the therapist juxtaposes the healthy wish to change and the unhealthy fears about changing: “You wish that you could find the answer, but you are not convinced that you will be able to” or “You would like to understand why you are so sensitive to criticism, but you are not sure that such understanding will make any real difference in terms of your actual vulnerability to it” or “A part of you wants to be known and understood but another part of you wants to remain unknown, unfound, hidden” (pp. 191-4). Stark also finds a place for work-to-be-done conflict statements: “Although you know that coming twice a week enables us to do more in-depth work, there’s a way in which (at this point in time) you are feeling that it takes too much out of you to be investing so much time and effort and money in our work together” or “Even though you know that you are someday going to have to recognize that your mother was never there for you in the ways that you would have wanted her to be, you find yourself thinking that if she could but admit that she was wrong, then it would make things so much easier” (pp. 196-7).

To aid with the working-through, grieving process of psychotherapy, several other kinds of statements are offered. Examples of the disillusionment statement would be: “You had so hoped that I would be able to give you answers, and it angers you that I haven’t done that”; “You were so hoping that I would not make the same kinds of mistakes that everyone else has made, and it makes you very sad that I too have now let you down”; and “Sometimes you wish I knew what you were thinking without your having to say it, and so it’s annoying when you find yourself having to explain it to me” (p. 218). As other examples of working though, Stark offers integration statements: “When your heart is breaking, as it is now, you can’t imagine that you could ever dare to trust me again”; “When you are feeling this despairing, you can’t remember ever having had any hope whatsoever” (p. 219).

Stark’s defense of relentless entitlement features the patient’s conviction that the therapist has “it” or knows “it” but is somehow refusing to cooperate—i.e., that the therapist is not the perfect parent that the patient wanted him to be. Relentless entitlement defends against disillusionment that the bad object never will become good, that the patient never will attain the love that she wanted in the way that she wanted it and from those whom she most wanted it. Relentless entitlement is a part of the resistance to working through the positive transference disruptions, as well as the negative transference realities. The feeling is that it should not have happened the way it did or been the way it was and so the patient feels she is entitled to have it different now.

As a child, to have confronted and acknowledged the horrid truth about his infantile objects would have been tantamount to psychic suicide. Now, in the context of being “held” by the therapist, the patient dares finally to face the horror of just how bad it was. As he confronts the truth, he feels the pain of his devastation, no longer needing to deny its existence. Belatedly, he grieves for the wounded child he once was and the damaged adult he has now become. (p. 266)

Through experiencing disillusionment in the historical past, as well as in the therapeutic present, and grieving the loss of how the person would have wanted relationships to be, the mature hope that comes from mastering disillusionment arises from working to attain something in current and future relationships that is fully realizable. In the context of being held by the therapist, the patient can let herself feel (in the present interpersonal context) the pain and outrage she feels about her therapist’s (non-traumatic) disappointment of her, as well as her parents’ (traumatic) disappointments of her. By facing these disappointments with discouragement and despair and finding that she survives them, the patient is able to find her way to a healthy capacity for hope based on realistic aspirations, not unrealistic, unattainable dreams and goals.

I have personally used Martha Stark’s Working With Resistance in fifteen small study groups of practicing psychotherapists, with excellent results. Therapists in early phases of practice find the book gives them practical help with extremely difficult situations, while seasoned therapists and psychoanalysts find many of their assumptions and ways of approaching patients to be seriously challenged. All find this relationship-centered book revealing, permission-giving, extremely practical, and personally inspiring.

Lawrence E. Hedges is a psychologist-psychoanalyst in private practice in Orange, California. He is director of the Listening Perspectives Study Center and the founding director of the Newport Psychoanalytic Institute. He is author of numerous papers and books on the practice of psychoanalytic psychotherapy.
Young-Bruehl’s *Subject to Biography* belies the caution that one should not judge a book by its cover. In this instance, the painting “Oh, Mama, will it ever be the same?” by Ronna Harris suggests at first glance a single woman at her full-length mirror and her reflections, while a second glance reveals three different dark-haired, pink-gowned women, dressed and posed similarly, in perspectival retreat from the viewer, variations on a theme of feminaleness yet each retaining definably idiosyncratic characteristics. As introduction to Young-Bruehl’s work, the cover aptly and evocatively suggests readings and re-readings, the empathy of woman biographer for her woman subject, the finding of one’s self—in one or another way—in the other, and the melancholy yet liberating response to the painting’s query, “No, it will always be different.”

Defining her perspective as “psychotheoretical criticism,” in this collection Young-Bruehl invites us into her method and her genre via 15 essays, written and presented or published between the late 1980s and the mid-1990s, and divided into two parts—The Practice of Psychobiography, and Feminism and Psychoanalysis. As a whole, the book can, I believe, be read as part of Young-Bruehl’s intellectual-autobiography, illustrative of and subject to her multiple lenses—psychoanalyst, feminist, historian, and biographer—and in pursuit of her own compelling questions. While comment on each of the essays is beyond this review, I will respond to several.

In Part I of the collection, emphasis is on the practice of biography and the subjects whom Young-Bruehl has pursued. This section opens with “The Biographer’s Empathy with Her Subject,” in which she clearly and compactly suggests types of empathy that a biographer might employ. In most of the remainder of the first half of this collection, Young-Bruehl continues to apply her theory of biographical study, especially to Anna Freud and to Hannah Arendt.

Acknowledging that her work on Arendt is seated in felt similarity of style, an intellectual kinship forged at least in part via her participation in Arendt’s seminars, Young Bruehl enters her study of Arendt via what she terms “like-to-like” (concordant) biographer’s empathy; a likeness in “mental life and, more fundamentally, type of character” (p. 20). In two long essays she parses feminism’s engagement with Arendt’s work and considers commentary on her work in three “generations,” offering detail on Arendt’s major writings and foundational arguments, and viewing her work as reflective of her character style. In “Hannah Arendt among Feminists” via positing that Arendt was “trying to point out a vast modern political dilemma—a potentially or insipiently
dictions in both research and clinical modes: “...nothing in the last two decades has made (Anna Freud’s) approach any less relevant or cogent or her historical example as a respondent to social conditions ay less important” (p. 85). I concur.

Part II of the book, Feminism and Psychoanalysis, begins with “Re-reading Freud on Female Development,” a scholarly “theory analysis exercise” (p. 175) emphasizing that Freud did not review or rework his early theories of female development on the basis of his later theoretical positions. As historian, Young-Bruehl traces Freud’s emphasis on masochism, superego development, narcissism and inadequate sublimation in female development, and points out that “internal inconsistencies that would have shown up had Freud made a retrospective review of his earlier formulation... did not appear” (p. 173). In this context she asserts her ties to the Freudian vision: “with regard to female psychology, I hope for a resurgence of plurals... plural stories of... types of masochism, types of superego formation, types of narcissism, types of creativity. I have tried to argue that these plurals were latent in Freud’s view of female psychology and need only interpretation to reveal themselves” (p. 173). Her argument here, as in her position that Freud’s view on female development was forged in his analysis of his daughter, is stated quite matter-of-factly yet, in my eyes, lacks sufficient supportive evidence.

In “Feminism, Psychoanalysis and Anorexia Nervosa” Young-Bruehl offers her critique of feminist psychoanalysis as having deleted libido theory from its tenets and therefore excluded an understanding of eating disorders as related to adolescent wishes and appetites; she goes on to examine abandonment of sexual and aggressive impulses in favor of good-enough mother and relatedness and concludes that in such theorizing there is no true intrapsychic and therefore the probability of internal conflict is overshadowed by references to cultural realities. This position is extended in the last chapter of the book, “What theories Women Want,” to an historical perspective on the bad/rejecting mother as center-piece to pseudo-analytic understanding in the 1950s and the abusive/traumatizing parent as its corollary in recent years.

In that last essay, Young-Bruehl takes as her far-reaching project the multiple implications of the paradigm shift in American psychoanalysis. The theme of the plurality of developmental courses for female development is again central. Young-Bruehl critiques object relational, self-psychological and interpersonal psychoanalytic stances, and concludes that in all of these, treatment is conceived of as the provision of adequate mothering. Extending this position into a definition of psychological health, she posits that in such theories “(t)he ideal personhood... is a mothering personhood” (p. 239).

She also critiques the emphasis on gender differences as resulting in the position that one sex or gender is better than the other, the most dangerous consequence of which is that it “valorizes—rather than analyzes—female pathology, making women’s illnesses into heroic endeavors to reject masculine impositions” (p. 251).

As her curiosity and investigations trace an arc from her disappointment at not finding Martha Freud in “Looking for Anna Freud’s Mother,” to her disappointment at the absence of an oedipal father in many contemporary feminist positions, Young-Bruehl poses and pursues big questions, traces large arcs, circumscribes and navigates large areas in what she names in the last essay of the book her “psychotheoretical criticism.” At the same time, these essays are quite intimate: she describes how she came to “biographical tenderness” regarding Anna Freud, and asserts that she and Hannah Arendt are both “productively narcissistic.” Similarly, by struggling again and again to assert her clearly personal commitment to psychoanalytic characterology as a productive mode of inquiry and to multiple storylines for normal female development as the only viable avenue for learning more about women’s lives, Young-Bruehl “does” autobiography. Even in the introduction, Young-Bruehl pointed to these intellectual commitments and so, I believe they warrant further attention. Both of these favored concepts are seated in an underlying principle of ego psychology, the synthetic function, by which the ego creatively and uniquely, idiosyncratically constitutes a symptom, or a creative endeavor, or a life story. So there is a theme within a theme, and I would like to know more.

Are there disappointments for the reader? Yes. Young-Bruehl’s commitment to her own intellectual agenda is clear; however, I believe the strength of her arguments in a number of the essays included would have been extended if there was a piece on characterology and another on the implications of a plurality of developmental story line for women. She comments in the introduction on her deflation at the reception a presentation she made on characterology got—I would have liked to judge for myself. Regarding the second, it seems a significant question that if the fixed, unidimensionality of female development is something to be deconstructed, what additional benefits will a multiple story-line theory offer? If there are multiple lines, would she posit nodal points? If multiple lines are the answer, how does she respond to the remaining categories—masochism, superego deficits, etc.?

Perpetually critiquing spaces upon which one would assume her to stand—the feminist, the psychoanalyst, the biographer,—while at the same time pushing their limits, Elisabeth Yong-Bruehl offers a self-portrait in this intellectual autobiography, one that puts her in the company of her subjects, one that, in words she uses to describe Hannah Arendt, paints her as a woman of unattenuated “independent-mindedness.”

Gemma Ainslie practices and supervises in Austin, Texas. She is on faculty of a number of Institutes and training programs. Recent interests include the interface between psychoanalysis and film, poetry, and memoir.
In this groundbreaking book, Alan Roland’s stated purpose is to integrate psychoanalysis with art and the artist. The first part of the book illustrates the importance of delineating the unique psychological issues of the creative artist if they are to be helped by psychoanalysis. The second part reexamines the relationship of the dream to art and how psychoanalysis has defined primary and secondary process. Drawing on his own experience as an artist and his deep understanding of the artist from a clinical perspective, Roland sees art taking the paradoxes and poetic metaphors in dreams to a higher level, and he critiques the hierarchical organization of primary and secondary processes as well as current ideas about art in psychoanalytic theory. In the third part, Roland reviews the history of psychoanalytic criticism to show how it has fallen into the trap of reductionism and how awareness of this as well as deeper understanding of creativity and aesthetics can make it a more useful tool in bringing psychoanalytic understanding to the dramatic arts. His scholarly knowledge of both literatures, as well as his experience as a visual artist, librettist, playwright, and a psychoanalyst with a multicultural perspective, brings a scope and complexity to these integrations uncommon in the psychoanalytic literature.

While many psychoanalysts, among them, Rank (1932), Kubie (1958) Milner (1969), Winnicott (1971), Schactel (1959), Rose (1980), have addressed the secondary place creativity has been placed in psychoanalytic theory, no one has systematically addressed the particular problems of the career artist. As Roland writes “to be an artist today involves far more than being creative and productive...To evolve an artistic career in today’s American society usually requires a degree of initiative, entrepreneurship, networking and social skills that is as, or more demanding, than any other career” (p. 14). Through expanding analytic theory and technique to address the issues of the career artist, Roland simultaneously gives finely tuned validity to the unique problems of the artist and to the analytic process as a means of helping the artist fulfill his vision.

Among the issues Roland addresses is how to deal psychoanalytically with problems related to artists’ parental and familial attitudes in conflict with their artistic aspirations, their need for selfobjects and supportive mirroring ones, differentiating from family’s or the culture’s ideas and attitudes towards art, problems of envy of other artists and towards other artists, and how success can arouse intense paranoid anxieties, resulting in attacking others and oneself.

In the example of “Hal,” a recognized filmmaker, Roland illustrates the difficult struggle involved when the artist finds himself in opposition to his own need to be a responsible family man as well as his family’s idea of who he should be. This can be a substantial obstacle in doing the aggressive networking, finding supportive others and pushing through to a successful career. This and other case material illustrate how essential it is for the analyst to understand the plight of the artist and the centrality of the creative unconscious to effectively facilitating development of the artistic self in a world where support and validation is not easily available to the artist’s plight.

Roland sees the development of internal, idealized figures as transformational objects to be critical in the artist’s development. The psychoanalyst might become the first internalized object to support the artist patient in forming the necessary mentor or fellow artist relationships essential to his career. He emphasizes that the selfobjects of the artist differ from the non-artist, in that they serve to enhance his self-esteem as an artist and recognize his talent. Roland brings out how painful it can be for the artist not to have significant others who are in tune with his artistic self and talents, particularly in a culture that tends to value utility.

As several other analysts have recognized, notably Rank (1932), the artistic and creative self is inseparable from the spiritual self. Here as well, Roland points out that psychoanalysis, particularly Freudian psychoanalysis, has tended to view spiritual pursuits and experience as either
regression to early parent-infant experiences or as some form of psychopathology. In opposition to this stance, Roland sees the realization of the artistic and spiritual self as a rare, highly developed accomplishment.

In this regard, Roland broadens psychoanalytic thinking in line with Jung. Whereas Freudian developmental theory is mainly concerned with childhood through adolescence, and separation and individuation from parental figures, Jung dealt more with adult development. He saw the spiritual and creative development of the person going beyond involvement with the family. For the full individuation of the self and reaching the peak of development, integration of the dark shadow elements, opposites, as well as the subjective and objective aspects of the self was necessary. This means parting with the crowd and convention and valuing solitude as much as relations as a way of accessing forbidden or unconscious parts of the self. Such integration is the core of both spiritual and artistic struggles and is central to what is aesthetically satisfying. Dewey (1934) held integration to be the characteristic of every work of art. And “the completeness of the integration is the measure of its aesthetic status” (p. 272).

Bringing in creativity and spirituality as significant aspects of the self, and expanding development to include the full integration and differentiation of the self redefines pathology. If accomplishments in the creative and spiritual areas are seen as supreme achievements, does one view over-attachment to the rational and secondary process as pathology? Given that artistic effort, and revelation of forbidden aspects of the self, often meets with opposition and ignorance of the process in the culture and within the self, might periods of depression, despair, anxiety and aloneness be essential phases of an artistic struggle? Relationship, pleasure and even life sacrifice, out of commitment to an artistic or moral vision, in the psychoanalytic lens, might be viewed as masochism, self-destruction or the workings of the death instinct. Given this and the difficulty the artist frequently has in finding an audience for his work (which often addresses denied truths and injustices of the society) I did not feel sufficient emphasis was given to the contribution these forces make to the artist’s inability to become successful, even with perseverance and awareness of inner obstacles to succeeding. In addition, success as demonstrated in a successful career is not always the measure of success in the arts.

One of the psychoanalytic terms Roland puts a substantial effort in redefining is primary process. He writes:

Rather than being inferior to rational, secondary-process thinking, symbolically expressive thinking of a metaphorical nature, using primary-process mechanisms, is intrinsically far better suited to represent simultaneously and in depth a far broader spectrum of psychic life than other more rational modes, and becomes the basis for meaningful and valuable paradoxes (p. 55).

The dream in Roland’s view is the exemplary product of primary process, a unique communication, with the “incipient makings of a paradox, which can then be realized through creative interpretive work…” (p. 46). Next to art, Roland sees the dream as a symbolically superior expression. He builds his formulation on the ideas of Noy (1969), who viewed primary process as serving integration of new experience in the self and giving expression to the self rather than dealing with outer reality. Roland is also indebted to Deri (1984), who emphasized that the rich symbolization of the primary process gives unparalleled expression to the various and complex aspects of the psyche.

He points out that dreams and images have the power to slip through defenses, but without the artist’s imaginative, conscious process shaping these into artistic forms, the primary process material remains in incipient form. The artist, in developing heightened consciousness of the flow of images, metaphors and dreams within and through his art, Roland believes, has the ability to achieve the greatest integration of the self. Imagery for the poet, Roland points out “reaches up into the artist’s imagination and down into his unconscious” (p. 73). But Roland’s re-vision of primary process as contained in the “imaginative part of the secondary process as distinct from the more usual logical, rational and casual thinking” (p. 150) is such a departure from how the term is generally used by psychoanalysts, it seems to call for new terms that avoid the duality, hierarchical thinking and division of mind in which these terms have been embedded. “Imagination” is an integrative process drawing simultaneously on the unconscious and conscious. I believe there is more to be gained by freshly rethinking the imaginative process than struggling to understand it through a terminology established for a different purpose.

The third part of the book, which addresses the history of reductionism in psychoanalytic drama criticism, amplifies the concerns in the first half. Roland highlights the pitfalls that psychoanalytic criticism has fallen into in the past, among them are the limitation of seeing works of art as derived from unconscious fantasies that reflect various psychosexual stages of development, for example, seeing Hamlet as a reflection of Oedipal issues; looking at unconscious motivation or psychopathology in a character to illuminate a literary work; looking to the author’s life to understand a work of art; seeing art as a defense against repressed wishes; seeing art as a form of the dream or daydream expressed within a formal aesthetic framework, and not having an adequate grasp of aesthetics.

Contending with a tradition set in motion by Freud
of using the dream and daydream as paradigms for literary works and biography to shed light on art (e.g., Leonardo Da Vinci). Roland sees literary work as a “much higher level of integration than dream imagery and aims at more universal meanings rather than particularized biographical ones” (p. 99). He shows how various psychoanalytic concepts like internalized identification or expanded use of fantasy beyond the psychosexual, to include, for example, Klein’s idea of infantile greed leading to power urges, can offer to dramatic criticism some of the deep knowledge of people psychoanalysis has accumulated. Roland’s warnings of reductionism, and the importance of a psychological approach in literary criticism operating within the work’s artistic framework and not vice versa, pave the way for a more fruitful integration. His ideas echo Rank (1932) who long ago believed that a scientific psychology could not contend with art, that art gives form to abstract ideas of the soul...feed by a higher consciousness, and the artist cannot be explained on purely individual-psychological grounds. One can lend one’s understanding of Oedipal issues to Hamlet, but to then think Oedipal issues are the key to understanding Hamlet, misses the artistic value of Hamlet. The key to Hamlet, as to any human being, is that there is no key. This said, Roland’s expanded framework of understanding challenges the idea of any fixed or complete understanding, or “use” of art to communicate ideas. Art communicates through highly developed metaphors, images and paradox, which leaves one with an aesthetic experience rather than a point of view. Each of psychoanalysis’ insights make a contribution to understanding character or dynamics in a play, but it is somewhat like the story of the blind men before an elephant. Each come up with the idea of the elephant from what they touched, but none get a whole picture of the elephant.

The plays of Pirandello and Pinter, which Roland examine, dramatize western man’s search for authentic self and the tragic/comic reverberations from his loss of it. Six Characters in Search of an Author is, as Roland sees it. Pirandello’s creation of an author who is a metaphor “for an inability of the creative self to achieve self-realization.” With the power to create he is not impotent but has the power to “portray not only the human condition but the human impasse as well” (p. 116). The lack of developed characters in the play and their cardboard nature suggest man’s unrealized being, his loss of self. Here the theme he brings out is a central to the book—the loss of the creative is not only a tragedy for the artist, but for all men and for their capacity to be authentic in relationships as well.

The plays of Pirandello, particularly Henry IV, raise the key question, according to Roland: At what cost to his humanity does man sustain this vicarious mode of living? He sees Henry IV’s metaphors and central paradox integrated with the three dimensional characters and philosophy creating a unified vision—of how man yields to self-destruction through masquerade and self-deception.

This book is an achievement that can only have come from a psychoanalyst and artist immersed in both endeavors. His artistic sensibilities alert us to pitfalls in reductionistic, analytic thought, his analytic sensibilities to the pathology specific to the creative process and universal to all, even the most talented artists.

Freud said in his paper on Dostoevsky: “Before the problems of the creative artist analysis must, alas, lay down its arms” (Gay, 1989, p. xxiii). This was in line with Freud’s idea that the creative or transcendent spirit was a gift of the few, and not fundamental to the human condition. Perhaps Freud was aware that these few would be harmed by a theory that did not see the creative and spiritual as central to human existence. He saw his theory and cure as geared specifically to the neurosis that grew out of repressed sexuality, not to the frustrations related to non-fulfillment or one’s spiritual and creative goals.

Roland has sharpened the instruments of psychoanalysis, allowing us to see more clearly both the universal place creativity and spirituality have in human existence and the central place it has in the career artist. But there are residuals of the theory he is challenging in his use of concepts that have come to have meaning in the context of the theory in which it was developed, but have not been adequately redefined in the context of the expanded vistas Roland has opened up. The fact that he has opened up these vistas is important to psychoanalysis, psychoanalytic literary criticism and the artist. While the artistic and spiritual may be fully realized by only the few, it is inherent in all. Analytic consciousness that recognizes this is essential for the full development of any person seeking analysis, but critical for the artist. For those treating artists, or those who want to bring greater understanding of the creative process into their consciousness, this book is indispensable.

REFERENCES

Elaine Schwager is a member of IPTAR in private practice in New York, and the author of a book of poems, I Want Your Chair (Rattapallax Press, 2000)
Judith Harris joins a long tradition of authors valorizing the benefits of writing (and other art forms) for dealing with pain in Signifying Pain: Constructing and Healing the Self through Writing. She combines her expertise as poet and teacher of writing with a lifelong interest in psychoanalysis to suggest that educators focus on their students as “writing subjects” rather than limit their interest to the writing product. Students can use writing as a means of exploring their unconscious to integrate experience and to develop a meaningful life story. Psychoanalytically informed teachers can foster this exploration, using the teacher-student relationship to facilitate the process.

Harris attempts three separate and ambitious goals: to demonstrate the cathartic, healing power in the act of writing, to note parallels between psychoanalysis, confessional writing and dramatic monologue, and to encourage the application of psychoanalytic principles and understanding to the teaching of composition and creative writing. Interweaving with these larger goals are themes that are equally compelling: women writing about their experience in patriarchal society, men and women making sense through writing of their experience of mental illness and of their treatment by psychiatry and the medical establishment, and the importance of taking individual suffering into the public realm, for it is only when private suffering is exposed that society can respond. These underlying themes all speak to the refusal of the role of victim through giving voice to one’s experience.

In her enthusiasm, Harris takes the analogy between psychoanalysis and the therapeutic benefits of writing too far by claiming that the writer’s audience is equivalent to the analyst. She states that the act of writing can accomplish as much as psychoanalysis without recognizing the differences between the processes and that both tools are limited without a rigorous attention to integrating what has been learned. In putting forward the benefits of writing to the writer (particularly confessional writing that brings painful truths to light), Harris indicates that the writing stands on its own merits, without addressing the distinction between writing that benefits the author from writing that is aesthetically meaningful and valuable to the reader. She assumes that giving voice to pain benefits the reader by articulating the reader’s own pain and establishing a bridge of shared human experience.

Harris’s focus is on pain, on its symbolization and transmutation through the act of writing. Pain accrues to many experiences in life: loss, failure, and trauma being chief among them. Painful experiences may be repressed, pushed from consciousness into the unconscious until such time as the person is better able to cope with the pain. In extreme cases of trauma, experiences may not be encoded verbally at the time of the trauma, but are stored as dissociated body memories and/or affect states (Solomon & Siegel, 2003; van der Kolk, McFarlane, & Weisaeth, 1996). Harris suggests that, because writing allows the author some distance from her subject, unconscious contents may begin to surface in the writing. The process of writing about painful or traumatic events after the fact brings them into the symbolic realm (language) over which the person has some control. This gradually allows the writer to know what she does not know, to accept and to process what has been unacceptable. This is a logical extension of the traditional psychoanalytic goal of making the unconscious conscious. The more painful the experience, the more difficult it is to integrate and metabolize the experience into words. Harris says that “personal writing can be a means of creating a stable identity and regaining ego strength lost in crisis or infirmity” (p. xv) and that “writing about personal experience translates the physical world into the world of language where there is interplay between disorder and order, wounding and repair” (p. 2).

Harris cites the work of James Pennebaker and his colleagues (1997, 1991) whose research consistently demonstrates the value of writing about stressful events. “Writing about traumatic experiences produces improvements in immune function and translating experiences into words forces some kind of structure onto the experiences themselves” (Pennebaker, 1991, p. 166). As the writer begins to tell the story of her trauma and to create a structured narrative, she gains mastery over the events.

Harris is a poet and uses her understanding of poetry to illustrate the parallels between writing about pain and psychoanalysis. She cites confessional poetry and dramatic monologue as two cases in point because both assume the presence of an audience. Confessional poets address their readers while dramatic monologues “cannot exist without an audience already present in the poem” (p. 111). What matters to a psychoanalytic audience is Harris’s correlation of the poet with the analyst and the empathic audience with the analyst.

Confessional writing, often addressing themes of individual, social or political violation, allows the author to throw off the burden of guilt or shame that may have been demanded by those who abused, oppressed, or failed to
acknowledge the pain of the author. Further, it allows the author to retell her story in her own terms, without impingement by others. This certainly parallels the process of psychoanalysis, where the analysand begins to construct a meaningful narrative of her life. But when Harris states that “when a reader empathizes with a writer’s signification of pain or illness, that reader is already a part of the cure” (p. 8), she takes the analogy with psychoanalysis too far. First, the reader is not audience to the writer’s pain in the same way that the analyst is to the analysand. There is no direct way for the reader to impact or shape the writer, although the reader may well be transformed by the writing. Second, the fact that writing can be healing does not imply that writing can “cure.” It would be wrong to think that the traces of suffering and pain can be eliminated through writing or through psychoanalysis. They can only be alleviated and better understood.

Harris argues that the imaginary reader or audience to whom the writer is writing influences the work. “Both psychoanalysis and confessional poetry provide a place in which subjects can vent conflictual feelings and ideas in the presence of a reflective and quizzical other. (Whether it be an analyst or reader, this other also comes to embody an observing aspect of the self)” (p. 178). This conflation of an imagined other (the reader) with a real other (the analyst) is problematic. It is precisely the separating out of the real analyst from the imagined (projected) analyst that is the meat of psychoanalytic work. Without it, the analysand is not able to understand and identify the ways in which she is shaping experience in painful or unproductive ways.

Harris further says that “a writer, like a patient in psychoanalysis, who is aware of exposing raw material in the form of dreams, associations, or even confessions, knows that whatever she has to say, however upsetting or shocking, is always dependent on a listener’s readiness to hear it.” Again, I disagree. One needs to disentangle the truly valuable effects of writing from the also valuable but different benefits of psychoanalysis. A writer is alone in the process of writing. However the writer may conceive of her audience, that audience remains a fantasy during the process of writing. The benefits of writing accrue to diarists who never share their work with others and to writers of the Great American Novel whose opus never leaves their bottom desk drawer. Those who offer their work to the world but find it poorly received also benefit from the process of having written. However one thinks of these benefits, they are very different from the experience of being in the room with an actual other three or four or five times a week and having one’s experience actually received, held, metabolized and answered in ways characteristic of that analyst’s personality and theoretical orientation.

As a teacher of creative writing, Harris places less emphasis on what students say directly and clearly in their own voice than on what they say in associative and allusive language. “The students must try to express what the poem itself, and not the writer, is trying to say” (p. 179). By allowing the poem to speak, the student may bring material that was previously unconscious into the open. This is a valuable process and certainly parallels that of psychoanalysis.

Harris also understands that “a student’s awareness of unconscious conflict, resistance, or self-defeating behavior is usually not sufficient to produce change.” But she believes that “students must share their personal experiences through writing so that genuine learning can occur” (p. 199). The fact that a student can now write about something that was previously unavailable does not mean that its impact has been understood or digested, or that there are not further things to be understood that are not yet available.

Harris encourages writing teachers to familiarize themselves with psychoanalytic precepts so that they can facilitate their students bringing unconscious material to light. Based on her reading of Lacan, she recognizes the “potentially therapeutic aspects of the teacher/student dyad” and the possibility that students will work to improve their writing because “they identify with and want to please the teacher” (p. 198). She encourages teachers to focus less on the writing product and more on the writing subject.

Although the relationship between teacher and student can be very powerful, encouraging students to “confess” and to reach for previously unavailable material can have a seductive and destabilizing impact that may go well beyond what most educators are prepared for. Writing, like psychoanalysis, is elusive. It can be healing, integrative, creative, and yet it can fail to fulfill its promise for reasons elusive and obscure. The reasons reside in the complexity of the human psyche and it seems, therefore, somewhat dangerous to encourage educators to venture forth into these, for them, uncharted waters.

Harris’s attraction to psychoanalytic thinking and its utility for the creative process is offset by enormous ambivalence in her depiction of the medical and psychiatric establishments. Although she champions psychoanalysis and counts herself as one of its avid students, her book as a catalog of maltreatment at the hands of doctors and mental institutions is daunting, from a discussion of Charlotte Perkins Gilman’s The Yellow Wallpaper; to poems by Robert Lowell, Ann Sexton, and Sylvia Plath, to her personal autobiographical contribution describing an adolescent breakdown and hospitalization:

My doctor, Dr. Panicky, believed in hypnosis, which he explained as the purging of original trauma through regression techniques. I would lie down on the cabbage-green couch, and he would swing a pocket watch
over my head while I counted down from twenty and hyperventilated. Then he would take my hand and move it with his hand in some peculiar parody of an exorcism. I would wake up screaming in a fetal position. This would happen rhythmically and punctually three times a week. I still cannot read Kafka. I now understand that this technique is a distant descendent of Charcot’s first experiments on hystericis. I was merely a casualty of some misreading of an old classical text handed down from some magistrate of the psychoanalytic establishment to this third-generation doctor, who was fond of cigars, sadistic puns, and marble paperweights. This doctor was board certified; my parents scraped together every dollar they could to pay for these treatments. *In the very, very far distance of a corner of the soundproof room, I still imagine I can feel the weight of his body, see myself wrestling off the bulk of this man with his red beard, chain watch, vest, and notepad* [italics in the original]. (245)

Harris does not comment further on this experience, which at best speaks of incompetence and at worst sexual misconduct. Given her understanding of the damage resulting from inappropriate application of psychoanalytic principles, it is surprising that she encourages educators, with even less understanding, to apply psychoanalytic techniques.

There is a lack of psychological sophistication in this book that will be frustrating to most psychoanalysts. Harris does not make important distinctions between repression and dissociation, nor does she recognize the importance of working through material that has been “excavated” from the unconscious through techniques such as writing. She includes hypnosis as one of the tools of analysis (p. 93), perhaps based on her horrifying experience with Dr. Panicky.

“We must recognize that psychoanalysis itself, even as Freud practiced it, as a beneficial cure for psychological conditions, is an abreaction of trauma in the interest of undoing trauma itself. The process of recovering a patient’s trauma uses several known methods including hypnosis, free association, and the flooding of memories” (p. 39). Most analysts today would not recognize themselves in this description.

It seems that Harris claims too much for writing and at the same time not enough when it comes to the possibility of healing. In her discussion of Sylvia Plath’s and Anne Sexton’s angry poems to their fathers, she acknowledges that these poems may reveal a self-destructive desire to be fused with the father. “Such expressions of rage directed at the paternal object are often more dangerous to the daughter than the external threat of the father himself” (p. 85) and may represent a way of keeping the relationship to the father alive through an abusive and destructive fantasy rather than through having to deal with reality. There is no healing here and both authors’ deaths by suicide suggest that their writing was insufficient to their pain. And yet the fact that writing could not avert the depression and suicide of these authors does not invalidate its enormous potential to help each of us examine and integrate our experience.

Perhaps too many boundaries are blurred in this book: boundaries between confession and analysis, between mental illness and the human condition, between writing as an art form and as a tool for self-discovery, between therapy and education. Every life contains pain and suffering but not all pain is traumatic and not all suffering leads to breakdown. The agony of depression leading to suicide or of bipolar illness resulting in multiple hospitalizations is different from the “common misery” that belongs to being human. It is obvious that writing did not cure Sylvia Plath or Anne Sexton or Robert Lowell or any number of other truly wonderful writers. Did writing ease their suffering and was suffering necessary to their art? Harris does not make this clear.

Harris is writing within a tradition that acknowledges the important relationship between writing and pain. Isak Dinesen said “All suffering is bearable if it is seen as part of a story.” But writing is only one aspect of creativity and pain but one aspect of being human. The overarching relationship, as Deena Metzger writes, is between “creativity and self-knowledge. Ultimately, one informs the other. Soon creativity and self-knowledge will seem like twin sisters, similar but distinct comrades who have a common origin.” For me, psychoanalysis has more to do with self-knowledge than with the alleviation of suffering. Harris is not the only one to link creativity to suffering (see D. Aberbach, 1989), but this seems to me to narrow the definition of both creativity and self-knowledge, especially for a target audience of educators and college age writers in university classrooms.

References


Desnee Hall is a psychologist in private practice in Scarsdale, NY. She has published articles on disclosure in psychotherapy and uses expressive writing in her work with groups and individuals.
Norbert Freedman is a revered teacher, researcher, and original thinker who has been highly influential in the functioning of the “Institute For Psychoanalytic Training and Research” (IPTAR). This volume, edited by Richard Lasky, is a tribute to Freedman’s creativity and influence on the psychoanalytic scene. It consists of a personal biographical and research summary introduction by Lasky, as well as twenty-two subsequent essays by prominent psychoanalysts most of whom are attached to IPTAR, but also including Sydney J. Blatt, Lawrence Friedman, Jean B. Sanville, Ricardo Steiner and Robert Wallerstein.

I approach this review from the position of a postmodern ego-psychological perspective, which includes emphasis on multiple forms of both intrapsychic and interpersonal conflict. This makes it necessary for me to “translate” some of the concepts and terminology into various communication forms which for me are more familiar (i.e., symbolization as the ability “to gain psychological distance from raw (internal or external) experience” (p. 1) translates to the ego capacity for self-observation and affect modulation.). Given the differences in language and conceptual phraseology, the similarities to the topics and processes described in this volume and those of more traditional ego psychological conflict theory are striking.

As with any collection of separate essays the quality and clarity varies among individual contributions. But one theme that runs through most of them is the praise and acclaim for Freedman and his impact as a role model and thinker. Lasky quotes Freedman himself in regard to symbolization:

The psychoanalytic attitude is a symbolizing attitude. We listen to our patient’s stories as signifiers of multiple meanings. And, we listen to ourselves from multiple perspectives. Our patients deal not only with drives, self, or objects, but they also try to deal with symbolization of drives, self, and object relationships. What matters consistently is the process of translation and transmutation. Psychoanalysis may have been born in theory of dreams and matured in the theory of transference and countertransference, but these are all unthinkable without a concept of mediation and transformation. It is a process of linking items in different spheres of the mind where one represents the other. It is a process where experience, stated as a fact through self-reflection, becomes symbol. It is through such a network of mediation that psychoanalytic work accrues and when this is throttled impasse ensues. Hence, it is along lines of symbolization that we can account for psychoanalytic work and psychoanalytic change. It is this perspective that has given rise to my most recent interest in symbolization as a process specific to analytic treatment.

And it is a process that belongs to common ground because every analyst, in every theoretical orientation finds, him- or herself embracing a symbolizing attitude. Such a recognition calls for a specific psychoanalytic theory of symbolization, rooted in but overriding known cognitive or information processing approaches. (p. 18)

“Desymbolization is concrete and repetitive, with an insistence it is not only on the sameness of things in situations but also sameness of the self and of others. Defensively this mood of mentalization is based on profound disavowal, implementing the wish not to know.”

“Only single unwavering perceptions of experience are used and they are treated as concretized facts, rather than being understood as a construction, as one of many possible interpretations” (p. 19). In other words the person’s feelings and beliefs are experienced without question as reality.

Between these extremes are intermediate levels of the capacity for symbolization. Incipient symbolization is the early possibility of relating body-linked emotions to past and non-verbal modes of expression. Discursive symbolization expresses the widening of inner space and the ability of the analytic couple to begin to reflect together on the impact of relationships and the beginning of self-awareness. Dynamic symbolization implies that “something unknown or unconscious is being integrated, bound, and linked.” It refers to the recognition of contradictory per-
spectives on the self or on the other person. These contra-
dictions will vary in structure from chaotic and incoherent
to cohesive and realistic.

An additional contribution of Freedman’s ideas has
been in the utilization of videotaped psychoanalytic ses-
sions which allow the researcher to observe movement and
other physically manifest experiences, both of the analyst
and of the analysand, and to correlate these with the flow
of psychic experience expressed verbally and in that sense
to explore on a more sophisticated level the correlations
between psychic mental function and physical activity and
symptomatic expression.

There are a number of themes that tend to unify the
different contributions in this volume, although each may
be presented in a slightly different way. One is the multiple
levels and forms of communication in the clinical setting,
including the verbalization of various “body language”
activities, the manifest content expression of a dream,
acting out and with it also the concept of enactment, the
importance of transference-countertransference responses,
and the analytic relationship which emerges progressively
in the dyad, and the needs to establish trust and reestablish
it when broken. Another theme through many of the con-
tributions is the analyst as a new object in the patient’s life
experience, and the emphasis on the crucial importance of
the analyst’s response to the patient’s difficulties and distor-
tions. The idea of symbolization as a process leading to rec-
ognition by the analysand that the transference experience
is not the same as reality.

Another common theme is the essential importance
of the earliest mother-child relationship and developmental
process that evolves out of that relationship including the
capacity for symbolization and for a significantly trustful
relationship.

The emphasis throughout is on the analytic process
as encouraging the shift in the analysand from raw primi-
tive potentially annihilating states of affect to the capacity
to modify such experience into secondary process verbal-
ization. This occurs in a slow and stepwise process that in
some ways recapitulates the original development through
the use of the analyst to re-experience that process with a
new object, and the analyst’s capacity to maintain connec-
tion without retaliation.

Silverman’s case report illustrates that the anal-
ysand’s sense of self and self-worth are a function of the
interaction with the mother. The need of the analysand to
maintain the negative self-image is a justification for hatred,
which then continues the tie to the original object. In this
context her idea is similar to those of self psychology and
the individual’s sense of self being a function of reflection
of the mother’s empathy and care and concern which is
internalized by the child. Describing the various ways
of communication other than verbalization with which the
analyst interacts with the patient she emphasizes that forms
of implicit communication may represent procedural knowl-
dge and open unanticipated forms of being together. This
in self psychological terms would be the analyst’s prolonged
immersion in empathy and empathic connection to the
patient as a new form of interpersonal interaction.

Lawrence Friedman presents symbolization as a
form of attraction and considers language and mathematics
as having achieved the ultimate level of abstract thinking.
“Treatment has to do with what is being put into language
as well as how language facilitates the selection. When
we say that psychoanalytic treatment creates or restores
symbolizing we really mean the treatment fosters accurate
abstractions and a fluid process of symbolizing. So our first
question is how abstractions come to be formed and the
second is what influences their formation” (p. 211). For
Friedman, “habits and words have something in common,
since both are examples of abstraction” (p. 216). Language
and the ability to describe inner experience is a process
of abstraction, which then allows an individual to become
aware and to recognize the qualities of his or her interac-
tions with other people. This is particularly the case with
the analyst, where the analysand’s habitual abstraction and
expectation can at times be challenged by the analyst’s
unexpected and non-confirmatory reactions and responses.
“In each case the analyst’s unexpected behavior would
challenge the abstractions that comprise the patient’s preex-
isting transference” (p. 226). (A concept close to the “cor-
rective emotional experience” of Alexander, but without the
element of conscious manipulation.)

Within the confines of this review it is not pos-
sible to extensively summarize each person’s contribu-
tion. The papers cluster around issues of transference
and countertransference and the idea that symbolization
allows the patient to recognize the distinction between the
transference feelings or fantasies and the reality, whereas
in dysymbolized transferences the patient experiences the
transference as reality and there is little capacity for self-
observation and self recognition of the fantasized nature of
the response. There is a heavy emphasis on very early pre-
verbal experience in the mother-child interactional matrix
out of which the capacity for the development of language
becomes an important basis for development for the capac-
ity for the use and experience of symbolic thinking. If this
interaction is significantly pathological, the child persists in
procedural memory leading to problems of desymbolitzion.

Another line of contribution is the concept of trust
and the therapeutic alliance and its importance in the pro-
cess of analytic work and capacity to experience the analyst
as trustworthy at a symbolic level. There are inevitable
interruptions in the sense of trust (similar to the emphasis
on breaks in empathic communication in the self-psychological model) and the urgent need to restore the capacity of the patient to trust.

Another contribution focuses on the need for some analysands to deny pathology in the parent in order that the child can maintain a sense of attachment to a protective object. The impact of the disturbed parental thinking on the identification and the capacities for symbolization and learning in the child can be intense.

Throughout the contributions there are a significant number of brief, and some more extended, case vignettes meant to illustrate some of concepts being presented. Some of these tend to be somewhat sketchy and therefore of less value than others where the detail and relevance to the point being made are significantly more effective.

Generally speaking this is a somewhat variable collection of contributions focused around the research and concepts of Norbert Freedman in which various authors attempt to elaborate on one or another aspect of Freedman’s thinking and work. For someone like myself not already familiar with the vocabulary and concepts involved it can be a slow and difficult volume to read, and yet as one does so one appreciates the ways in which the phenomena of clinical interaction are similar. In spite of our theoretical and technical differences and the varying ways we describe them the end result is an appreciation of the commonality of our clinical psychoanalytic experiences. The end result is a worthwhile effort and the reassurance that in spite of our individual idiosyncratic way of describing and conceptualizing what we see the commonalities reinforce and reassure one that the enterprise of clinical psychoanalytic experience is validated through more than one perspective. “A rose by any other name...”

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**The Trauma of Freud: Controversies in Psychoanalysis**


I personally like Paul Roazen, and have great respect for his writings and studies of psychoanalysis as intellectual history. One might make the claim with a degree of confidence that indeed he originated a new field of scholarship. I admire his dedication to historical truth and not simply the word as presented from above as well as what seems to be his inherent gravitation to the “underdog”;

name those psychoanalysts who have been overshadowed, maligned or made into “non-persons” by the powers that be, i.e., Ferenczi, Tausk, Rado, Fromm, Erikson, and Jung. With that in mind, I must add that I have not always agreed with his conclusions or inferences but trust the motives underlying them. I do not categorize him with the “Freud bashers” and agree with his assessment of Freudian studies that “A sober assessment of what he accomplished may make less likely the kind of shallow polemical assaults on Freud that have become so fashionable lately” (p. 69). His feelings and evaluation of Freud are summarized by the following statement: “Along with being a great writer and psychologist, Freud was a revolutionary in the history of ideas, which means that he was also hard and a fighter. Freud sought to affront the pieties of his times, and sometimes even consciously identified with the devil in Western history” (p. 130). Not a bad legacy.

One criterion for judging a book is whether or not the author’s stated purpose is fulfilled. For Roazen, the desire was to “…lead others in the future to look on all such matters with more of the nuances that a serious historical subject deserves” (p. xii). Accepting this criterion, the book is a success, and hopefully this review will be seen as part of that unfolding discourse. The trauma of the book’s title is defined by Roazen as based on the fact that “Freud succeeded in decisively transforming how we think about ourselves.... Freud shocked civilized readers, and reactions to his system of thought have seemed mandatory. It has recently been suggested, “one could say that the history of psychoanalysis consists of a continuous conversation with Freud” (sic!) (p. xv), and much of this book deals with that transformation. I will not comment on the parapraxis that appears in the quote, other than to point out that perhaps it reflects Roazen’s desire to differentiate the real Freud from the one who has been handed down by sycophantic followers.

In a series of chapters, dealing both with controversies that have marked the still brief history of psychoanalysis, and often pungent reviews of books, written by scholars in the field, as well as advocates of specific positions and even academic poseurs, Roazen neatly ties together the trends and demonstrates how much of what previously appeared as truisms was not based on fact but mere hagiography. Roazen’s critique of Robert Caper can apply unfortu-
nately to much of the literature in the field, “Clinicians such as Caper ought not to be able to think that they can proceed to bat out books about psychoanalysis without being called to account by the normal standards of everyday academic life” (p. 82). I agree and must add that the same intellectual standard should apply to Roazen, but more about that later.

This book reflects Roazen’s forty-plus years in studying, as well as interviewing the pioneers in psychoanalysis and his lifetime attempt to set the record straight. One must wonder, why after all this time, the psychoanalytic establishment still is leery about the truth of the field, and the early Freudians, as if an historically true representation would diminish the power of their contributions or the potency of psychoanalysis as a method of investigation. On a lighter note, but one of equal importance, the book is an engaging read, full of information, passion and the obvious love for the work to which the author has committed his professional life.

Now for my disagreements, queries, or nuanced reading of the topics Roazen discusses. As for the Jung chapter; Roazen is on target in pointing out the numerous contributions and foreshadowing of contemporary psychoanalysis that can be found in the Jungian canon. Not only training analysis, but the mutuality of treatment, the use of countertransference, the emphasis on the “self” and the unfolding of developmental paths are all there in his writings and, as Roazen rightly points out, rarely mentioned in the standard psychoanalytic literature. Where I think Roazen underplayed the reason or at least one of the reasons for Jung’s relative neglect by the Freudian field is the question of Jung’s politics and how they might be reflected in his theory. I cannot discount Jung’s flirtation with Nazism as simply “unfortunate” (p. 31), “regrettable” (p. 32), or “naive, even stupid” (p. 40). The fact that the analytic establishment left a lot to be desired in their attempt to not have the Nazi movement impinge on the “sanctity” of the psychoanalytic endeavor, nor Freud’s inscription of “Why War?” to Mussolini cannot lead to an equation with Jung’s role in the therapeutic movement during the years of the Third Reich. It is also hard for me to reconcile within the same chapter the following two statements that appear, literally, on the same page “Linda Donn’s Freud and Jung: Years of friendship. Years of Loss is not a scholar’s book” (p. 18), and, “even the most knowledgeable readers have things to learn from Donn’s careful research” (p. 18-19). Which one is it?

The question arises of the necessary background to be a psychoanalyst since at various points Roazen criticizes both Anna Freud (p. 105) as well as Melanie Klein (p. 80) for the absence of medical training and how that impinges on their therapeutic and diagnostic abilities. The same seems to apply to Freud who was indeed a neurologist as Roazen claims. Roazen states, “Those who are most familiar with Freud’s clinical practices have no doubt that his lack of psychiatric training was a handicap to his diagnostic abilities” (p. 132). Who? What are the sources for this statement? And, “A central inadequacy of Freud’s training was his lack of rounded psychiatric experience, for his practice tended to exclude cases of grave mental illness” (p. 140). Maybe. It should be remembered that psychoanalysis originally was a method of treatment for neurosis and Freud did differentiate between psychoneurosis and narcissistic neurosis.

Also we must question whether Freud was as removed from psychiatric training as Roazen infers. He did a “residency” with Meynart, did he not, and this is covered in Hirschmuller’s book Freud’s Encounter With Psychiatry (Editions Discord, 1990), which unfortunately has yet to be translated into English. Unlike 21st century Board certification, the case can be made that Freud’s familiarity with Kraepelin and Bleuler, as well as the work with Meynert, qualified him as a psychiatrist. It also should be recalled that the title Psychiatrist applied to state employees of the Austro-Hungarian Empire who worked in state asylums and in many ways was off limits to Jews, even “Godless” ones such as Freud. If I am wrong on these points I am sure Dr. Roazen will not hesitate to correct me. I must also wonder why the criticism of Klein who “…only lacked medical training but never attained any kind of higher education…”(p. 83); whereas, Erikson, who matched Klein in the absence of credentials is seen in a positive light. “To the extent that Erikson continues to inspire new generations of analysts he will have succeeded in being a creative leader of the field” (p. 192). Perhaps Roazen is responding to factors other than training and academic degrees?

Roazen is quite correct in consistently challenging the standards of scholarship of much of the analytic literature. Indeed too much is shoddy, slipshod, and below academic publication standards. One requirement is that categorical statements be cited, substantiated or referenced. Here I have several questions for Roazen based on his own criteria. We find the following: “Even among the most ideologically emancipated contemporary psychoanalysts, relatively few are familiar with Jung’s clinical contributions” (p. 28). Where is the evidence for this? Within the last five years issues of The Psychoanalytic Review, Psychoanalytic Dialogues, and articles in Psychoanalytic Psychology appeared representing the clinical Jung. In regard to the British analyst, Karin Stephen, Roazen states: “I was authoritatively told that what kept her back was the emotional instability that eventually led to her suicide....” (p. 74). Having been instrumental in reintroducing Ferenczi to the analytic community, and exposing the attempt by Jones to smear him by diagnosis, a not uncommon characteristic within psychoanalysis for dissidents and renegades, Roazen presents the same argument, also unsubstantiated. Again,
who is the source? On page 147 we find the following: "Although it is luckily not known abroad, one of American psychoanalysis’s unique contributions has been that journals publish partially ghost-written works with artificially concocted bibliographies.” A hell of an indictment. But, which journals? What again is the source for this assertion? As editor of a journal for the last fourteen years and a colleague of many fellow editors within the field, I have never heard of this, nor have I seen any evidence to substantiate this claim. On page 146 we find: “The death of Jones’s first wife (about which rumor has long had it that much more was to be unearthed)...” What are the rumors? Who passed them on? What was the underlying agenda? As it stands this statement is too much of a tease and needs emendation. And finally, “There is no way practitioners can function without unloading some of their problems on their spouses and professional colleagues, so confidentiality is, in any event, a relative phenomenon. There is also the problem of malicious gossip, which psychiatrists indulge in like other human beings. Once again maybe, however, are peer groups, supervision and consultations considered violations of confidence? As to the other comments, here too, they are declared by fiat rather than by any empirical evidence supporting them.

There are several points, stated as facts, which are really interpretations, with which I take issue. We find on page 156, “According to one of Freud’s loyal Swiss disciples, Ludwig Binswanger...” It is a bit of a stretch to see Binswanger, one of the founders of existential psychoanalysis, and certainly not part of the “loyal followers” as a disciple, loyal or otherwise of Freud’s. At best we can call him an admirer, but certainly his own person. In fact the case can be made that he was one of the few non-followers with whom Freud maintained a respectful and friendly correspondence. We find the following in regard to the Chicago psychoanalytic scene, “In his lifetime, Alexander became highly controversial, and it is a sign of his impact in Chicago that ever since he left in 1956 analysts there have been so fearful of the charge of unorthodoxy that Alexander’s name almost never is cited by the people one might most expect” (p. 230). Fearful of being labeled “unorthodox”? Chicago? Is that not the base of Kohutian developments, and the “home” of self-psychology? Did Anna Freud not refer to Kohut as “antipsychoanalytic” (p. 97)? Indeed, Alexander has been largely and unjustifiably ignored. Is that the result of a fear of unorthodoxy, or perhaps other reasons?

This book continues the Roazen canon of exploration, with “no punches pulled” into the history of psychoanalysis. I can recommend it along with the rest of his writings for those readers committed to knowing what happened and not the sanitized version that is often presented in one’s training. For this alone Roazen deserves to be commended.

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Although many readers of this newsletter may deplore the burgeoning practice of finding a drug to “fix” every human problem, I want to suggest how much hard thinking we need to do. Close reading of the literature on the subject of pediatric pharmacology for psychiatric and emotional problems can provide useful information to challenge the unthinking acceptance that “drugs are the answer.” When closely read, the research studies used to justify drug treatment often do not support these conclusions and, many times, support opposite conclusions concerning the efficacy and safety of these drug regimens. In this article I will review a number of recent studies and address the flaws and limitations that limit or undermine the conclusions offered by researchers.

Using prescription medications to help children once referred to as minimally brain damaged (and now diagnosed as ADHD or ADD) has a long history. In 1967, Millichap and Fowler successfully launched the popularity of Ritalin in a major journal, Pediatric Clinics of North America. Millichap held the prestigious post of Chief Neurologist at Children’s Memorial Hospital in Chicago. Partly as a result of this article, Ritalin rapidly became the favored medical approach to the problems of the hyperactive child. Their meta-analysis of data on the use of other drugs made the case for Ritalin. Closer inspection of their findings, however, reveals a somewhat different picture. The data on Ritalin, however, consisted of six studies. Only one of the six studies reported double blind, placebo-controlled design. That was a 10-day trial with 32 children. Seventy per cent of those children showed side effects from the medication. This was stated in the Millichap and Fowler summary table; but it was not noted in their totaling of the appearance of side effects. Instead, they reported that only 14% developed side effects, based on three other studies that merely summarized impressions of the experimenters. In terms of improvement, the three studies in the literature up to that time that gave impressionistic accounts of the children’s responses indicated improvement in 75%, 87%, and 90% of the cases, respectively. Millichap and Fowler concluded that Ritalin was 83% effective, with side effects in only 14% of the cases. The case for Ritalin was made almost totally on the basis of these experimenter impressions and the findings on the one controlled double blind study were ignored in the conclusion.

A more recent example is an article on the effects of Adderall. Swanson, et al. (1998) report a study that seems to be well designed and demonstrates a dose-depen-
sample of bipolar juveniles. Dr. Papulos said that because of symptom overlap and comorbidities between the bipolar group and other, more commonly diagnosed disorders, these findings ought to be taken seriously.

In June, The FDA warned that Paxil should not be administered to children younger than 18 years of age (Reuters, 2003). The warning cited new material from various clinical trials showing that episodes of self-harm and potentially suicidal behavior were between 1.5 and 3.2 times higher in patients taking the drug than in those taking a placebo. As a wild guess, it might be that in a depressed state of feeling helpless, the administration of a substance that was supposed to take control of one from the inside augmented some youngsters’ feelings of crisis.

The issue has been debated for a long time. In 1992, Charles Popper questioned the value of continued use of such preparations with children and adolescents: “[Are] the clinicians ahead of the researchers, or [is] the handwriting on the wall just hard to believe?” The problem was addressed by Fisher and Fisher (1996) in relation to antidepressants for children. They found that as of that date, double-blind studies were almost unanimous that antidepressants were no more effective than placebos in treating depression in children and adolescents. Furthermore, they quote Riddle (1993) as only one of those who mentioned anecdotally that some children taking antidepressants suddenly and unexpectedly died. Despite these warnings, psychiatrists routinely prescribe antidepressants to children and teenagers.

Psychiatric drugs, like all drugs, return huge profits to pharmaceutical companies. These companies approach sales of drugs in the same way any business does – by striving to increase sales and “market share.” Children are a “growth” market for drug companies. The Wall Street Journal, for example, cited (in April 1997) efforts of antidepressant manufacturers to “open up” the children’s market to make up for decreasing growth in sales to adults. In 1996, the yearly sales of Ritalin approached one billion dollars (Block, 1997). It is not surprising that the pharmaceutical manufacturers would take the child market seriously!

Bassarath (2003) reviewed medication strategies for use in conduct disorders, attention-deficit hyperactivity disorder, mood disorders, and other conditions. He concluded that clinicians should use findings from controlled studies and where necessary uncontrolled studies to guide pharmacological practice. This and other studies start from the basic proposition that medication is the treatment of choice and that the only remaining question is the type and dose of the drug.

Sloppy research is endemic. In a double blind controlled study of Clomipramine by Flament, et.al. (1985), they note, “Improvement in obsessive-compulsive symptoms did not correlate significantly with plasma concentrations of the drug or its metabolites.” The very next sentence reads, “Clomipramine appears to be effective in the treatment of children with obsessive-compulsive disorder.” These two sentences contradict one another. Braconnier, et.al. (2003) report a study in the Journal of the American Academy of Child and Adolescent Psychiatry that is randomized, double blind, and multicentered. The study addressed efficacy of treatment with Clomipramine in comparison with treatment with Paroxetine. The two drugs represent different approaches to depression in adolescents. They conclude that the two drugs are equally efficacious, but given the “adverse event profile of Clomipramine,” the Paroxetine-type should be preferred. They caution, “These data support the serotonin hypothesis, but did not confirm it in the absence of a placebo arm.” At least they should be given credit for remembering placebos when they write up and think about their otherwise well-designed study. The last sentence of their conclusions emphasizes the need for more placebo-controlled studies.

A recent review of pharmacological treatments of autistic adolescents included the published accounts even of using magnesium and B vitamins, in its thoroughness (Baghdadli, et.al. 2002). Their conclusion: “There is no consensus on the use of psychopharmacological treatments on autism. Although there may exist many clinical observations, only few controlled studies have validated the efficiency and safety of these treatments. At the recent time and until having sufficient studies, drug treatment should generally be limited to severe disorders, for which usual psycho-educational approaches are insufficient.”

Brown University publishes an update on child and adolescent psychopharmacology. In October 2002, they reported the reactions of various investigators to increasing citations of presumed growth factor inhibition in children who receive SSRI treatment. This effect is described as unsurprising because the hypothalamus is part of the brain and it regulates growth. The discussants agree that the effects can be subtle and hard to differentiate from a child’s growth pattern without medication. Nonetheless, the discussants caution pediatricians (the primary prescribing group) to pay attention to the problem.

A particularly egregious example of the side effect problem occurs in relation to the latest class of drugs used for treatment of behavior. This class of drugs is called atypicals. That means that they do not seem to be associated with the regulation of serotonin. Risperidone is a frequently prescribed choice in this class. Unfortunately, its use in adults can cause an increase in levels of a patient’s prolactin levels. Excessive amounts of it in adolescents and adults leads to benign brain tumor in the pituitary, which produces severe headache and eventually, blindness. Fur-
ther, in females it is associated with sterility; in males, it is also associated with impotence. There are studies of the use of Risperidone with children that address the problem of prolactin levels. Masi, Cosenza, and Mucci (2001) checked prolactin levels at baseline and after ten weeks in 25 children whose ages ranged from 3.9 to 7 years of age. The baseline average serum prolactin level was 9.77 +/- 3.94 ng/mg/L. After ten weeks of Risperidone administration, the average prolactin level was 25.92 +/- 13.9 ng/mg/L (p=<0.001). In six children, only the upper level of normal was reached. In eight children, the level was more than twice the upper limit. The conclusion was that as no symptoms were noted, this is a safe drug. No data on prolonged usage was provided.

Our psychiatric colleagues are not immune to the dangers and perplexities presented by psychopharmacology. Almost all review articles that I find urge recognition of the need for better studies. Nonetheless, the bandwagon rolls on. The latest passenger is multi-medication dosing, suggested with the same level of scientific support as from the previous studies, including lack of attention to the possible interactions of the drugs on a subclinical, but significant, basis. One combination study of special interest was reported on at a meeting of Pediatric Academic Societies by Sandler and Bodfish (2003). They believed that the ADHD symptoms of 26 children were under good control with a stimulant. They decided to give the children half the accustomed dose, both with and without a placebo, in alternating weeks. Forty per cent of the children responded well to the half dose plus a placebo, with equally good ADHD control and fewer side effects compared to when they were on full doses of the stimulant. Parents and children themselves were informed fully about the study, so they all knew when the child took a placebo or not. Sandler said, “Using placebos could have great importance in treating not only ADHD but many other disorders of the central nervous system.”

Another study worthy of our attention is one by Russell Barkley in 1981. He did a pilot study of children who were diagnosed as ADHD, and their interactions with their mothers. Barkley established base levels of children’s negative behavior and compliance behavior plus mothers’ negative behavior. He then gave the mothers either Valium or a placebo. He then retested both mothers and children with the same three measures he relied on initially. There was no difference between the mothers’ negative behavior level when base lines were compared to placebo. When mothers were given Valium, the mothers’ negative behaviors decreased 83.3% compared both with their baseline and with placebo mothers. When mothers were given a placebo, children’s compliance rate decreased 8.6% in comparison with baseline ratings. The children’s negative behaviors nearly doubled to 91% increase in occurrence.

On the other hand, when mothers were given Valium, the children’s negative behaviors decreased by 83%, over baseline ratings. At the same time, the children’s compliance ratings increased 120%. It is intriguing to consider this little experiment as helpful in learning about research design as well as something about the dynamics of ADHD. The implication that you can treat ADHD by prescribing Valium to the child’s parent (teacher? therapist?) is rather stunning.

Furman (2003) notes that in 1993, for every 250 children diagnosed as ADHD in our country, only one was so regarded (and treated) in Europe. He quotes Fussier (1998) as finding that there has been a subsequent increase in the use of prescriptions in Europe, but the practice has doubled, perhaps tripled in America. Covering every logical aspect to the situation, including the role of HMOs, Furman concluded thus in regard to treatment of the active or overactive child: “ADHD is not a specific disorder or pathological entity but rather a collection of symptoms that could be manifested by a child in distress, a child in conflict within himself and/or in conflict with his environment. It has no more specificity than that and likewise, methylphenidate [Ritalin] has no specificity in producing its effects. The presence of such a constellation of symptoms should indicate the need for an evaluation of the child to ascertain the source of his distress so that measures could be initiated to effect their alleviation.”

Amazingly and alarmingly, Division 29 has brought out a brochure in conjunction with Celltech Pharmaceuticals, Inc. It declares that ADD/ADHD is generally considered a neurochemical disorder; most people are born with this disorder; and it is not caused by poor parenting, a difficult family environment, poor teaching, or inadequate nutrition. Albert Galves wrote in protest on the grounds that there is no scientific evidence to support these statements. It is available from Dr. Galves at agalves@saludclinic.org. The letter was published in the July 2003 issue of Coalition Report, the newsletter of the National Coalition of Mental Health Professionals and Consumers, which can be accessed: http://nomanagedcare.org/CoalitionReport7-03.pdf

We must appreciate the fact that the medical community does not simply accept that psychopharmacological products are usable because the manufacturers have satisfied the stringent (and expensive) requirements of the FDA. There is a sense when reading the literature that the constant search for better drugs reflects concerns about the inadequacy and safety of what is currently available. And there is a burgeoning number of studies to try to examine what are really the effects of drugs that are currently being prescribed. Nonetheless, it is scientifically naive to simplify the enormous complexity of brain functioning and ignore
our knowledge that all behavior is biochemical. Our biochemical activity is what distinguishes life from nonlife. What is involved in producing a single behavior, let alone patterns of behavior, is a marvelous challenge to understand. Standards of good science need to be applied to studies. That symptomatic behaviors have meaning needs to be respected and explored.

Those of us who have had pet dogs or cats are aware of how significant relatedness is on fundamental levels of personality, even without the privilege of psychoanalytic understanding. As therapists, however, we are unique in our training in both research and therapeutics. We who are psychoanalytically informed must be alert to our responsibility to communicate what we can say about the human condition. At the very least, we must continue to challenge the assumptions, findings, and conclusions of researchers who provide the assurance that medication is the “answer” to human difficulties, without evidence, reason or substance. I trust that this article will stimulate your biochemical processes to inquire more deeply into the very real dangers facing troubled children and their parents and in the resignation of our professional organizations in accepting this situation without challenge.

REFERENCES


ERRATA – SPRING 2003

On page 68, in the local chapter report on the Appalachian Psychoanalytic Society, the presenter for the Scholars Symposium was Marilyn, not Marsha, McCabe, and Jules Seeman was a colleague of Carl Rogers, not his student, as identified in the article.

ERRATA – SUMMER 2003

On page 36, in the Meet the Author section of the Spring Meeting summaries, Jean Safer’s description of the Caliban Syndrome was incorrectly identified as an aspect of the “damaged” sibling, but instead this refers to characteristics of the “normal” one.
AMELIORATING SUICIDALITY

I was once given a referral for a patient who called me stating that he was not coping well at work, and that he was upset over a relationship with a woman that he recently terminated. He was particularly vague on the phone, emotionally removed, and seemed somewhat ambivalent in the first place. We set an appointment for the following day, yet he failed to show. I simply thought he changed his mind due to his ambivalence until I received a call two days later from a psychiatric nurse at a nearby hospital stating that the patient had taken an overdose on the same day he was scheduled to see me. I spoke with the patient and we rescheduled an appointment for the day of his discharge from the hospital.

Clive was a stockbroker in his early thirties. When we first met, he was clearly mentally confused, tangential in his thoughts and associations, unable to articulate his inner experience with coherence or congruency, panicky, and deeply ashamed of his suicide attempt. He explained how he was increasingly unable to concentrate or complete his responsibilities at work because he was too distraught over his former girlfriend. At first he spoke of her and their relationship in very ambiguous terms, only stating that he was very uncomfortable and overly self-conscious being with her, which was so disconcerting that he had to end the union. During the initial meeting he was in a frenzied state because he felt so lost about his life. One overarching theme was his obsessive preoccupation that he was not happy in comparison to others, and only, if he could find certain answers to his confusion, he would be back to normal. As he put it: “Why can’t I just be like others? I see people laughing at their jobs. Why can’t I just be like them. It’s like my whole life has just stopped. I just want to be happy. I have to be happy now.”

Litman (1970) alerts us to four ominous signs of suicidal potential: (1) an impatient, agitated expectation that something must be done immediately; (2) a feasible, detailed lethal suicide plan; (3) narcissistic pride, suspicion, and hyper-independence; and (4) tendencies toward isolation and withdrawal, living alone, or living with someone emotionally removed or estranged. Clive fit these criteria, but what was overwhelmingly present was the urgency that he had to feel better about his life right then and there—at that very moment.

If suicidal trends are severe, patients should optimally be seen daily until the acute crisis is stabilized. The outlook is favorable if they feel more relieved after the initial interview, with decreased agitation and a slight lift in mood, and quickly form a dependent attachment to the therapist (Litman, 1970). At the end of our first session, Clive reportedly felt calmer and stated how comfortable he felt with me. We made an appointment two days after our initial meeting, but he called the next day feeling suicidal. We did some grounding techniques over the phone and he came to see me later that afternoon.

When Clive arrived, he was visibly shaking and paranoid, stating that he was not capable of controlling his impulses which felt alien yet compulsory to him. I was concerned that his suicidality had by now acquired an autonomous organization, which was dissociated from the rest of his self and experienced as ego-syntonic. Under these circumstances, the only way to put a floor under a patient is have him talk about what is most important to him at that time (Semrad, 1980). Rather than focus directly on the suicidality, or even worse, prematurely conclude that he needed to be hospitalized, I insisted that he tell me exactly what he was experiencing in that moment without holding anything back. He began to disclose that he found himself unable to stop thinking about Ginger, his former girlfriend, and that the constant thought of her was bringing on the urge to kill himself. He was obsessed with rehashing various aspects of their relationship, her facial expressions, their conversations—her specific disclosures of past sexual exploits with other men. He recalled how over the past four months since he had been dating her, he had become more preoccupied and self-conscious about his desirability, which made him question his confidence, capabilities, and self-esteem. Unable to concentrate or complete his work, he found himself fantasizing about her all day, wondering what she was wearing, how she was acting, who she was talking to, etc.—to the point that his whole reality as he knew it became encased in impending dread. He could not eat or sleep or carry on with his daily activities he once enjoyed, because he was constantly worrying about Ginger and her perception of him.

Clive confessed that there was something wrong from the very start with this woman, but he just couldn’t seem to let go; she had an animal magnetism and he was mesmerized. They were sexual with one another within hours of meeting at a bar, and their entire relationship from then on focused around sex. Despite the pleasure of sexual passion, he reported a fundamental discomfort in the way she made him feel; there was no emotional warmth or intimacy—just sex. He started having intrusive and disturbing fantasies at work, the gym, and wherever he went—fantasies that every man certainly lusted after her sexually, to the point that he about instigated fights with strangers whom he perceived were eyeing his girl. Ginger had such a toxic influence on his psychic cohesion, that he eventually had to end the relationship because he simply wasn’t functioning. As Clive put it: “It was like I was constantly walking on egg shells. I had to watch every little thing I thought or said; I couldn’t be me.” She did not take his rejection lightly and began to harass him at home and at work, threatening to show up and make a scene if he did not continue to see her. In the end, she had convinced him that he was “really fucked up in the head.” He rapidly decompensated after the break-up, and this is when his suicidal fantasies and
impulses started to take command over his psychic reality.

During this session I was more concerned with establishing a climate of understanding, stability, and safety rather than pursuing the etiology and psychodynamics of his suicidality. Bellak and Faithorn (1981) tell us that “one must demonstrate clearly to the patient a continuity between the immediate panic, the precipitating factors, and life history. This gives the patient at least some feeling of control over what seems frighteningly ego-alien” (p. 90). Clive was somewhat mollified and reassured that his panic and urgency was only a temporary reaction to unformulated and unarticulated conflictual inner experiences that we would later figure out more fully together, but for time being he needed to focus on his recovery. He had agreed to take a leave of absence from work, which relieved some of the immediate pressures. Given that he had never reported feeling suicidal before, nor did he ever have a relationship like this one that made him feel so disjointed and out of control, he was comforted by the conviction that he would eventually reconstitute and be able to put this behind him.

Later that evening when I was sleeping, I was awakened by a dream (if not a nightmare) that I was suicidal, that my mind was fracturing, that my life and all I knew were being compromised by the sensation that I was no longer in control of my own thoughts or impulses. Relieved to wake, but emotionally shaken, I immediately felt disconcerted. What did I identify with in my patient? Did I become a container for his self-destruction? Was this merely my assimilation of his projective identifications? Or was there a communicative aspect—a command hallucination—that resonated within my own dark interior? What archaic piece from my past was roused from its somnolent slumber? What uncanny death wish did this excavate in me? I instantly feared for Clive, and felt the need to check my phone messages. When I went downstairs to my office, I saw the red light flashing on the answering machine and knew it was him. I played back the message only to hear his languid voice in desperation and disquieted panic. I called him, but he did not answer, so I left a phone message on his machine explaining how worried I was about him and that I wanted him to give me a call immediately. Although I was on the verge of panicking myself, I decided to wait rather than jump the gun and run the risk of making a clinical blunder.

When he called the next day, he was acutely suicidal. He told me he was sitting in his bathtub for an hour and a half with a razor to his wrist. I insisted that he come to my office, but he preferred to talk on the phone instead. “Suicidal patients suffer from ‘tunnel vision’ and only see one particular solution. It is therefore important to show them that there are other options” (Bellak & Faithorn, 1981, p. 173). Clive told me that he did not see a way out of this nor could he envisage a future: his entire universe was colored by lack, chaos, and upheaval. In moments like this, we are reminded that if the therapist honestly reports feelings of helplessness in himself and of entertaining thoughts of breaking off communication with the patient, then an emergency situation has developed and it is time for some sort of active intervention (Litman & Farberow, 1970). How do you attempt to convince a person in this state of panic, dissociation, and irrationality that their solution is based in impulsive, desperate actions rather than more competent ones? How do you appeal to the autonomous portion of the ego that still has the capacity for rational engagement? How do you instill hope? This was the moment of crisis. Do I insist he come? Do I go to his house? Do I call the police? Do I have him hospitalized? “We are going to get through this together” I said. “Now talk to me.”

I got him grounded, he calmed down, we made a contingency plan, he reconstituted, and he was more hopeful. “The prognosis is most favorable if the patient, although depressed and contemplating suicide, thinks of those who would suffer from his deed” (Blanck & Blank, 1974, p. 266). This mobilizes attachment and empathic motivations that cling to the value of life. I asked him to think of his family and the impact his actions would have on them. He contracted for safety, promised to go to his mother’s house or the hospital if he felt unable to fight his impulses, and told me he would take a sedative prescribed by the psychiatrist to help him sleep.

The next day he was better, but disheveled. He told me that the one thing that gave him hope was my comment: “The feelings are only temporary: they will pass.” We reinforced our contingency plan: he was going to seek out support from his family, go to dinner with a friend, make himself do some exercise, and spend the night with his mother rather than be alone.

The intensity of Clive’s suicidality began to abate and we were able to look more closely at the insidious dynamics fueling his impulsivity and internal turmoil. Kernberg (1984) tells us that every suicide attempt or completion implies the mobilization of intense aggression not only in the patient, but within the interpersonal field, and this is why so many suicides are intersubjectively informed. Malan (1979) further urges us to consider suicidality “as a fusion of intense destructive anger expressed self-destructively on the one hand, and love, protectiveness, concern and guilt on the other—the patient would rather kill himself than harm the other person—and it is usually the anger that needs to be brought into the open” (p. 204). Intuiting that Clive was not telling me the whole story, I urged him to tell me what he had really been bothered by but could not seem to tell me directly. With intense discomfort and shame, Clive confessed that what had really disturbed him was Ginger’s unsolicited and provocative sexual disclosures about her past. Over the course of their brief relationship, she had managed not to spare him a single detail about her sexual appetites. She admitted to “fucking hundreds of men,” including enjoying “anal sex,” and frequently cruised men “simply to fuck” and disregard after she had had fill. Clive was particularly troubled by observing semen-stained sheets on her bed that she did not even bother to wash from her previous lover. But what was even more unsettling to him was her flamboyant...
need to explain how it was from a “big black buck” she picked up at a bar. Clive’s ego was assailed; he was unable to shelter himself from the pain of his own feelings of inadequacy. This threatened his integrity as a man based on the simple economy that his “dick” was the measure of his self-worth. To make matters worse, he was a premature ejaculator, which was a source of grave embarrassment and sexual ineptitude. At one point, in a state of dissatisfaction with his performance, Ginger referred to him as “Quick-draw McGraw,” thus rendering him humiliated and vilified.

Clive felt that something was wrong with him because he could not shake off the deep humiliation and significance of her disclosures. He wanted truth and honesty, but he didn’t want to know such brute facticity: “That’s reality Clive, you’re just goin’ have to deal with it,” she told him. Clive was drowning in his fundamental ambivalence between loving this woman—this “slut”—and hating her for how she made him feel so impotent and ineffectual. He was turning his aggression on himself, protecting her from his wrath and narcissistic rage that imperiled his psyche. He started to feel guilty for judging her so negatively, and feelings of betrayal were lacerating him with the need for self-punishment. At the same time he could not admit to himself that he hated her for feeling so inadequate and flawed. The injury to his ego was a nefarious, festering wound that unearthed primordial deprivations and pain associated with his relationships with his primary attachment figures.

He recalled that as a boy he was very clingy and dependent on his mother, experienced prolonged separation anxiety well into his elementary school years, and that he still relies on her emotionally as his primary source of support and comfort. His father, on the other hand, was a volatile and physically abusive man who used to beat him with a belt and shame him indiscriminately. As a result, Clive became a childhood bully, was always getting into trouble, and picked on and beat up other kids as a way of expressing and reenacting his own traumas with his father. When he was older, Clive attempted to channel his aggression in more sublimated ways through sports—he excelled in hockey. But his volatile temper and bad sportsmanship led to multiple fights on the rink to the point that his mother was too embarrassed to attend his games, and bad sportsmanship led to multiple fights on the rink to the point that his mother was too embarrassed to attend his games, and physically abusive man who used to beat him with a belt and physically abusive man who used to beat him with a belt and shame him indiscriminately. As a result, Clive became a childhood bully, was always getting into trouble, and picked on and beat up other kids as a way of expressing and reenacting his own traumas with his father. When he was older, Clive attempted to channel his aggression in more sublimated ways through sports—he excelled in hockey. But his volatile temper and bad sportsmanship led to multiple fights on the rink to the point that his mother was too embarrassed to attend his games, and physically abusive man who used to beat him with a belt

Hegel’s Anticipation of Psychoanalysis.

References


Jon Mills is a member of the Toronto Society for Contemporary Psychoanalysis and the author of The Unconscious Abyss: Hegel’s Anticipation of Psychoanalysis.
HIPAA AND MEDICAL PRIVACY: STATUS OF THE LAWSUIT

DAVE BYROM, PHD, PRESIDENT, AND PATRICIA DOWDS, PHD, VICE-PRESIDENT, NCMHPC

This is to report on the status of the litigation in Citizens for Health v. Thompson (Civil No. 03-2267) pending in Federal District Court for the Eastern District of Pennsylvania. As you may know, the National Coalition of Mental Health Professionals and Consumers is a cosponsor of this lawsuit and we are committed to raising funds to pursue this action in support of privacy rights. The complaint was filed on April 10, 2003, and an amended complaint was filed on May 5, 2003, 21 days after the compliance date. Currently, the case has 16 plaintiffs representing nearly 750,000 health care consumers and practitioners. The suit seeks to enjoin and declare invalid the provision in the Amended Health Information Privacy Rule that eliminated the right of individuals to decide whether their personal health information would be used or disclosed (the “right of consent”). The Court scheduled oral argument on the motions for summary judgment for November 24, 2003. There will be no discovery by either side. Based on the above schedule, it is likely that, after the case is argued in November, a decision will be rendered in early 2004.

Our counsel, Jim Pyles, has reviewed hundreds of thousands of pages of comments submitted in connection with the Amended Rule that was adopted on August 14, 2002. That review shows that approximately 150 organizations representing more than 130 million health care consumers and practitioners filed comments urging the government to retain the right of consent as set forth in the Original Privacy Rule. We also found that the comments in support of eliminating the right of consent were nearly all from insurers, health care facilities (such as hospitals) and their employees. In short, the rule making record of the Amended Rule shows overwhelming support among consumers and practitioners for preservation of the right of consent while support for elimination of that right was generally confined to health insurers and hospitals.

Numerous affidavits, with supporting documentation, were filed with our Motion for Summary Judgment on 9/4/03. These cited specific examples of privacy violations that were suffered since the April 14, 2003 compliance date, including: 1. Identifiable personal health information (PHI) was used or disclosed without patient consent. 2. Patients requested restrictions on the use and disclosure of health information, and the requests were denied or ignored. 3. Patients asked for a consent process, and their health care practitioner and/or care facility refused to provide it. 4. Patients were not given a notice of their privacy rights when they visited their health care practitioner and/or care facility. 5. Patients were given a notice of privacy rights that did not inform them of their privacy rights under state law, or contained some other defect. 6. Patients were unable to locate a practitioner who would provide a consent procedure or agree to restrict uses and disclosures of their health information. 7. Patients filed a complaint with a covered entity or HHS that has not been resolved satisfactorily.

• THE NATIONAL COALITION OF MENTAL HEALTH PROFESSIONALS AND CONSUMERS, The American Psychoanalytic Association and other groups and individuals filed this lawsuit to challenge the very constitutionality of this ruling. Constitutional scholars and civil rights groups are supporting these challenges. The first complaint seeks declaratory and injunctive relief against the Secretary of Health and Human Services for the issuance of amendments to the Health Information Privacy Rule that eliminate the right of consent and confer “regulatory permission” on covered entities and their business associates to use and disclose identifiable health information.

• THE BASES FOR THE COMPLAINT ARE THAT THE SECRETARY’S ACTION VIOLATES: The right to privacy protected by the Fifth Amendment; the right to familial integrity protected by the Fifth Amendment; the right to have conversations and communications with physicians and practitioners that are not made public as protected by the First Amendment; the notice and comment requirements of the Administrative Procedure Act; and the intent of Congress in enacting the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996.

• THE COMMITMENT OF THE NATIONAL COALITION OF MENTAL HEALTH AND PROFESSIONALS AND CONSUMERS IS TO CONTINUE OUR WORK on administrative, legislative and judicial actions to restore real protections of privacy rights. As our actions showed with the Clinton attempts, which were also driven by similar powerful industry lobbies, THIS CAN BE ACCOMPLISHED.

FUNDING APPEAL: THE PRIVACY DEFENSE FUND

THE NATIONAL COALITION OF MENTAL HEALTH PROFESSIONALS AND CONSUMERS needs your help in funding the extensive research and preparation for this lawsuit against the federal government. Donations can be made to “NCMHPC” and designated for “The Privacy Legal Defense Fund,” are possibly deductible as a business expense. Send to: NCMHPC, P.O. Box 438, Commack, N.Y. 11725; Phone: 631-424-5232. Our website- http://www.thenationalcoalition.org/
**COMMITTEE AND LIAISON REPORTS**

**SEXUALITIES AND GENDER IDENTITIES (SGI)**

**Dennis Debiak, PsyD, Chair**

**WHAT'S IN A NAME?** At the Division 39 Board meeting in Toronto this past August, our committee received Board approval to change its name to Committee on Sexualities and Gender Identities (SGI) from Committee on Sexual Identity and Lesbian, Gay, Bisexual and Transgender Issues (SILGBTI). This change was based on committee discussions as well as on feedback from the survey that we conducted of Division 39 members.

We feel that our new name reflects the complexity and fluidity of sexuality and gender identity and therefore is more inclusive. Our new name reflects the diversity of individuals and might be more inclusive of those who do not identify themselves using the traditional sexual orientation categories (heterosexual, lesbian, gay, bisexual) as well as more inclusive of intersex or ambiguously-sexed individuals and transsexuals (those who have sex-reassignment surgery as well as those who do not). It’s likely that our new name might not go far enough in reflecting the multiplicity and fluidity of sexual orientation, gender identity and gender expression and we look forward to further discussion of our name and the fascinating complexity that it reflects.

**MORE TO COME FROM TORONTO:** An historic event took place this summer at the APA Convention in Toronto. Divisions 39 and 44 (The Society for the Psychological Study of Gay, Lesbian, and Bisexual Issues) cosponsored a panel for the first time. The panel was entitled Skeletons Out of Our Closets: Psychoanalytic and GLBT Explorations.

The panel was chaired by Judith Glassgold, President of Division 44 and a member of Division 39, and Jaime Darwin, President of Division 39. Both gave moving introductions that discussed both the history of the relationship between the two divisions and their commitment to greater collaboration between the two divisions. Then, three papers were presented by individuals who are members of both divisions. Mark Blechner presented a paper entitled “What Psychoanalysis Can Learn from the Experience of Gay and Lesbian Practitioners,” Shara Sand presented “Daily Outings: Hide and Seek with a Twist,” and Scott Pytluk and Dennis Debiak presented “State of the Art: Introducing Students to LGBT-Affirmative Psychoanalysis.” These presentations were followed by a lively discussion with the audience. Excerpts from the papers will appear in upcoming editions of both the Division 39 and Division 44 newsletters.

**LOOKING AHEAD TO MIAMI BEACH:** SGI will hold the third installment of its Ongoing Discussion Group on Sexual Object Choices at the 2004 Division 39 Spring Meeting in Miami Beach. This time, our discussion will focus on sexual object choices in transgender individuals as a springboard for a larger discussion of the complex intersection between sexual orientation and gender identity. Dennis Debiak will moderate and our discussion leaders will be Deborah Anna Luepnitz, Debra Roth, Randi Kaufman, and Bethany Riddle.

In addition, SGI will cosponsor a reception/social hour with the Committee on Multicultural Concerns at the spring meeting. We hope you will join us in Miami Beach. For more information about SGI, please contact Dennis Debiak at ddebiak@aol.com.

**APA DIVISIONS FOR SOCIAL JUSTICE**

Since Division 39 was recently admitted to a coalition of Divisions called Divisions for Social Justice, I thought members would be interested in learning about the coalition. At the First APA Multicultural Summit and Conference in January, 1999 at Newport Beach, California, the presidents of the eight sponsoring and co-sponsoring APA divisions met to consider possible joint activities. The meeting was called by Division 45 President Joseph Trimble, and attended by the presidents of Divisions 9, 17, 27, 35, 43, 44 and 48. After some discussion, those attending decided that they all shared a common mission in the area of social justice. The group was named The Committee of Eight, and agreed to work together pursuing social justice issues both within APA governance (e.g., working together to appoint social-justice oriented individuals to APA committees; working with the Public Interest Directorate), and in terms of ongoing social justice related research, action, and public policy.

The group later changed its name to Divisions for Social Justice (DSJ), and expanded to 10 APA divisions with the addition, over the years, of Divisions 39 and 51. DSJ has primarily focused its activities to date on:

1. Promoting the appointment of social-justice oriented individuals to APA committees (through sharing nominations)
2. Supporting APA’s Public Interest Directorate (e.g., working with the Public Interest Coalition of Council)

1 With thanks to Kenneth Maton of the Division for Peace Psychology (48) who compiled the history of the coalition.
3. Compiling and distributing a list of social-justice oriented symposia sponsored by DSJ divisions at each year’s APA convention

Divisional representatives also can ask for support from other DSJ divisions on social justice related issues their division is pursuing (e.g., the Resolution on Poverty).

Structurally, the executive committees of each participating division appoint a representative for a 2-3 year term on DSJ. The chair (or co-chairs) of DSJ serves a one-year term, with the role of chair to be rotated among participating divisions. Meetings are held every year at APA, and every other January at the Multicultural Summit.

I have been appointed the Division 39 representative to the coalition and attended my first meeting this month in Toronto. Also in Toronto, the coalition sponsored a panel, The Psychological Effects of War and International Conflict. This panel emerged out of the concerns of some members of the coalition that there was no discussion of the impending Iraq War at the Council Meeting in Washington DC in February 2003. The panel included nine people (including myself) who made brief statements on the theme. Phil Zimbardo, Past President of APA, chaired the panel. The panel was very well attended (standing room only) and the coalition plans a follow-up panel for the Hawaii meeting next summer. Also at the coalition meeting, I was elected Chair-elect for 2004 and Chair for 2005. I am very pleased that Division 39 has joined this coalition, which is gathering increasing influence within APA. I invite suggestions and questions from people about the work of the Divisions for Social Justice, and the role that the Division of Psychoanalysis can play in it.

MULTICULTURAL CONCERNS

COMPETENCE IN DELIVERING SERVICES TO CULTURALLY DIVERSE CLIENTS

The mission of the Committee for Multicultural Concerns is to sensitize psychoanalysts and psychodynamic therapists to recognize and effectively respond to issues of culture, language, and ethnicity in psychoanalytic theory and practice. It is timely to address the issue of cultural competence in the provision of our services. Competence in providing services becomes increasingly complex as we meet clients from diverse backgrounds in our pluralistic society. The face of America is constantly changing, making it more urgent to engage in systematic efforts to become more knowledgeable, proficient and multiculturally responsive.

In the Spring 2003 issue, this column reported on a panel the division presented at the third National Multicultural Conference and Summit in Hollywood, CA, January, 2003. During these proceedings, the “Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists” was officially presented with a chronology of its development over the past two decades. The APA Council of Representatives approved the guidelines in August, 2002 and published in the American Psychologist May, 2003. These guidelines constitute a state of the art document based on principles derived from empirical research, providing basic information, relevant terminology and references related to multiculturalism and diversity. It is conceived as a living document expected to continue to expand with an expiration date of 2009—underscoring the need for vigilance and reappraisal. Each guideline provides specific strategies that are invaluable. They are stated as follows:

Commitment to Cultural Awareness and Knowledge of Self and Others—Guideline 1: Psychologists are encour-aged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.

Guideline 2: Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness to knowledge of, and understanding about ethnically and racially different individuals.

Education—Guideline 3: As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.

Research—Guideline 4: Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds.

Practice—Guideline 5: Psychologists are encouraged to apply culturally appropriate skills in clinical and other applied psychological practices.


Due to limited space and for the purpose of this article, discussion will be focused on guidelines 1, 2 and 5, illustrating how practitioners are intimately responsible and involved in the process of delivering culturally competent services.

Guidelines 1 and 2: These guidelines require that as practitioners we be attentive to our personal race/ethnic biases and countertransference resistance, which could interfere with or distort the therapeutic process. Special efforts should be made to consider the existence of cultural factors in the working alliance, to resistance, transference
and countertransference. Consideration should be given to: the therapist’s awareness of self; the historical and current experience of what it may mean to be an individual from a different culture; the therapist’s personal values that influence how the therapy is conducted; the way that the presenting problem and the goals for therapy are viewed by therapist and patient; and, finally, the match between the value system of the patient and the goals for therapy. These considerations should put the therapist more in touch with some of the personal views and biases that may impede the process (Morris, 1998). Guideline 2 continues to stress that interpersonal interactions occur within a multicultural perspective. A compelling argument was made for the importance of being knowledgeable about federal legislation enacted to protect groups marginalized due to ethnicity, race, national origin, religion, age, and gender. This awareness would make practitioners better informed and appreciative of the socio-political consequences.

Guideline 5 focuses on the client within a cultural context by recognizing that the client might have socialization experiences, health and mental health issues and workplace concerns associated with discrimination and oppression. Relevant factors in a client’s history may include pertinent generational history, such as citizenship or residency status, fluency in standard English and extent of family support and availability of community resources. Other factors include issues related to level of education, change in social status as a result of coming to this country, and work history. Level of stress related to acculturation may play a role in the establishment and maintenance of the therapeutic alliance. Assessment practices should include knowledge of the validity of instrument or procedure used, and interpreting data appropriately by considering the cultural and linguistic characteristics of the person being assessed. Intervention practices should be sensitive to the unique worldview and cultural backgrounds of the client by incorporating an understanding of the client’s ethnic, linguistic, racial and cultural background into therapy.

As practitioners we must continue to develop our personal and cross-cultural awareness, knowledge and skills. This discussion is merely a beginning and hopefully it will motivate you to read and absorb these comprehensive guidelines. Feedback from you would be appreciated.

REFERENCES

NOMINATIONS AND ELECTIONS

Congratulations are in order to those who won the recent Division elections. The results are as follows:

- Council Representative: Neil Altman
- Secretary: Marilyn Jacobs
- Members-at-Large: Joseph Couch, Mary Lou Lionells, and Karen Maroda.

We would also like to extend thanks to those who competed in the election as well as all those who assisted in the election process.
During the last Council meeting, the following points were raised for discussion:

- **Budget:** It was reported that the APA budget has turned around. Whereas in February a deficit of anywhere from $1-4 million was projected for 2004, at this point a surplus of $600,000 is projected. The buildings owned by APA have been refinanced on very favorable terms, and the organization's working capital has been replenished.

- **Guidelines:** The council passed a resolution to the effect that any guidelines put forward by a Division and approved by APA council would be considered APA policy.

- **Endorsements:** The council passed a resolution to the effect that endorsements of statements made by other organizations will not supercede APA policy in cases of conflict.

- **Pro/Con Statements:** A proposal was put forward to amend the bylaws so as to replace pro/con statements with “explanations” when bylaw changes are proposed to the membership. This is because in most if not all cases, any resolution put to the membership with a pro/con statement fail. The maker of the resolution felt that it is not good to put proposals to the membership in an adversarial context in any case. Others pointed out that if the required third of the Council votes to ask for a pro/con statement, a minority can in effect undermine the majority. The resolution passed; however, in accord with current bylaws, more than a third of the Council reps voted to have a pro/con statement included when the bylaw change with respect to pro/con statements is put to the members for their vote. Thus, some pointed out, the bylaw change will fail, validating the concerns of some of those who thought a bylaw change was necessary!

- **Fellows:** Lewis Aron and Sophie Lovinger were approved as Fellows from Division 39. Congratulations Lew and Sophie!

- **Specialty Accreditation through ABPP:** A proposal to encourage APA members to seek specialty accreditation through ABPP was withdrawn due to anti-trust concerns.

The CE Committee was established to allow the Division to provide activities as part of the Spring Meeting each year. At this point, plans for next year are all but complete and we will be offering five CE Workshops on Wednesday, March 17. An advertisement on page 14 of this newsletter contains additional information. Also, during this year’s meeting we will be offering CE credits for four clinical case seminars that will be offered over the course of three days during the meeting. This is a first for the Division and we hope it will prove a success. The seminars will allow for in-depth discussion in a small group setting that should facilitate development of trust. Please see the Spring Meeting brochure for additional information.

The CE Committee has also been a support for local chapters and other component parts of the Division to offer CE credits for educational activities and this continues to be an important resource for our members. By paying one yearly fee, the Division is able to save local chapters and other groups a considerable amount of money. Eighteen local chapters that have participated in the CE program this year and Section V also offers CE credits through its website. During the program year 2002-2003 there have been over 200 activities offered. Over 3500 participants have earned CE credits and a great many of those served have been non-psychologists as well.

The committee includes Reuben Silver and Pat Strasberg. Bill MacGillivray was chair of the committee until August, and Pat Strasberg took over in September. In addition to the formal committee, each local chapter designates a coordinator who works closely with the chair and provides the documentation required.

The committee operates under the authority of APA and it must report on a yearly basis the number and kinds of activities offered. This year, the committee completed a re-application process and requested a 5-year extension of the program, begun over ten years ago. APA CE rules are primarily meant to ensure “consumer protection” by informing potential participants of the value and costs of the programs offered.

Any component group within the Division is eligible to develop CE programs under the authority of the committee. Interested groups should contact Pat Strasberg who will provide the CE Handbook and other materials necessary to take part. You may contact her at pstras@optonline.net.
This year we will be continuing our on-line discussions of papers and of monthly clinical questions. Our first discussion this fall was on Ann Taylor Fleming’s book, Marriage: A Duet – Two Novellas, (New York: Hyperion Books, 2003) which focuses on infidelity and its consequences. Barbara Gerson moderated the discussion. Our next discussion will be on an article by Virginia Goldner entitled When Love Hurts: Abuse and Victimization In Intimate Relationships.

In April, the Section VIII Board voted to open eligibility for our $400 graduate research grant to the entire Division. The grant is to support graduate student research in the area of psychoanalytic family and couple therapy. For information on deadlines and requirements, please contact Leo Weisbender, leofw@aol.com

The theme for our fall newsletter is Psychoanalytic Family Therapy. The deadline for submissions is October 22. Our spring newsletter will be devoted to a response to Jaine Darwin’s Presidential Initiative of encouraging participation in “projects in our communities that demonstrate the benefits of applying psychoanalytic thinking to real world problems.” We plan to include articles on projects that Section VIII members are doing in the community.

We are very pleased that the Section VIII Invited Panel for the 2004 Spring Meeting in Miami will include a focus on the experiences of gay and lesbian couples. The title of the panel is: The Social Construction of the Family and the Decision to Have a Child in Same and Opposite Sex Couples: Implications for Couple Therapy. I will be chairing the panel and the four presenters, Dennis Debiak, Ann D’Ercole, Virginia Goldner, and Deborah Anna Luepnitz, will each respond to a series of focus questions: 1) How does what constitutes “family” get defined and by whom? 2) How does the process of deciding whether to have a child reactivate issues around the definition of family and re-activate latent issues of separation, difference and acceptance within one’s social network and especially in terms of one’s family of origin? 3) How does this differentially affect same and opposite sex couples considering having a child? 4) What are the implications for couple therapy? We are planning to leave a good deal of time for discussion from the floor. We expect that this panel will be an important step in an ongoing dialogue within our section regarding the needs of gay and lesbian couples and families.

In August, three Section VIII members presented papers at the American Psychological Association Meeting in Toronto for a panel entitled The We and the I: The Pitfalls and Possibilities of Focusing on Individual Issues in Couple Therapy. Mary-Joan Gerson, Joyce Lowenstein and Justin Newmark presented various perspectives on both the importance of exploring individual dynamics and on ways of incorporating them into the couple treatment. Mary-Joan Gerson discussed the relevance of attachment theory, originally an individually focused schema, in work with couples. Her position was that the couple therapist should generally remain vigilant about mutating or segmenting the cycle of the couple’s inter-attachment dynamics and the intense affect experience generated by these dynamics. Because attachment schemas are coded so deeply in experience, Gerson often finds metatropic work transformative; she provided an extended case example of her approach. Joyce Lowenstein presented a case in which she used her countertransference to an individual within the couple to help the couple better understand their interactions. Dr. Lowenstein works from an object relations model. When working with a couple, the couple is her patient and she does not see individuals within the couple separately. Her focus is on projective identification as it is experienced in the transference and countertransference. Justin Newmark, working from a relational perspective, stressed the importance of understanding each partner’s dynamics, as well as the necessity of working through those individual dynamics whose presence disrupt the couple’s successful functioning. To that end, he first attempts to do so in the context of the couple, but will readily work with one or both partners individually if the need arises. He presented several clinical examples in which the individual work greatly augmented the couple work. In the lively discussion that followed, the audience raised very interesting questions, including: dealing with serious psychopathology in couple treatments, the necessity and content of communication with individual therapists, and the risks involved in holding individual meetings.

We are now finalizing plans for our website which we are expecting will be accessible very soon. Included in our website will be information for non-members, including a section on information for the public about psychoanalytic couple and family therapy, and a members only section which will include access to our archived newsletters and a membership roster by location. For more information about any of our activities, I can be contacted by email at SMS@psychoanalysis.net or by telephone at 212-877-3857.
SECTION V: PSYCHOANALYST PSYCHOANALYST CLINICIANS JOHANNA TABIN, PHD

The loss of Mort Schillinger is felt throughout the Division, but his contributions to Section V were particularly great both as president and as membership chairman. To the very last of his days, though very ill, Mort remained attentive as president of the Section. Mort was a person of ideas and action. We will miss his vision and his focused energy. In honor of all he contributed to Section V, our biennial Division-wide essay contest will now be known as The Morton Schillinger Essay Competition.

We are proud that the 2002 winning essay, David Lichtenstein’s “The Appearance of the Other in the Attacks of September 11,” has been published in Hating in the First Person Plural: Psychoanalytic Essays on Racism, Homophobia, and Terror: (Donald Moss, Ed., Other Press). This year’s competition, on “Meeting the World as a Psychoanalyst,” will conclude on February 1, 2004. The details are on the Section V website (www.sectionfive.org). The winner will be announced at the Spring Meeting in Miami. We were able to announce in August the winner of the Section V 2003 Biennial All-Division Graduate Student Essay Contest. The winner is Gabriella Serruya, Institute for Graduate Clinical Psychology at Widener University. Her essay, entitled “Enchantments and Hauntings: Encounters with the Magic of the Unconscious,” received the First Prize of $300. Her essay is posted on the Section V Web Site. Three other entrants received honorable mention. It was reassuring for the future of our field to see such high quality in the submissions by people who were still at the graduate student level. Also on the Web Site are two new CPE programs. Free to members of the Section, they provide 3 CE credits each.

Looking to Miami, Section V will present a panel on early infant development, chaired by Mark Sossin. News from the Board includes election of Mark Mellinger as President, and Sergio Rothstein as Secretary, and Lisa Pomeroy as Member-at-Large representing the West Coast.

SECTION VI: PSYCHOANALYTIC RESEARCH SOCIETY E. LISA POMEROY, PHD

The Psychoanalytic Research Society has several new members of the Advisory Board. The new members include: Joseph Couch, Kenneth Levy, John Auerbach, Drew Westen, Morris Eagle, Lynne Layton, Sherwood Waldon, and Sidney Blatt. We are pleased to have such outstanding additions to our Advisory Board. Other members include Gerald Stechler, Antonio Halton, and William MacGillivray.

Section VI is pleased to announce the Miami Division 39 Spring Meeting presentation “The Clinical Process: An Empirical Perspective,” featuring Drew Westen and Kenneth N. Levy. Morris Eagle will serve as discussant. This presentation will be important to psychotherapists for it will focus on the treatment of borderline personality organization and the empirical understanding of the therapeutic process. This should be a fascinating meeting!

The final bit of news is that the Society made a well-received presentation during the August Division Board Meeting. Called “Talking Points,” the Section is developing brief outcome study descriptions to be available for clinicians, APA, the public, etc., that demonstrate the effectiveness of psychoanalysis and psychoanalytic psychotherapy. This rough draft was a move toward the development of “Talking Points” brochure that will make available clinical research for non-researchers with easily understood information on psychoanalytic outcome studies. In this way psychoanalytic psychologists, and other mental health practitioners will have easily accessible research data to support the validity and efficacy of psychoanalytic treatment.
I have a few thoughts I’d like to share before beginning the section report. Just last week on the second anniversary of September 11, I experienced an odd set of feelings that took me by surprise. I thought with some bitterness that at least on the anniversary of the death of loved ones, you know who and what you’ve lost. You can allow yourself the sadness and grief and a chance to remember all of the ways you miss that person. This was an especially odd thought since I would not wish the death of a loved one on anyone, much less envy the opportunity to mourn such a loss, if it indeed occurred, as it did for so many people on September 11, 2000. Then in the midst of talking to a patient who, upon entering my office, remarked, “So, it’s September 11, “ I realized how many unnamed losses we have incurred in this short period since the devastation of 9/11. It’s not exactly accurate to say that what we’ve lost (and continued to lose) is unnamed. In fact, I’ve taken to frantically clipping newspaper articles to try to keep track of the systematic unraveling of the fabric of our social and communal lives with each passing day under the Bush administration.

John Berger recently wrote, “There are historical periods when madness appears to be what it is: a rare and abnormal affliction. There are other periods, like the one we have just entered, when madness appears to be typical.” (The Shape of a Pocket, 2001) Something about the “typical” quality of the madness we are in the midst of renders the assaults against us nameless. Robert Lifton’s “psychic numbing” comes to mind; however, the visible images of nuclear disaster are replaced with an audible white noise, which, if carefully listened to contains within it a tragic symphony with too many themes to keep track of. I am grateful to the patient I referred to earlier because at least he was able to register what I fear the majority of American’s have psychologically “typified.” In a disquieting voice he calmly noted that he imagined that the losses we have sustained to our public life in these two years alone may not be recouped in his children’s lifetime.

Let me be specific so as not to mystify what I’m talking about. The two most recent headlines of the articles I clipped out of the (back pages) of the San Francisco Chronicle read, “100,000 poor families could lose rent help; Bill effectively cuts housing subsidies, activists say”; “San Francisco - New Rules for Overtime Hit a Snag.” referring to the bill proposed by President Bush which would strip as many as 8 million workers of their right to overtime pay. At the moment that bill has been defeated by 11 votes. As I say, these are just two random recent clippings. I can feel the hysteria (difficulty organizing my thoughts) rising as I think about the simultaneous requests for $87 billion to continue in Iraq; the proposed tax cuts for the rich; the relaxation of air pollution regulations, and the signs on billboards in front of Berkeley High School celebrating the last minute windfall that kept some of the teachers from being laid off due to the state budget crisis.

How do we keep track of everything we are losing? It feels like bucking the tide of Hurricane Isabel. My hope is that this could be a radicalizing time. Too many lines (hopefully) have been crossed. People have begun to organize. My fear is that the dynamics involved in the generational transmission of trauma have been set in motion; that is, as the attacks on our safety nets have become more and more “typified,” the total effects on our lives (internal and external) are being absorbed into the air we breathe, leaving us dulled into inactivity. The coming election is one opportunity to wake up.

In light of all that is going on around us, Section IX continues in its modest mission of offering information, programs, and local and national organizational about how we as psychoanalytic mental health practitioners can help. Beginning last April at the 2002 Spring Meeting, Section IX sponsored a panel on “The Fate of Hope In a World at War”, featuring Juan Carlos Volnovich, psychoanalyst from Argentina, and Nancy Hollander, president elect of Section IX, talking about globalization and the collapse of the Argentine economy, and the thrilling and spontaneous uprising of the Argentine people in the face of that collapse. The paper is available, as is the tape, which includes an unusual depth of conversation that took place following the presentation. The Section also sponsored another poster/programs fair in which representatives from the local Minneapolis and St. Paul community brought posters and information about innovative clinical and community programs. We will be continuing to organize these program fairs and forming a national network of providers and information available to the Division 39 community. We also cosponsored with Section VIII an informal discussion of issues related to the transmission of generational trauma.

On the local fronts, we in the San Francisco Bay Area cosponsored a community wide event about “Therapy in a Time of War.” Much like the event we sponsored following September 11, this gathering included poetry reading, music, meditation and a group discussion. An informal gathering was also held in New York. The Bay Area local chapter of the section has held regular monthly meetings and decided to become more involved in understanding how a single payer health care system could work in this
state and country. We will be meeting with representatives from the California Physicians Alliance to study this subject further. We have also decided to devote a portion of our time to reading articles together.

Neil Altman, our past president, delivered the keynote address at the Division 39 summer meetings in Toronto this past August, on “Race and Racism 2003: Facing Ourselves.” Neil also served as Division 39 representative to the APA Division for Social Justice, and was elected Chair of that Division. I want to thank Neil on behalf of our section for his hard work and for expanding the arena in which progressive work can be done within the APA.

I’d like to let you know about the Section IX Board. I will serve as president until January 2004, after which Nancy Hollander will step in as president. Other officers include: Past President; Neil Altman; Secretary: Karen Rosica; Treasurer: Lu Steinberg; Newsletter Editor: Steve Botticelli; Members at large: Muriel Dimen, Ruth Fallenbaum, Stuart Pizer, Chris Bonowitz, Lynn Layton, Steve Seligman; and Section Representative to the Board; Frank Summers. Past Board members, whom we hope will stay involved, are Adrienne Harris, Nina Thomas, Elizabeth Goren, and Ronnie Lesser.

During the Spring Meeting in Miami Beach, Section IX will be presenting a panel Being a Clinician in Contemporary America: Class, Race and Politics in the Consulting Room, with papers delivered by Susan Gutwill, Nancy Hollander, Gary Walls and Lynn Layton. We will also be participating in the IARPP conference in Los Angeles in April 2004, with a panel on what it means to be an American, with papers by Neil Altman, Nancy Hollander and Rachael Peltz.

There is much concern on our Board about how the Section can better serve the needs of its members. Please let us know, either by direct mail or using the section list-serve what you would find most interesting and useful at this time. We are available to hold discussions of current events, newsletter articles or discussions on topics initiated by any section member. Those of you who have not renewed your membership should have received notices. Please remember to renew. In the meantime I wish you all well in this dreadful time and encourage you in any of your efforts to change things for the better.

**UPCOMING EVENTS**

- **November 6-9, 2003**—Creating New Therapeutic Possibilities, 26th Annual International Conference on the Psychology of the Self, Marriott Downtown Hotel, Chicago, IL. For additional information: http://www.psychologyoftheself.com/conference/ or email to conference@psychologyoftheself.com.
- **Sunday, November 16, 2003**—Nourishing, Nurturing and Food for Thought, Eric Asimov, noted New York Times food columnist, keynote speaker. Heed University conference at the American Conference Center, 780 Third Avenue (at 48th Street), New York City. Contact information: conference@heed.edu, Telephone: (212) 332-0905, or toll free (877) 287-2456.
- **Saturday, November 15, 2003**—Beyond Doer And Done To: Resolving Impasses And Working With The Intersubjective Third, Northern California Society for Psychoanalytic Psychology. Veteranis Memorial Center Theater - 203 E. Fourteenth Street, Davis, CA. For additional information, contact www.ncspp.org or Thomas Arizmendi at 916-789-1567
- **Saturday, December 6, 2003**—Working With Difficult Patients, Fall Conference of the Appalachian Psychoanalytic Society with Nancy McWilliams. For additional information contact William MacGillivray at drmacg@bellsouth.net or 865-584-8400.
- **February 19-22, 2004**—Psychoanalysis and Narrative Medicine, a Conference at the University of Florida, Sheronon Gainseville Hotel. For additional information, contact Peter Rudnyskty at Department of English, P.O. Box 117310, University of Florida, Gainesville, FL 32611, or email to plr@english.ufl.edu.
- **March 10-14, 2004**—Working at the Frontiers, the International Psychoanalytical Association 43rd International Congress, Sheraton Hotel, New Orleans, LA. For information, contact www.ipa.org.uk.
- **April 29-May 2, 2004**—Unpacking the Clinical Moment, 2nd Biennial Conference of the International Association for Relational Psychoanalysis and Psychotherapy, Loews Hotel, Santa Monica, CA. For additional information: www.iarpp.org.
The Austin Society for Psychoanalytic Psychology began its year with a retreat in August. This year we did something different. Our newly formed Advisory Board, made up of past presidents of the Austin Society, joined our current Board of elected officers for the morning. During that time, the past presidents talked about how the society was formed, who were charter members, and the themes of programs through the years since 1983 when it began. After a lunch break, the Board got down to the business of upcoming conferences and monthly meetings.

The theme for our monthly meetings this year is Psychoanalytic Influences in the Culture:

- September 10 - Ricardo Ainslie, University of Texas Professor in Educational Psychology presented his research on the killing of James Byrd in Jasper, Texas in a presentation entitled “A Psychoanalytic View of the Murder of James Byrd.”
- October 8 - Austin author Steve Harrigan in concert with Frank Thompson, noted author, filmmaker and film historian from California will talk about “The Alamo: Real and Imagined.”
- November 12 - Pam Sachant, will talk about her dissertation research in art history about artist, Eddie Arning, hospitalized at Austin State Hospital in the 1930’s. She will show slides of his work and explore psychoanalytic motivations for his work.
- December 10 - A 5-member panel will discuss “Psychoanalytic Perspectives on Portrayals of Psychic Trauma in Literature.” The panel is Carolyn Bates, Richard Campbell, Cynthia Lee, Keith Kessler, and Cyndy Playfair.
- January 14 - Robert Abzug, O.H. Radkey Regents Professor of History and American Studies at the University of Texas, will show an 80-minute documentary film of Holocaust survivor Henry Landwirth’s late in life journey back to his home in Krakow. Dr. Abzug served as historical consultant and advisor.
- February 11 - Josie Whitley will present “You Don’t Know Me: The Mysterious Otherness of the Other.” She will talk about the experience of growing up Mexican-American culture in which one fits in both worlds and neither. She will use poetry to elaborate.
- April 14 - Dayna Burnet will present her dissertation research in “Born to Light: The Voice of the Film Artist.”
- May 12 - Charles Ramirez-Berg, University Distinguished Teaching Professor of Radio, TV, Film at the University of Texas, will use film to explore “Representing Internal States of Mind in Movies.”

Daniel Siegel will be in Austin October 4 and 5 for our Fall Conference. Friday night is open to the public and Dr. Siegel will talk about “How Relationships Shape Who We Are” based on research he did with co-author Mary Hartzell, culminating in their book Parenting from the Inside Out. Saturday will be open to mental health professionals only and Dr. Siegel will spend the day discussing what “‘The Developing Mind’ Means for Psychoanalysis.” In preparation for this conference, Richard Campbell has offered five 10-week courses on neuroscience, attachment, and affect regulation. JoAnn Olsen and Alan Davis will teach a class on parenting based on Siegel,’s book Parenting from the Inside Out.

Our Winter Conference on February 27 and 28 will feature Neil Altman. The Friday night talk open to the public will be “Race and Racism in America 2003.” The Saturday conference open to mental health professionals only will be “Race and Culture In and Out of the Consulting Room.” Gemma Ainslie, Sherry Dickey, and Cynthia Lee will each teach a course on writings suggested by Dr. Altman in preparation for his visit.

We plan to offer a 3-hour ethics course that is being drawn up. Part of the requirement of the Texas State Board of Examiners of Psychologists is a yearly 3-hour course. We hope to use film and literature to make the required points about ethics. Joann Ponder has volunteered to chair that committee.

We have a newly formed Arts Committee that Ricardo Ainslie has agreed to chair. Our goal is to educate our society members and the public through public forums where art, film, and literature with be discussed with a psychoanalytic understanding.

Officers for 2003-2004 are Sherry Dickey, President; Cheryl Armbrust, Past President; Joann Ponder, President-Elect; Karen Habib, Treasurer; Lynne Banatyne, Secretary; Richard Campbell, Education and Training Committee, Co-Chair; Marianna Adler, Education and Training Committee, Co-Chair; Joanne Olsen, Multidisciplinary Representative; Laurie Seremetis, Interdisciplinary Representative. Our website which lists our activities is sss.austinaspp.org.
The year ahead is shaping up to be a rich and exciting one for the Washington Professionals for the Study of Psychoanalysis. Hurricane Isabel served as a backdrop for our annual Board retreat. The absence of electricity, flooded basements and downed trees did not deter our Board from meeting to finalize plans for our coming year’s activities.

Our Program Committee has been very active. The theme of our seven Monday evening dialogues is: The Therapist as Person: Visible and Invisible Intrusions Into the Therapeutic Space. Guided by our presenters, we will explore the impact on the treatment of the therapist’s disability, loss of a spouse, sexual orientation, cultural heritage, relocation of an office and advancing age. Additionally, we will explore how therapy shapes the therapist.

One of our main events will be our annual Fall Conference, to be held on November 16, 2003 featuring Jonathan Lear. The theme of his presentation will be Therapeutic Action: How Can Irony Change the Soul? He will discuss the impact of subjectivity, objectivity and irony on the therapeutic process. Many of the myths and misconceptions surrounding irony will also be addressed, as well as the importance of renewing our engagement with the fundamental concepts of our practice.

Our seminar series continues to be very popular and well attended. Meeting in the facilitator’s home or office, they offer a more intimate venue for addressing a number of topics.

We continue to reach out to graduate students in a number of ways. One of our major initiatives is the Jonathan Bloom-Feshbach Award, which encourages psychoanalytic research and writing. This year, we’ve had a number of papers submitted for consideration, covering a variety of topics.

Finally, as part of our 20th anniversary observance, we will be honoring our past-presidents at a brunch in their honor. In addition to the festivities, we will be reviewing the evolution of psychoanalysis during their tenure. Hurricane Isabel did triumph over our original celebration, but we’ve rescheduled for February 28, 2004. We’re resilient!

Washington Professionals for the Study of Psychoanalysis

Connie Halligan, PhD

The Western Massachusetts and Albany Association for Psychoanalytic Psychology (WMAAPP) continues to actively sponsor diverse events with a psychoanalytic focus in our region, which encompasses the Berkshire and Pioneer Valley areas of Massachusetts and the Albany area in New York. Major programs offered this year included presentations by Carol Gilligan and Marsha Levy Warren, entitled Speaking Truth Truly: Adolescent Girls and the Process of Initiation, and by Charles Strozier, entitled, Psychoanalysis and Fears of the Apocalypse. We are looking forward to a Fall 2003 presentation by Sue Erikson Bloland, daughter of the celebrated psychoanalyst Erik Erikson, entitled, Childhood and Society: The Next Generation. Ms. Bloland will speak on the nature of fame and its impact on intimacy and interpersonal dynamics in her life and the lives of others touched by celebrity.

This year WMAAPP sponsored two courses. One was on Love: Distortions and Delights, taught by Norma Johnson and Joel Rosen. The second was on Clinical Work with Dreams, taught by Paul Lippmann. Paul also gave a talk entitled, The Birth of Psychoanalysis and the Holocaust: The Love-Hate Relationship of Freud and Jung. We also offered several Saturday morning study group meetings. Talks included; Jack Miller, on the body in psychoanalysis; Aiden DeLaCour, on her psychosocial peace building work in Rwanda; Alan Roland, on psychoanalytic therapy with artists; Patricia Everett, on Dianne Ackerman’s poetry written during the course of her psychoanalysis; David Ray and Carole Salvador, on organizational consultation; James Young, on memory and the monument, and Kirby Farrell, on the language of the inner life.

An issue of particular interest to WMAAPP currently is that of welcoming people trained at psychoanalytic institutes to our group at the level of full membership status. Up to now, full membership has been limited to licensed mental health professionals. We are also now offering free membership to graduate students. Through our Community and Professional Affairs Committee Newsletter, we address our ongoing concerns about managed care and HIPAA. Finally, we are developing a website so that we may enter cyberspace, at last.

Western Massachusetts and Albany Association for Psychoanalytic Psychology

Joanne Yurman, PhD
I. Call to Order: President Darwin called the meeting to order at 8:45 a.m.

II. Proxy Votes: A. Brok for J. Reppen when absent; J. Reppen for A. Brok when absent; H. Seiden for H. Davis; N. Altman for N. Thomas; L. Zelnick for D. Ehrensaft when absent; M. Jacobs for B. Welch when absent

III. Draft Minutes of January 25, 2003 Meeting

Motion 1: To approve the draft minutes of the Board meeting of January 25, 2003 as submitted. Action: Passed Yes – 20 No – 0

IV. Information Items

a. Academy of Psychoanalysis Election Results: Dr. Jacobs announced the results and they were also in the Agenda packets.

b. Program at Meeting of Canadian Psychological Association: Dr. Slavin reported that there is a new Section on Psychoanalysis in Canada. The Division is on an invited panel at their first meeting in June. Title of the panel is: Psychoanalysis in Canada. The Division is on an invited panel at the coming meetings.

c. Annual Report of the Division: Dr. Jacobs brought the report to the attention of the Board. The report is in the agenda packet. Dr. Darwin also read a letter from Division 44 thanking Division 39 for giving them time on the Program and for supporting their position on military advertising with the discriminatory nature of gender issues within the military.

d. PEP CD: The PEP CD contract has been signed. Dr. Darwin thanked N. McWilliams and Dr. Slavin for their work on this project. She also thanked Dr. Manosevitz for getting payment for the contract expedited.

V. Budget Report

Dr. Manosevitz distributed a tentative final on the 2002 financial and the first quarter for 2003. He gave explanation regarding unusual expenses that were “one time” expenses. The expenses were all for important projects within the Division. He reported that he expected to have a final on 2002 for the August meeting. He also reviewed the 2003 budget explaining that the expenses for the PEP CD project have been paid from 2003 funds. Dr. Manosevitz also distributed a guideline for reimbursable expenses.

Motion 2: To approve the budget revisions as submitted. Action: Withdrawn

VI. Update on Old Business

a. Internet Development Issues

1. Web Site launch – April 1, 2003: Dr. Zelnick gave a presentation on the new Division web site via an interactive projection display. He also introduced his committee members. The web site is also on display at the meeting registration area. Dr. Zelnick’s report included an extensive explanation of navigating the site and the variety of information available online within the web site. Dr. Darwin thanked Dr. Zelnick and his committee for their work to make these important advancements in the Division’s web site.

b. Education and Training Committee: Dr. Orfanos reported that they have implemented a workshop during the APA conference on teaching psychoanalytic psychology. They will continue to have this workshop at the coming meetings. They have developed fact sheets on myths and truths of psychoanalysis as well as curriculums for teaching psychoanalysis. Much of this information will be placed on the new Division web site. They are also planning to implement an all day continuing education course beginning with the APA meeting in Hawaii. In working with the APA Education Directorate he is trying to help them understand how the Division wants to communicate to other APA psychologists information regarding psychoanalysis. His committee is interested in possibly having a resolution passed by the APA Council that states policy that psychoanalysis is alive...
and well and is a very important part of psychology. He will pursue this with the Division Council Reps.

c. **Graduate Student Committee:** Drs. Schwartz and Rosica reported that their committee is working to increase their presence at the Spring Meetings. They are also working to increase their membership numbers for graduate students. They are looking at ways to utilize Local Chapters in their recruitment. They are hoping to work more closely with the leadership in the local communities. They want to increase visibility on the website, making more interactive and more exciting to graduate students. They have had a site on PsyBC for graduate students for the last four months. It has not been as active as expected and they will need to assess its value for the future. Sending emails through the Division office has been more effective in reaching the graduate student members. He encouraged members to work with graduate students they have contact with to become more involved in the activities, as well as submitting papers for consideration for presentation at Spring Meetings.

Dr. Reppen mentioned the Stephen A. Mitchell award for Graduate Students. He encouraged those who have contact with Graduate Students to encourage them to apply for this award.

Section V is sponsoring a Graduate Student Essay contest. Section IX sponsors an award for an Essay. Section VIII sponsors an award for Section VIII graduate students. Section VI also sponsors awards. This information will be forwarded to the Graduate Student Committee chairs to list on the web site.

d. **Out-Reach:** Dr. Lionells reported that her committee has received approximately 70 responses to the letter sent out by the Outreach Committee looking for data on outreach programs that currently exists. Many of the initiatives are sponsored by organizations, but individuals have initiated many. Dr. Lionells discussed some of the many different programs that are currently in affect in communities across the country.

The committee has also received requests from members for ideas and guidelines for implementing programs in their communities. The committee will network with these members, offer information and assist them in networking with organizations and/or individuals who have already implemented the programs. They also want to stimulate interest to initiate new programs and projects throughout the country. They will use the web site to get information out to members. They will work with Section IX to have a “project fair” during the next Spring Meeting for individuals and groups to display their information on the programs in which they are involved. They will look for ways to publicize the projects and the members who are involved in the work. They will work directly with the Public Information committee on this project. Drs. Fulton and Ainslie thanked Dr. Lionells and her committee for their efforts. Working in partnership with this committee has been very helpful and encouraging.

The Public Information brochure has been very well received by Division members. The brochures are now available for purchase by members for a nominal cost, by contacting the Division office. She also discussed the media-training workshop their committee is conducting with the assistance of APA. She encouraged members to attend. They are also looking at ways to have online information available. They are looking at getting public relations individual to sit on each Spring Meeting planning committee. Additionally, they will be reaching out to Local Chapters through interaction with Section IV. They have asked Section IV to designate a Public Information individual in each Local Chapter.

e. **In-Reach**

1. **Diversity in psychoanalysis:** A discussion was held regarding diversity within psychoanalysis and within the Division. The need to reach out to include minority groups in the different aspects of the Division activities was also discussed. It is important to begin talking to Division members to recognize members who are minorities and to encourage those individuals to become involved in Division activities and Division leadership. Dr. Darwin asked that members funnel their ideas to Dr. Ramirez for further discussion at the August meeting.

VIII. **Membership Committee**

Dr. Couch summarized his written report. His committee continues to work on retention and recruitment. Recruitment is close to 3% at this point. There are a variety of reasons for people who discontinue their membership. The committee has developed a recruitment packet and members who would like a packet can simply contact the Division office and one will be shipped to them. He then summarized the rationale for the motion stated below.

**Motion 3:** Beginning with the 2004 membership year, any member of the Division who is not a member of APA may request Division Life Membership (dues exempt) status if they are 69 years of age and have been a member of the Division for at least 10 years. This request will not be put into effect automatically, but must be made in writing to the Division office. Action: Passed – Yes – 22; No – 1; Abstentions - 1

IX. **New Business**

a. **2004 MN Spring Meeting Report:** Dr. Darwin introduced Natalie Shear and Jennifer Grudza to the members and thanked them for their work in managing the spring meetings. Dr. Greenspon was welcomed to the meeting and thanked for the great work on the programming of the Spring Meeting. He made a few brief remarks and thanked the Board for their support in the committee efforts.

b. **Henry Seiden Proposal:** Dr. Seiden discussed his written proposal regarding the PEP CD and how it can be disseminated to members and others. He referred to his written proposal and asked the Board to consider additional dialogue on the issue, and encouraged the Board to proceed with a negotiation to make this service available for members. This negotiation would offer a subscription annually to the members. Further discussion was held regarding how
to implement a workable plan for members. Dr. Darwin proposed naming a committee to see what the interest is and the numbers of members that we would have available to work out the a possible negotiation plan.

c. IARPP 2004 Meeting: Dr. Darwin announced that the issues surrounding the dates of the IARPP Meeting and the Division Spring Meeting have been resolved and the two groups leaders will meet to discuss issues for the future.

d. 25th Anniversary of the Division: The “celebration” will be launched at the 2004 Spring Meeting and continued throughout the year and finalized at the 2005 Spring Meeting. Drs. MacGillivray and McWilliams volunteered to sit on a committee to work on publicizing this special anniversary.

e. Ethnic Minority Seat on APA Council: Dr. Altman informed the Board of the position of APA to increase ethnic minority participation on Council. Dr. Ramirez will look into identifying our ethnic minority members. It is the hope that these members will be interested in leadership positions within the Division.

f. PsyBC and Memo from Dan Hill: Dr. Darwin referred the Board to the information memo from PsyBC in the agenda packets. This proposal could generate non-dues revenue for the Division as well as giving PsyBC more exposure to the members. Ideas were expressed and many members felt this was worth investigating more thoroughly.

g. Support of Ron Levant, Ph.D., for APA President: Dr. Alpert gave rationale to support Dr. Levant in his quest for APA President.

Motion 4: To support Ron Levant, Ph.D., for APA President. Action: Passed Unanimously

X. Committee Reports

a. Interdivisional Task Force on Managed Care and Health Reform: Dr. Goldberg distributed a report on the activities of this committee. He thanked the Division for its support of this Committee.

b. Federal Advocacy: Dr. Goldberg discussed his activities in this role. He briefly discussed the issues regarding parity and felt encouraged this issue could be placed on the congressional agenda. He also reported on the support parity has within congress. He discussed the Association Health Ban – and told the Board the intent was to have this issue defeated. The third item is Medical Malpractice – and a cap has been placed on it.

c. APA Council of Representatives: Dr. Altman gave a summary of Council activities. He stated that the presidential initiatives of the of the current APA president are not completely in line with the Division, but he is positive regarding open lines of communication between him and the Division and is a very energetic President. Dr. Altman gave a brief summary of the financial status of APA as well as other pertinent issues.

d. CAPP, HIPAA and APA Resilience Campaign: Dr. Manosevitz thanked the Board for supporting the presentation on HIPAA during this Spring Meeting. He made some brief comments regarding some of the rules and regulations of HIPAA. He referred the Board to a CAPP report that had been distributed to the Board earlier in the day. He made a few brief comments regarding his report. He encouraged members to email their support to the parity bill in congress. Members can go directly to the portal and link to a form letter set up by APA to send to their congressman/senator.

e. AD HOC Committee on Scope of Practice: Dr. Aron, chair of the Ad Hoc Committee on Scope of Practice, introduced the members of his committee. The point of this committee is to look at the new licensing law passed in New York. The implications for Division members and others practicing in New York are being explored by this committee. They will look at a variety of ideas to work with NYSPA and with the legislation. They will work with the New York members to encourage participation and input. They will work to develop a psychoanalytic psychology Division of NYSPA. This will help increase interest for Division members in New York to participate with NYSPA. They will then use this Division to encourage members to become ABPP certified.

f. Task Force on Psychoanalysis and Health Care: Dr. Gerson gave a brief explanation of this Task Force’s charge and activities. They hope develop methods to articulate the value of psychoanalytic therapy in physical illness and health care. They would also like to develop a way to relate with physicians in this area of therapy attached to physical illness and pain. They are open to any ideas, thoughts and input from members.

XI. Calendar of Events: Forthcoming Meetings of the Division

a. 2003 APA (8/7 – 8/10) – Toronto
b. 2004 Spring Meeting (3/18 – 3/22) – Miami: Dr. Corn gave a brief overview of the program for the upcoming meeting.

c. 2004 APA (7/28 – 8/1) – Honolulu
d. 2005 Spring Meeting (4/12 – 4/17) – New York
e. 2005 APA (8/18 – 8/21) – Washington, DC
f. 2006 Spring Meeting (4/19 – 4/23) – Philadelphia
g. 2006 APA (8/10 – 8/13) – New Orleans
h. 2007 Spring Meeting (4/18 – 4/23) - Toronto

XII. Calendar of Events: Division Business Meetings

a. Executive Committee
   1. May 2003 (TBA) – Telephone Conference
   2. August 7, 2003 – Toronto

b. Board Meetings
   1. August 8, 2003 – Toronto

XIII. Adjournment

There being no further business to come before the Board at this time the meeting was adjourned at 2:50 P.M.

Secretary: Marilyn Jacobs, PhD
Recorder: Ruth Helein
HELEN BLOCK LEWIS MEMORIAL AWARD FOR PSYCHOLOGISTS

The endowment for the Advancement of Psychotherapy at Massachusetts General Hospital and Division 39 will award a $300 prize for the best unpublished work in the general area of psychodynamic psychotherapy. This may take the form of a paper, a write up of a clinical case highlighting dynamic issues in the treatment, or any form that demonstrates efforts to show mastery of psychodynamic concepts. In addition, the award recipient will be invited to attend the Annual Meeting of Division 39. Division 39 and the Endowment for the Advancement of Psychotherapy will support all meeting-related expenses. All current doctoral psychology graduate students not in formal analytic training are encouraged to submit applications and papers. The paper should be of publishable length (i.e., no more than 40 pages, excluding bibliography). Applications will be reviewed by a joint committee composed of Division 39 members and members of the Endowment for the Advancement of Psychotherapy. Applicants will be notified of results no later than February 1, 2004. Further information and specific details/criteria can be found online at www.advancepsychotherapy.org or contact Anne Alonso, PhD, Director, Endowment for the Advancement of Psychotherapy, Massachusetts General Hospital, ACC-812, Boston, MA 02114, telephone: 617-724-0808, email: annealonso@aol.com

DEADLINE: DECEMBER 15, 2003

SECTION VIII, COUPLE AND FAMILY THERAPY AND PSYCHOANALYSIS

Section VIII is pleased to announce that one $400 grant is to be awarded for the best proposal by a graduate student who is doing dissertation research in the area of psychoanalysis and family and couple therapy. Doctoral candidates who are members of Division 39 are welcome to apply. The deadline for applying is January 10, 2004. For further information, write to the Chair of the Research Committee, Leo Weisbender, PhD, at leofw@aol.com.

DEADLINE: JANUARY 10, 2004

SECTION V, PSYCHOLOGIST PSYCHOANALYST CLINICIANS

Section V announces its 2003 Biennial Division-Wide Essay Competition. The subject this year: Meeting the World as a Psychoanalyst. First Prize: $1000; Second Prize: $200. Winners will be selected by blind review. The winning essays will appear on the Section V Web Site (available to everyone), as is the custom. We anticipate good food for thought on how being in our profession affects us. The essays may later be published in a print journal, if the writers wish to pursue this. Here is what you need to know to enter the competition: Eligibility: Membership in Division 39. Format: One page for identification, including the title of your essay, your name, street address, e-mail address, and telephone number. Six copies of the essay, with the title, but no personal information on them. Length: Up to fifteen pages. Submission: Six copies plus the identification page go to: Section V Office, 333 West 57th Street, Suite 103, New York, NY 10019-3115. If you have further questions, please contact Johanna Tabin by phone at 847-835-0162 or by e-mail at jktabin@juno.com. The winners will be announced by Section V at the Division 39 Spring Meeting in March 2004.

DEADLINE: FEBRUARY 1, 2004

STEPHEN A. MITCHELL AWARD

Papers are invited for the second annual Stephen A. Mitchell Award. Established by Psychoanalytic Psychology and the Board of the Division of Psychoanalysis, the award honors our esteemed colleague as well as a graduate student whose paper is deemed exemplary by a panel of judges, all journal editors and Division 39 members. The award includes a $500 cash prize, airfare and registration for the Division Spring Meeting, at which the paper will be read, and publication in Psychoanalytic Psychology. Deadline for submission is July 1, 2004, and presentation of the paper will be at the 2005 meeting. Five printouts of the paper should be submitted to me according to the procedure for submission to Psychoanalytic Psychology and should include a cover letter indicating that the paper is being submitted for the Stephen A. Mitchell Award. Division members with academic affiliations, in particular, as well as all members are strongly encouraged to invite graduate students to submit papers. There are no restrictions as to topic or theoretical orientation, although the papers must be of a psychoanalytic nature. Manuscripts and questions should be addressed to the editor: Joseph Reppen, PhD, ABPP, Editor, Psychoanalytic Psychology, 211 East 70 Street, New York, NY 10021-5207, 212/288-7530 (voice), 212/628-8453 (fax), reppen@datagram.com

DEADLINE: JULY 1, 2004
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