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FROM THE PRESIDENT: Politics and Bedfellows

Nancy McWilliams PhD

I n this column I expand on the second presidential initiative I mentioned in the previous newsletter: my hope to join forces with other psychoanalytic groups in pursuit of common goals. Given the political, economic, and ideological pressures that are threatening everyone identified with psychoanalysis (and, arguably, everyone within the broader humanistic tradition in which the examined life is valued), we cannot dissipate our energies fighting with each other when we could be addressing together the threats to our common survival. Irrespective of the differences in our professional settings, orienting theories, philosophies of education, and standards for training, and notwithstanding our painfully checkered history as a movement whose in–groups have repeatedly treated out–groups with unconscionable arrogance, all of us are currently under siege and need to find ways to cooperate.

Psychotherapy is rapidly being swallowed up by a mass, technocratic culture from which we once were able to preserve some potential space, some room for the uniqueness of the individual sufferer and the sanctity of the therapeutic relationship. The industrialization of therapy reflects the power of pharmaceutical and insurance companies, abetted by an ostensible public indifference to issues like privacy, attachment needs, and the complexity of change. These social forces are much bigger than we are, but there is some strength in numbers, and some value in trying to speak truth to power with one voice.

One ongoing undertaking that has paved the way for more far–reaching collaboration among psychoanalytic organizations is the involvement of Division 39 in the Psychoanalytic Consortium. The other Consortium members include the American Psychoanalytic Association (APsaA, or “the American”), the Academy for Psychoanalysis and Dynamic Psychiatry (“the Academy”), and the American Association for Psychoanalysis in Clinical Social Work (AAPCSW, formerly NMCOP, the National Membership Committee on Psychoanalysis in Clinical Social Work). Organized originally to address the ill–fated Clinton health care reforms, the Consortium went on to articulate consensual standards of its component groups for psychoanalytic training and to foster the establishment and incorporation of the Accreditation Council for Psychoanalytic Education (ACPE). It has also defined membership criteria for other psychoanalytic organizations interested in becoming part of the Consortium.

I am told that the early meetings included considerable acrimony and frustration, but the current tone—not surprising when people with vital interests in common slowly get used to each other and try to work in good faith—is notably cooperative. Relationships built during the Consortium discussions have paved the way for, among other accomplishments, the international collaboration that produced the Psychodynamic Diagnostic Manual and the recent ecumenical celebrations of Freud’s 150th birthday at the Austrian Embassy in Washington, DC.

Joint ventures with the American Psychoanalytic Association

It is twenty years now since the settling of the lawsuit that opened the institutes of the American to nonmedical practitioners and made affiliation with the International Psychoanalytical Association possible for non–APsaA
groups. The current leaders of the American include people trained with nonphysicians on an equal basis. The President–Elect, Prudy Gourguechon (see her disturbing and timely article in this issue), began her analytic training in the first post-lawsuit class and tells me she has no professional memory of the “bad old days.”

Although there is ongoing competition between institutes of the American and other psychoanalytic training centers, and although many of us have legitimate complaints about how members and organizations of the American have behaved in specific instances, there is no longer much evidence of the systematic discrimination that once poisoned relationships between ApsaA and most psychologist-psychoanalysts. It is time to work together where we can.

One reason for collaboration is to avoid diffusing our energies by duplicating each other’s efforts. Several projects recently inaugurated by the American could have just as easily been spearheaded by Division 39, and ApsaA leaders have enthusiastically sought our members’ involvement in them. For example, Prudy Gourguechon has launched the “10,000 Minds Project,” an effort to get psychoanalytic ideas back into university (especially undergraduate) courses, textbooks, and colloquia. Several Division members, including Jim Hansell, Lisa Damour, Judith Logue, David Ramirez, and Greg Lowder, have been centrally engaged in this initiative.

In that connection, Greg Lowder is developing a powerpoint presentation on the scientific evidence supporting psychoanalytic interventions. The finished product will be usable by any lecturer who needs to make the point that there is a solid foundation in conventional empirical studies for what we do. Larry Zelnick has put a link from our Division 39 Web site (www.division39.org) to an ApsaA site on empirical evidence for psychoanalytic ideas. The excellent compilation there was developed by Andrew Gerber and several other Division members who were on the ApsaA committee that initiated the project. More material will be added as time goes on.

The Candidate, an ApsaA-supported online newsletter for people going through analytic training, includes Division 39 members among its editors. They are soliciting articles about candidates’ experiences in training, whether in ApsaA institutes or elsewhere. On another front, Richard Fox, a past president of ApsaA, has asked for a Division 39 presence on his committee on the future of psychoanalytic psychotherapy. Judith Logue has started attending those meetings.

From our end, I have asked Lynne Moritz, the current President of the American, for ApsaA support for a joint Division 39/ApsaA conference highlighting the work of psychoanalytic scientists, providing invited researchers time to work together on issues of mutual concern, and perhaps ultimately producing a consensus statement about “evidence” and psychoanalysis.

She has obtained agreement from the relevant boards of the American that our respective organizations can co-sponsor two meetings in 2008, one connected with the Division 39 Spring Meeting in New York, the other attached to the ApsaA meetings the following June. Sidney Blatt and Glen Gabbard are working together on this project, with the help of Mark Hilsenroth and Andrew Gerber. They are currently at the brainstorming state, and many creative ideas are being considered. We can assume that the considerable public relations skills of Dottie Jeffries of the American will be applied to publicizing these events.

Collaborations with other psychoanalytic organizations

Division 39 has also agreed to join a dizzying number of cosponsors for a conference on psychoanalytic education organized by Arnold Richards and Jane Hall, to be held in New York on the first weekend in December 2007. Their call for papers and participation announces the intention “to join together out of a mutual concern for the future of psychoanalysis and to discuss how to make education in this profession attractive and vibrant in today’s world.” I encourage readers to check out their Web site at www.psychoanalyticced.net.

Through the Consortium and other connections, Division 39 has good relationships with leaders of the Academy and AAPCSW. Many of our members also have warm affiliations with the International Psychoanalytical Association, the Association for Autonomous Psychoanalytic Institutes, the International Federation for Psychoanalytic Education, the International Association for Relational Psychoanalysis and Psychotherapy, the International Council for Psychoanalytic Self Psychology, and other groups. I am hoping we can offer our resources to one another as we deal with different aspects of the contemporary devaluation of psychoanalysis.

Some thoughts about NAAP

Because of the controversial licensing laws they have achieved in Vermont, New York, and New Jersey, the National Association for the Advancement of Psychoanalysis has made serious adversaries of many
psychologist-psychoanalysts. In the interest of full disclosure, I should note that I am a graduate of an NAAP-affiliated institute (the National Psychological Association for Psychoanalysis) that was highly invested in attaining laws under which psychoanalytic professionals from outside the tri-disciplines could practice. NPAP was founded by Theodor Reik, the first psychologist-psychoanalyst, in whose defense Freud wrote “The Question of Lay Analysis,” and it retains a commitment to training analysts from nontraditional backgrounds. These attitudes suffused my analytic training and have become part of my own professional identity.

Nevertheless, notwithstanding my loyalty to my institute, like most Division 39 members I have been troubled by many aspects of the legal victories that NAAP has achieved. The laws they have managed to get passed have defined psychoanalysis and psychoanalysts in terms of training that is far less extensive than what is required by most mainstream institutes, including some of their own member institutes. I believe that their victories will have painful unintended consequences for all of us (see Laurel Wagner’s article on this topic in Culture & Society, 2007, 12, 51-64, available at www.palgrave-journals.com/pcs/journal/v12/n1/full/2100112a.html).

Notwithstanding the serious differences between NAAP and many of us in the Division about what defines a psychoanalyst and what training qualifies one for that title, however, I think we need to remember that NAAP’s ceaseless campaign to attain a clear legal status for all their members derives from a passion for applied psychoanalysis. NAAP is full of people who are committed to analytic ways of working—not a role for which everyone is clamoring these days. Outside of credentialing, allies for NAAP institute through programs to practice, they can be expected to get interested, as most of us do during our development as therapists, in opportunities to participate in the wider analytic community, to learn from its leaders, and to contribute to common projects.

Decades ago, at a time when APsaA regarded psychologist analysts as “lay” practitioners and refused recognition to anyone trained outside their institutes, leaders of the American tried to get the United States government to accept APsaA as the sole arbiter and certifier of things psychoanalytic. It was NAAP that successfully challenged APsaA’s hegemony and preserved a space for the psychoanalytic legitimacy of the rest of us. Despite my unhappiness with their recent legal definitions of psychoanalysis, I remain grateful that they were there when most psychologists were in the out-group. I suggest that we be open to cooperating with our NAAP colleagues in any enterprise that stands to benefit all of our respective members.

In making the case for as much inter-group cooperation as possible, I do not seek to minimize genuine differences among psychoanalytic bodies, and I am not adopting a Pollyanna-like attitude that “we should all just get along.” What I am saying is that the social forces that are undermining psychoanalysis and the psychoanalytic therapies demand a united response, and that separate psychoanalytic groups engaging on different fronts in the current battle for our survival should not be working at cross-purposes or in isolation. Once we have safely reestablished the legitimacy of psychoanalytic practice in the surrounding culture and in the larger mental health community, we can again afford the luxury of sparring with one another.
Were we able to prevail upon Freud to address us, he might smile at our deliberations about repression, disavowal and dissociation. He might wryly remind us that as early as 1893 he had already described the “blindness of the seeing eye” as an experience in which “one knows and does not know a thing at the same time”.

Now more than ever we are beset with competing models and theories regarding these issues. This conference will raise fundamental questions about the way the mind is structured. Are we uncovering layers of repressed material and/or encountering a multiplicity of selves? What are the psychic processes that keep certain experiences out of awareness? What is the place of trauma in psychoanalysis? How does the body express or collude with not-knowing? How do we come to know the things we know and tolerate the ambiguity inherent in not-knowing or, more confusing still, sort-of-knowing?

We are all familiar with the confusion of spending time steeped in the realm of uncertainty. We invite submissions of papers that highlight not only theoretical questions but also clinical and emotional experience. We invite you to grapple with what you do not know and tell us what you do know, sort-of-know and wish to know.

**FOR EACH SUBMISSION:**
- Send four (4) copies of the proposal with a TITLE ONLY (omitting names). NO FAX SUBMISSIONS WILL BE ACCEPTED.
- Create a cover page containing: Your name(s), address, fax and/or email, title of submission, and, for each author, his/her primary affiliation and a ONE PAGE Curriculum Vitae.
- FOR PANELS ONLY: Submit four (4) copies of the following (a)150-word overview of the panels; (b) A 350-word abstract for each paper. Panels may include two, three or four presenters. Keep in mind that ALL PANELS will be limited to 1 hour 50 minutes. Discussion between presenter and audience is encouraged.
- MEET THE AUTHOR/EDITOR has a delivery time of 50 minutes and requires a 150-word overview WITH name(s) INCLUDED.
- For Each Submission include 2 learning objectives and instructional level (introductory, intermediate or advanced) with your 150 word overview. See Division 39 website to complete required CE Information Sheet and to find guidelines.

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*Please specify issues to be addressed in this discussion (or informal) format
**The Core Planning Committee encourages graduate and undergraduate students to present their psychoanalytically relevant research

**NOTES:**
1. All presenters must register and pay for the Conference. NO EXCEPTIONS. Please consider this when putting together your program.
2. Only three (3) proposals will be accepted per person. Scheduling decisions are non-negotiable.
3. Psychoanalytic Psychology has the right of “first consideration” for all papers and panels under the aegis of the Division of Psychoanalysis (39).
4. Please direct all questions regarding submissions to the Conference Co-Chairs: Jean Petrucelli, Ph.D. email: dppetrucci@speakeasy.net and Melinda Gellman, Ph.D. email: mgel@mindspring.com

Send all submissions to: Division 39 Spring Meeting
c/o Natalie P. Shear Associates, 1730 M Street, NW, Suite 801, Washington, DC 20036.

**DEADLINE FOR SUBMISSION: POSTMARKED BY SEPTEMBER 7, 2007**
Nationally known Beverly Hills psychologist, Dr. Toni Bernay died on April 30, 2007, after a brief but valiant battle with a recurrence of lymphoma, according to her son, Mitchell Bernay. In 1976, she was among the first graduates of the California School of Professional Psychology and she immediately became one of the leaders among psychologists, including serving as a board member of the school from which she graduated. She was actively involved with the Los Angeles County Psychological Association and the California Psychological Association, and ultimately served on the Board of Directors of the American Psychological Association. She was a co-founder of Women in Psychology for Legislative Action, a political action committee. She appeared frequently as an expert on local and national television and radio shows.

Dr. Bernay made significant contributions to the field of psychology in these areas: the emergence of women in the work world, and the psychological impact of cancer. With Dorothy Cantor, she wrote the groundbreaking book, *Women in Power—The Secrets of Leadership*, which studied the psychological development of women in high elected office throughout the United States. The book led to the opening of the Leadership Equation Institute, which was dedicated to developing visionary and effective transformational leaders.

When her late husband, Saar Porrath, MD, was diagnosed with cancer, Dr. Bernay returned to the field of her early research concerning coping with cancer. Together, they developed a program to help patients advocate for themselves in the healthcare system. Last year Rodale Press published their book, *When it’s Cancer: Ten Essential Steps to Follow*. The Porrath Foundation, which she founded after his death, will continue the important work that they launched together. Finally, Dr. Bernay was one of the named plaintiffs in the federal anti-trust lawsuit that opened up the doors of analytic training to nonmedically trained psychological professionals in the United States.

Dr. Bernay was born and raised in New York City 70 years ago. Although admitted to the New York High School of Performing Arts, she attended Evander High School in the Bronx and was graduated with a B.A. from Hunter College. In 1957, she headed to California where she received her MSW from U.S.C. before earning her Ph.D from the California School of Professional Psychology. She is loved and remembered by the countless many whose lives she touched everyday. In lieu of flowers, donations can be made to the Porrath Foundation for Cancer Patient Advocacy.

FROM THE EDITOR

I apologize for getting this issue to you so late, although I hope it will be worth the wait. I spent the better part of May more or less blind, having undergone eye surgery for cataracts. Although the operations were quite successful, the transition to better vision was not accomplished immediately and it took many weeks of adjustment to finally be able to read and work on the newsletter without blurry vision. I am still adjusting to life without eyeglasses after 50 years, amazed that the world is so much larger and more vivid.

Before touting what is being offered in this issue, I would like to correct an error in the last issue. Sophia Richman reviewed Henri Parens’ memoir, *Renewal of Life*, and I thought I had found a picture of Dr. Parens to illustrate the article. Unfortunately, I relied upon Google Images to find a picture and the photo that showed up turned out to be a shot of Vamik Volkan. My apologies to both distinguished colleagues. Although Vamik is a handsome devil, isn’t he?

There are several articles in this issue that address the current crisis in health care and mental health care in this country (and Canada) with a report from Jon Mills on the problems of mental health care in Canada and Prudy Gourguechon’s observations of the problems facing psychoanalysis in particular. There is also a review by Keith Cook of Ivan Miller’s book, *Balanced Choice*, detailing a way to address the problems of financing an adequate health care system. I think it is terribly important that our members and all psychotherapists take seriously the need to advocate for our craft. Our professional organizations are simply not equipped to stay focused on the threats to psychotherapy.

I also hope you will take the time to read Marilyn Jacobs’ report to APA concerning Division 39 activities. Although I was familiar with the various activities she described in the report, the sheer volume of Division activities was impressive. The range and quality of our programs and initiatives is quite impressive and can only continue with the active efforts of our members to contribute their time and effort to following through with the Division’s ambition to advance psychoanalytic psychology within our profession and within the wider reaches of psychoanalytic practice. In this issue, you will also find a list of current committee members who contribute to the success of the Division through their volunteer efforts.
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Psychoanalytic Research

Editors Note: As the editors of this section of the newsletter, we are pleased to present two articles that utilize empirical methodology to study domains of interest highly relevant to clinical practice. Though each paper focuses on a unique area of research, they are similar in demonstrating how research can often provide meaningful clinically useful information. Dr. Goodman describes a quantitatively based method of assessing four areas of supervisee competence. He reviews existing methods of clinical supervision, presents an alternative methodology, and then uses an ongoing supervision of his to flesh out the application of these methods in context. Hal Shorey discusses the relationship between Attachment and Hope theory, and describes how he has used his research in the treatment of two separate patients. The authors have offered their e-mail addresses for correspondence. We offer our e-mail addresses as well. We look forward to any feedback from the readership about this column: <tkatzenstein@parterners.org> or <csiefert@partners.org>

Hope for Psychotherapy: An Attachment Theory Perspective

Hal S. Shorey

Although the preoccupied and dismissing individuals use their styles consistently, there is a subset of children who are not able to cope with parental behaviors so as to fulfill their security needs. This “disorganized” childhood attachment style (Hesse & Main, 2000) develops when children attempt to get security needs met from adult caretakers who are nonresponsive, frightening, or frightened. Lacking “secure bases” these children do not develop adequate social skills, fail to develop senses of self-efficacy, and have marked deficits in affect regulation. In adulthood, this developmental pattern is hypothesized to correspond to the “fearful” attachment style. Those with fearful attachment exhibit by far the worst achievement and mental health outcomes of the other attachment style groups.

Because attachment styles are reinforced across the developmental years, the attachment styles we observe in our adult clients are likely to be extensions of those developed in childhood and relate systematically to adult psychopathology (see Shorey & Snyder, 2006 for review). Understanding attachment-style-specific mental health outcomes, as well as how people with different attachment style pursue their goals can further be understood in terms of hope theory.

Hope (Snyder 1994; 2002) is a trait-like disposition composed of having (a) well-defined personal goals; (b) the pathways, or strategies, to reach those goals; and, (c) the requisite agency, or motivation, to use those pathways in the goal-pursuit process. Because of their abilities to attain important personal goals, high- relative to low-hope people have overall better achievement and mental health outcomes (see Snyder, 2002 for review).

Developmentally, Snyder proposed that hope is instilled through secure relationships with consistently available and responsive adult caregivers in childhood.
Our empirical research supported this hypothesis, finding that more adaptive parenting recollections from childhood predicts secure adult attachment. Secure attachment then directly fosters the development of hope and mental health (see Shorey, Snyder, Yang, & Lewin, 2003). The reverse also applies. Maladaptive parenting predicts insecure attachment styles, lower levels of hope, and more psychopathology.

The type of research just described is based on average response patterns across people. At the level of individuals, however, we have found that contrary to those with other insecure attachment styles, people with dismissing styles have high levels of hope. This is consistent with conceptualizing them as autonomous goal-driven strivers. Nevertheless, high-hope dismissing individuals do not appear to benefit from their high-hope thinking when it comes to mental health. They evidenced poorer mental health outcomes relative to high-hope secure people, and no better mental health outcomes relative to their low hope counterparts (see Shorey, 2006 for review of this entire line of research).

The reason that high-hope dismissing people do not benefit from hopeful thinking appears to be that their hopes are based in achievement as opposed to social life areas. As shown in the structural equation models in Figure 1, for secure, preoccupied, and dismissing people, achievement hope does not relate directly with better mental health. Social hope, however, does relate to mental health even for those with dismissing styles. Even when looking at negative outcomes specifically, such as depression in Figure 2, achievement hope does not relate to lower depression for the secure, preoccupied, or dismissing attachment groups. For the fearful group, achievement hope does relate directly to both better mental health and lower depression, but this relationship for the fearful group amounts to a "defensive achievement orientation." As avoidance goes up (along with social isolation and distress), achievement hope goes up also. Given the direct negative effects of attachment avoidance and anxiety on mental health and depression, however, any positive effects of achievement hope are more than offset for those with fearful attachment styles.

The relationships between social and achievement hope are perhaps the most interesting information in the model in Figure 2. For the secure group, social and achievement hope are balanced and reciprocally interactive. These relationships between social and achievement hope can be used by therapists in deciding when to implement various interventions with their different attachment-style clients. For the preoccupied group, higher achievement hope leads to higher social hope. For the dismissing and fearful groups, higher social hope leads to higher achievement hope.

The Case of a Dismissing Client
This case involves a man in his late thirties who presented with depression in the context of achievement failures. He had been struggling for 10 years trying to develop his business. When he sought treatment, he was having difficulty motivating himself to go to work each day, to drum up business, or to follow through on completing jobs he had already secured. As a result, he was struggling to meet his financial obligations and was under significant stress. He felt that this financial stress was driving his depression. Furthermore, he went so far as to rule out social causes for his depression (e.g., “Therapists always want to ask about your childhood, but my childhood doesn’t have anything to do with what is going on with me now so I don’t want to talk about it.”). Moreover, he was very clear about what he wanted in treatment—help getting back on track in pursuing his work and achievement area goals.

Based on the initial interview, I formed the tentative hypothesis that this patient had a dismissing attachment style. Aware that trying to engage him in confronting social issues could easily result in his dropping out of treatment, I agreed to join with him in targeting his achievement functioning. I was overt, however, in telling this dismissing client that I did not think improving his work performance would result in remission of his depression because his core issues were likely relational. I explained this in the context of a brief psycho-educational description of attachment theory and the dismissing style.

As treatment progressed and we worked on his work performance, I periodically reminded the patient of this idea. Then, when we were preparing to end our short-term behaviorally oriented treatment (with modest improvement in depressive symptoms), I was direct in suggesting to the client that he was not likely to experience the long-term recovery he sought if he did not work on his core interpersonal conflicts. To make this point, I presented him with the model for the dismissing attachment style in Figure 1 (p. 9). Seeing empirical support that pursuing only achievement goals was not likely to result in less depression or improved mental health, the patient reengaged in treatment. We shifted to using more of a psychodynamic approach to work through his family of origin issues and present day interpersonal functioning. Over the course of the next 9 months, he made steady progress to the point where he no longer met criteria for a depression diagnosis (although some residual dysphoria remained). Functionally, this previously isolated individual was dating, actively engaging with friends, and had a much more flexible coping armature.

The Case of the Preoccupied Client
My second case example involves that of a preoccupied
Figure 1
Relationships between attachment hope and mental health, where circles represent latent variables, curved lines with arrows on both ends represent covariances, solid lines between latent variables represent direct effects in the direction of the arrow, and dashed lines represent mediated effects.

Chi Square = 385.86, df = 346, p = .07
RMSEA = 0.038, CFI = 0.98

Figure 2
Relationships between attachment hope and depression, where circles represent latent variables, curved lines with arrows on both ends represent covariances, solid lines between latent variables represent direct effects in the direction of the arrow, and dashed lines represent mediated effects.

Chi Square = 382.97, df = 321, p = .01
RMSEA = 0.044, CFI = 0.94, NFI = 0.93
client who sought treatment for depression in the context of a relationship breakup, identity issues, and ambivalence about his career and academic trajectory. In the course of our initial psychodynamic psychotherapy, this client was chronically focused on, and in distress over, his “on again off again” relationship. He had a negative self-view, lacked direction, and felt disrespected by his girlfriend.

As we worked on his interpersonal and family of origin issues, this patient remained highly focused on his consistently volatile romantic relationship. When he distanced himself, his girlfriend wanted him back. When he went back, he started feeling insecure and asking for reassurance—at which point she would distance herself from him until he disengaged in agony. As they cycled through this process, the patient’s typical question in therapy was, “What’s wrong with me?” My answer was that he was overly focused on his relationship.

Using a psycho-educational approach, I instructed this client in the basics of attachment theory and, specifically, the cognitive, affective, and behavioral patterns of preoccupied people. In this context, I suggested to him that his hypervigilance was contributing to his relationship problems. Using the model for preoccupied individuals in Figure 2 (p. 9), I showed him how focusing on his achievement goals and raising his achievement area hope was likely to increase his social hope. This approach then could allow for a lessening of situational distress, improved relationship, and remission of depressive symptoms.

The patient agreed with this conceptualization and plan, and we shifted our treatment to target working on academic and career goal-setting, strategizing, and motivation (i.e., raising achievement hope). Over the course of the next 9 months, this patient decided to pursue a career as a doctor and applied to medical school. At the same time, he became more focused in his academic work, found it easier to earn high grades, and found experienced reward and satisfaction in his work. As he focused on his achievement life, his relationship with his girlfriend stabilized and he reported feeling more confident and better respected. At last report, one year after treatment, this patient was in medical school and still in relationship with his girlfriend.

CONCLUSION
Although the present article was brief, and did not cover the constructs in depth, it is my hope that the reader will have come away with a curiosity, if not direct interest, in how the attachment and hope constructs can be used in treatment. The interested clinician can gain much insight into this area by a direct reading of the cited references in this exciting and innovative area of clinical practice.
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Mental health service delivery in Canada is maintained by organized medicine, pharmaceutical manufacturers, and the insurance industry, each advocating a quick fix treatment mentality that continues to be spoon-fed unscrupulously to the masses. As a result, there has been a wholesale brainwash by the new drug culture within contemporary society that has been received with open arms by a passive public in search of a fast cure. These propagandizing efforts have paid off, for the public shows little interest to change. They are discontent but manipulated by persuasive medical professionals to take drugs rather than face their suffering more directly and effectively. They pine for help but are offered few alternatives. As a result, psychology has been underutilized and diminished in value for what it genuinely has to offer the Canadian public. Psychoanalytic paradigms are simply marginalized. Mainstream medicine advocates for chemicals, and this appeal to authority is hard to resist due to the medicalization of mental healthcare in Canada. This is further due to a collective identification based on the wishful fantasy to have problems magically disappear. The pill unconsciously symbolizes this fantasy.

In a sober revelation on “The Erosion of our Profession,” Kenneth Eisold (2007) alerts us to how psychoanalytic psychology in the United States is dogged by social, political, and economic pressures to conform to the mainstream medicalized expectations of expedient cure, marketplace demands for economic utility and efficiency, and the loss of autonomy and control we once enjoyed in providing treatment based upon our own professional sensibilities and training. I would like to contribute to his insights by alerting American practitioners to the plight of mental healthcare in Canada.

By way of introduction, a word about the Canadian healthcare system is in order. Healthcare is part of every resident’s right based on social-democratic principles that govern this country’s political-humanistic commitments to its citizenry. As a result, patients do not have to pay directly out of pocket for medical needs since a large percentage of their taxes go to sustain egalitarian healthcare delivery for all people. This is socially conditioned and an expected legislative right. However virtuous this system is, it also tends to produce a sense of entitlement: people are frugal, and in some cases stingy, when it comes to paying for what they believe should be ‘free’ by virtue of their right to healthcare. This equally applies to mental healthcare.

The mental healthcare industry in Canada is dominated by medicine. Psychologists, psychological associates, masters level therapists, and social workers in private practice are not covered by the healthcare system; only physicians are directly paid by the government. This becomes problematic when patients need therapy but have no free service to turn to. Because Canada is dominated by a pharmacological model of mental health treatment, people will most often be given medication for their difficulties, which is inculcated by medical authority. By and large, individual psychotherapy is rarely delivered by the medical community including psychiatry. Moreover, there is a dearth of government funded psychotherapeutic resources in the community because they have been largely displaced by biochemical interventions. Because individual therapy is not promoted as widely as psychopharmacology, people often end up suffering rather than seeking out talk therapy through direct expense. When they do, they are often prescribed CBT by their family doctors because that is the current model adopted by Canadian practitioners inculcated by academic empirically-based training institutions and endorsed by the Canadian Psychological Association. Psychoanalytic psychologists are vilified by mainstream practitioners and often discriminated against by insurance providers, allied mental health professionals, as well as the profession of psychology itself.

What I wish to argue is that the politics of mental illness dominated by medicine, pharmaceutical companies, and insurance corporations is creating a crisis for Canadian mental healthcare. This crisis is largely the result of a quick fix model that is economically driven to create profit for those providers who participate in this truncated, deficient, and politically institutionalized method of service delivery. The public is not only being manipulated, they are also dissuaded from seeking out what could be more beneficial because the healthcare monopoly devalues the viability of alternative and better modes of psychological practice. The biologicalization of medicine and psychiatry has collapsed the human being into physical reduction, hence claiming that mind is nothing but brain. The main solution they profess is in the form of a chemical. From this standpoint, the complexities of human emotion, thought, perception, consciousness, and unconscious experience are nothing but material states in the brain that can be controlled by pharmacology. This viewpoint has palpable philosophical and logical limitations (Mills, 2002), ignores the quality of lived experience or what it means for each individual who suffers, negates the phenomenological, existential, and humanistic commitments to treatment, and is amoral at best.
and unethical at worst. Furthermore, the new drug culture politically and economically oppresses alternative healthcare providers, and privileges one modality of therapy contra empirical evidence produced from the behavioral sciences that challenge the primacy of psychopharmacology. Medicine and pharmacology see any competing discipline who espouses an opposing viewpoint as an unwelcome trespass that is swiftly marginalized. The medical establishment often does whatever it can to discourage the presence of trespassers and ensures they have only a minimal say because of cherished group narcissism, political loyalties, competition, and perceived dangers to its level of influence and power over popular culture.

In my many years of practice as a clinical psychologist and psychoanalyst, working in both the public and private sectors, I have observed with increasing dismay the egregious inadequacy of mental health service delivery in Canada. As a general rule, most of my patients who seek me out for therapy have already been put on psychotropics, many of them several different types, and they are not happy with the results. Even those who are functional on medication still feel it is inadequate because they are not entirely free from their suffering, something a pill cannot take away. They will often concede that drugs merely mask the real issues or numb a person from dwelling on inner anguish they would rather avoid and not think about—not to mention they produce troubling side effects that in some cases are detrimental to physical health. Based upon my direct professional observations working in public healthcare environments as well as the prima facie testaments of my patients, I offer the following reflections.

Legitimate arguments can be made that organized psychiatry and psychopharmacology are more expensive than psychological treatment modalities, are unethical when they are systematically abused by the establishment, show inferior treatment efficacy, have poorer long-term outcomes, and politically subjugate the role of psychology and psychotherapy paradigms though they prove to be at least equally but often more useful and ameliorative. Organized medicine opposes alternative healthcare providers from joining national and provincial medicare programs due to direct threat and economic self-interest, and perpetuates the mythology of fast and expeditious cures, which collectively deceives, indoctrinates, and gives false hope to an uneducated Canadian public who are vulnerable, helpless, and wishful for brief and immediate treatment interventions that produce rapid results. Canada needs a wake-up call.

Mental healthcare in Canada today is alarmingly inadequate. Statistics on prevalence rates of mental illness are astoundingly high and little is being done except medicating the masses who moan for instant relief. There is a paucity of government funded outpatient, community, and rural mental health facilities that provide direct clinical consultation, assessment, and individual therapy to adults, children, adolescents, and their families; psychology is being utilized less and less in hospital environments. The second main reason for all visits to family physicians are for depression, and 33% of all hospitalizations in Canada are due to mental illness as either a primary or secondary diagnosis (Mood Disorders Society of Canada, 2006). The cost of keeping someone with serious mental illness in the hospital is estimated to be $170, 820 per year. Furthermore, 37% of mental health patients are readmitted to the hospital within one year of their discharge (Canadian Institute for Health Information, 2006).

The medical profession and pharmaceutical industry heavily influence governmental policy, public opinion, and healthcare decision making instituted by these politically and economically powerful groups who are largely responsible for fostering the illusion of the quick fix. And the public buys it. There are many reasons for this phenomenon including the voice of medical consensus, public ignorance, financial limitations, media misinformation, and mass fear, anxiety, and avoidance of truly facing the cause of one’s suffering. This defensiveness perpetuates the unconscious fantasy that psychological problems and personal woes will mystically vanish if we deceive ourselves long enough. The truth is, they don’t, and they won’t simply go away. Although psychopharmacology is of immense benefit for chronic forms of mental illness such as schizophrenia, bipolar disorder, and severe depression, medications are being routinely and unjustly over-prescribed for the slightest degree of emotional discomfort or ordinary unhappiness. Prescription abuse is rampant among general practitioners and psychiatrists who choose to see no other avenue to mental health service delivery than the pill. Perhaps there is some symptom relief for some patients, which is of practical value, but a pill doesn’t solve the problems let alone address the reasons why one suffers to begin with. The big scam is getting people to believe that all mental experience—one’s thoughts, feelings, attitudes, perceptions, and desires—boils down to a chemical in the brain. And the corporate drug peddlers, insurance bean-counters, and majority of doctors exploit this belief by gratifying the hopes and vulnerabilities of an uneducated public who rely on the dictums of medical science to deliver them from psychic pain.

The first line of defense against mental illness in this country is pharmacology. We are medicating our children for displaying the slightest degree of overstimulation, inattention, failure to listen, follow directions, or mind their parents—all passed off as ADHD. We label adolescents as oppositionally defiant and conduct disordered when they act out their anger or challenge adult authority, and dis-
pense mood stabilizers when they express intense emotions that threaten their parents’ or school personnel’s control over them. And we prescribe adults anti-depressants, anti-anxiety agents, sleeping pills, pain killers, and muscle relaxants the minute they complain to their family doctor of normal stress, adjustment difficulty, loss, or emotional anguish rather than encouraging them to seek professional therapy and work through their struggles verbally. The over-prescription of medication is part of a false social consciousness seduced by the fallacy of the quick fix institutionalized by our healthcare system. As the first course of action, most citizens are conditioned to talk to their family doctor who has no training in psychiatry or psychology, yet who often acts as an expert in the behavioral and social sciences, experiments with medication, oversteps professional competence by pretending to know how to intervene with emotional conflict, or simply gives pep talks and offers false reassurances rather than referring patients to professionals who are appropriately trained in psychotherapy. And when therapy is encouraged, it is often only after patients become extremely distressed or are in crisis.

A small minority of physicians actually practice psychotherapy and bill the medicare system for this service. To make matters worse, there are no formal requirements or proof of adequate training in order to bill for this service, and it is the case that doctors, such as family practitioners on the front lines of primary care, conduct so-called therapy or counseling who have conceivably never cracked the cover of a technique book let alone took appropriate graduate-level courses or received ongoing clinical supervision and training. It is simply obscene that medicine is able to misrepresent its area of competency to government officials and policy makers who dole out budgetary approval and pay for psychological services for those not trained to deliver, and that there is no accountability for requiring formal training. As a result, therapeutic incompetence runs rampant with no adequate watchtower or enforceable consequences. Moreover, doctors have the right to terminate their involvement with any patient at anytime the patient does not follow the doctor’s professional advice. Not only is this an unrestricted monopoly, it is also a palpable abuse of power. For example, I had one patient who was terminated by his lifelong family doctor because he no longer wanted to continue his anti-depressant medication because he believed his therapy with me was more effective. Because there is a shortage of family physicians, whereby many citizens go without personalized healthcare, patients may feel that they have no other choice than to follow their doctor’s orders or be left out in the cold.

Psychiatrists can be just as bad because the large majority of psychiatrists in Canada become pimps for the pharmaceutical industry that give them financial incentives, perks, and free gifts to peddle the latest experimental drug on the market that promises better efficacy and fewer side effects than previous ones. The medicare system only encourages doctors to see people as quickly as possible out of fiscal restrictions and demand. These doctors consequently focus on symptoms rather than on the true causes of their conflict, attach a psychiatric label with the word “disorder” behind it, and give them a prescription to hand to a pharmacist. Most psychiatrists in Canada do not perform therapy nor are they properly trained to do so, yet they pretend to be. In most cases they only assess, diagnose, and dispense drugs. People are herded in and out like cattle. Patients are lucky to get a 30-minute interview during an initial consultation, and may be put on a 3-month waiting list for a follow-up appointment. There is often no real human connection made or continuity in seeing a psychiatrist—no real relationship formed; the patient is viewed as an object that is broken and needs to be fixed. Patients are no longer
seen as experiential beings who are mired in conflict and emotional turmoil and who crave human comfort, as the Latin term *patiens*, derived from the Greek word *pathos* signifies, namely, those who suffer. Instead the suffering becomes clinically objectified as biological anomalies whereby people become things to be rebuilt rather than human subjects with their own unique intrapsychic organizations and interpersonal struggles. Through this impersonal mode of treatment, people don’t feel felt—they don’t truly feel understood or validated, yet they are reassured by their doctor that a pill will help.

Contemporaneously, the field of psychology and the competing modes of psychotherapy and counseling services being promulgated can be equally limiting. Psychologists are trained by academics who by and large do not practice clinically. They are researchers who care more about publishing and establishing a research reputation. There are no PsyD training models in Canada that mirror the solid practitioner-based training that structures the curriculum of most professional schools in the United States which place a high premium on clinical training, service delivery, field experience, and supervision. And there are absolutely no clinical psychology departments in Canada that train students in psychoanalytic practice. As a result, psychology graduate students are often not even exposed to psychoanalytic or psychodynamic principles, which tend to be viewed as antiquated and unscientific. Instead, trainees and are mainly taught a circumscribed view of clinical practice. As in the United States, psychoanalytic psychology is immersed in the “evidence based” turf wars that divide and polarize psychology, and what seems to be “empirically supported” and advocated for these days are recipe, cookie-cutter, manualized treatment approaches that range from six to twelve sessions in length.

Contemporary academic psychologists are so over-identified with providing a scientifically based model of practice, that they have become pawns of organized healthcare that thrive on the quick fix philosophy. They either prostitute themselves out by offering brief treatments because most insurance policies offer little coverage, misrepresent themselves, as Eisold (2007) also confesses, mainly to appease the political pressures to conform to the medical and short-term treatment regimes dictated by insurance policies; stand idly by and let psychiatry role over them passively without protest; or adopt the current fad of practice based on what academics who do not practice tell them what they should be doing. For the most part, Canadian academics know very little about what really goes on in the consulting room because they conduct manufactured research studies far removed from clinical reality rather than provide direct service delivery. This is such an endemic problem in the clinical training of psychologists that it is no wonder so many people find psychology to be an inflated form of common sense with little value.

There is an anti-therapy culture in Canada. This is not because Canadians are unwilling to profit from what therapy has to offer, but rather it is due to a lack of knowledge, discouragement from medicine, economic prohibition, entitlement to free healthcare, social stigma, and the limited impression psychology makes on the Canadian public. What is rather ironic is that while it is okay to take medication for a psychiatric condition that is labeled a “mental disorder” by a doctor, it is not deemed helpful by the same doctor to talk with a specialist about it. Why is this so? Perhaps it is because medicine is not so impressed with what psychology has to offer. Psychology in Canada is an academic and research enterprise with a fine reputation, yet it lacks adequate professional preparation for those who will embark on direct clinical and counseling work. Consequently, psychologists are largely ill-trained to practice because they are trained by academics who teach but do not do, hence they lack practical skills in psychotherapy, largely offer brief treatment models that cater to the quick fix mentality or the recent research fad rather than what truly works in the consulting room, and are biased against competing psychological paradigms that do not conform to vogue empirical and political pressures. What I have in mind are the evidence based treatment wars that have transpired within the discipline of psychology whereby one politically dominant research group attempts to discredit the theory and methods of others because they do not engage in the same form of research or practice. This has amounted to ridiculous splitting on the part of psychology in order to find a leverage to legitimate its practice to medicine, the drug companies, and insurance providers who are not likely to deviate from what medical authorities tell them. Because the acceptable mainstream treatment modality is medication maintenance, evidence based approaches have jumped on the medical model bandwagon and have adopted a sterile, manualized step-by-step approach to therapy that is often time-limited in duration, stilted, regimented, and focuses on very select short-term goals that often gloss over the real problems and their etiology. As a result, therapy has disgracefully devolved into telling people what to think and how to behave. Insurance companies love this because they promise a quick fix. In reality, however, the patient gets a little better but there is very little long-term change. They simply come back into mental health treatment at a later date once the bandage falls off and the cycle starts all over again. The buck gets passed and passed with no permanent solution in sight. Here psychiatry and mainstream academic psychology are equally limited.

In a large majority of cases, quick fix approaches are theoretically naive, methodologically superficial, lack
treatment efficacy, defy logical coherency, fail to account for the overdetermined complexity that informs mental health and illness, lack holistic approaches to wellness, and are embarrassingly shallow. Moreover, they’re unethical. By perpetuating the quick fix mentality to a public hungry for symptom relief, we keep them ignorant, collude with their denial and avoidance of dealing with the real problems honestly and directly, and rob them of having exposure to legitimate and viable alternative approaches to mental healthcare that our Medicare system does not practice nor endorse. Instead, the medical model of treatment is firmly wed to preserving the status quo by sustaining fruitless solutions that are palpably ineffectual, futile, and cosmetic band-aid tactics that do no more than suture up an infected wound.

People deep down desire not to know anything about what truly afflicts them or what torments them, and they will spend their whole life running away from facing inner demons if they can. Psychoanalysts have always known this, but they are often discredited by mental health providers because they puncture our illusions and take away our security blankets that jeopardize the wishful hopes and fantasies that are part of people’s unconscious defenses. And no one is immune. Professionals such as doctors and psychologists equally find their own introspection and self-examination just as painful to bear as the masses; so they deceive themselves into thinking that they can heal others through simplistically naive treatment strategies.

They too are human, and opt for the fantasy that there are easier solutions to the afflictions that life bestows. Here enters the pill.

The quick fix mentality is promulgated by the healthcare industry and reinforced by the conditioned illusions that govern popular culture based on ignorance and the desire not to know. Pharmacies and psychologists also promote this line of treatment for emotional problems, and there are big bucks in this deliberately calculated and sustained commoditization of healthcare. An insidiously obscene form of dependency on the medical profession for the verity and pursuit of psychological normalcy is a dangerous practice based on the mythology of the doctor as omnipotent healer. I am not denying the fact that medications help. They most certainly do in many cases of severe mental illness.

I am opposed to the following: the narcissistic arrogance of medical authoritarianism; the ostensive passivity and unquestioning attitude of the masses who are slaves to social conditioning; the institutionalization of rote prescription writing; the brazen conceit of claims to objective certainty based on dogmatic adherence to a scientific epistemology when science is neither certain nor purely objective; the intellectual lassitude of not considering other avenues of healing; and the lazy unreflectiveness borne from a biased, myopic, and uncritical way of thinking that pharmacology should be the first line of action against mental discomfort—when this is in fact the very thing that keeps people
on prescription medication for psychological comfort is not ameliorating the underlying discomfort, it is only masking it. And doctors know but ignore this fact because they are overburdened by the healthcare system. They simply want patients to go away. The pill expedites this process. The pill has become the concrete symbolic surrogate for all the inner laborious work and unavoidable suffering that comes with overcoming painful life tribulations inevitably encountered in the process of psychic healing that most people are not willing nor brave enough to face head on.

But when it comes right down to it, the main endemic issue fueling the crisis in Canadian mental healthcare is the dominance of organized medicine that is not likely to change its practices nor relinquish its governance. And when the public does nothing to challenge the supremacy of medical authority, they merely become sheep in the meadow herded toward a pill factory. Canadian medicine oppresses many viable approaches to mental health treatment that are indisputably recognized and justified in other countries but are omitted from society’s repertoire and medicare dollars. There is very limited attention to the role psychology can play in childhood, adolescent, and family prevention, education, health and behavioral medicine, rehabilitation, forensics, and outpatient services that are not available to the public under the medicare system. The doctors and drug companies are taking all the resource dollars away from community outpatient and rural mental health programs when they are potentially more effective in keeping people functional, adaptive, adjusted, and employed.

Canadians are disturbingly underserved when it comes to receiving quality mental healthcare services, but they do not have the resources nor do they know where to turn to for help. Medical authorities, pharmaceutical manufacturers, and insurance companies offer no viable alternatives except for quick fix solutions and band-aid style remedies. The media, which relies on the expertise of medical professionals, only perpetuates public ignorance about what is the best standard of mental health treatment available. Because there is such an entrenched medical model bias that saturates the whole mental healthcare system, little is being done to investigate the long-term efficacy rates of psychopharmacology let alone contest its monopoly. And all the public policy makers do is back medicine with little discretion when medication is needed.

Canadian citizens have the right to adequate mental healthcare and need advocates who are willing to challenge the status quo. Medication is not the only answer nor should it be the first line of defense in the majority of cases, but we are led to believe otherwise. The public is misguided because it does not have all the facts. We are duped into believing that drugs are the best way and the cheapest form of treatment for the mentally ill, when they are more expensive and in the majority of cases less ameliorative in the long-run. There is a large cost to mental illness including the economic loss of work time and potential productivity, but more importantly, the loss of quality of life. If the pill only masks but does not cure, then is it worth fooling ourselves any longer, even if it offers us some hope? As Freud (1913) reminds us, nothing in life is more costly than illness or stupidity. Because statistics tell us the proportion of disabilities that are due to mental illness has increased exponentially and dramatically in the last two decades, current mainstream approaches are obviously not working.

What are possible solutions? Although an adequate response to this question cannot be fully addressed in his brief report, the following reflections may be considered:

- Demystify medicine.
- Expose the pharmaceutical companies for spreading false hopes through the newspeak of medication.
- Ban propaganda that brainwashes the public to desire pills over facing their problems honestly.
- Educate the public on the value of talk therapy.
- Establish more medicare funded outpatient, community, and rural mental health centers that are nonmedically oriented and governed.
- Emphasize early prevention and intervention including child, youth, and family education.
- Tighten regulation of mental health service delivery.
- Expand the option for regulated health professionals such as psychologists to participate in the national medicare system.
- Grant prescriptive privileges to psychologists for those who are adequately trained and can exercise more discretion when medication is needed.
- Penalize and remove opportunities for boundary violations of claims to legitimate practice.
- Ban therapy offered by nontrained medical practitioners who bleed the medicare system and abuse public trust.
- Provide better holistic education and training to physicians, psychologists, social workers, nurses, and therapists of all kinds.
- Ensure better clinical training for psychiatry and psychology in all graduate and postgraduate institutions.
- Mandate universities and training centers to hire and tenure faculty who actually practice rather than have those who teach but do not do.

These are but a few of the solutions on my wish list that we may entertain in order to lift the plight of mental healthcare in this country.

But what would be a more forceful approach is for
the Canadian Psychological Association to consider and press into service proposed changes and demand that the government allow psychologists to join the national medicare system. Psychologists should be allowed the choice to become service providers under each provincial health insurance plan. This would shift the healthcare monopoly and provide the Canadian public more options in their mental healthcare treatment needs. The CPA, perhaps in unison with the College of Psychologists of each province and territory, could follow the precedence set by the American Psychological Association’s lawsuit against the American Psychoanalytic Association for discrimination against and refusal to train nonmedical mental health professionals in psychoanalysis by not admitting them to their training institutes. The CPA could make a viable case for the necessity of making psychological treatment regimes available to the public under the national medicare system that are delivered by registered psychologists and not by untrained medical practitioners. A lawsuit against the government may be the most effective route that would introduce national attention and debate and perhaps a sea-change in mental healthcare service delivery. This would also ensure that psychoanalytic psychologists will not have to continue to be discriminated against by the medical profession, allied mental health professionals, the insurance industry, and its own kind.

A final caveat for Americans—given that social realities, public need, and political opinion influence political and economic trends, if the United States shifts toward a socialized public healthcare system similar to Canada, psychotherapy should be highly advocating for joining the medicare system. This would be one way to augment its freedom, ensure to retain its right to make its own self-governing decisions, and have its own autonomy over how it wishes to structure its professional practices as a discipline.

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Jon Mills
psychologist@sympatico.ca

The Chicago Center for Psychoanalysis, a postgraduate training program leading to a Certificate in Psychoanalysis, welcomes applicants who have state licenses in a mental health field (e.g., PhD, PsyD, MD, LCSW, LCPC). Besides state licensure, requirements include malpractice insurance, post-license experience practicing psychoanalytic psychotherapy, and two years of either personal psychoanalytic psychotherapy or one year of a personal analysis. Once accepted, candidates who have not begun a personal analysis must do so before taking their first class.

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My purpose in this article is to make a rather counter-intuitive case: that as psychoanalysts, we have a special and unique opportunity, maybe even a responsibility, to influence, of all things, cutting edge health care policy. I believe that psychoanalytic outreach to the broader community is absolutely vital to our future, and perhaps even essential to the salvation of a society gone amuck with impulsivity, superficiality, and lack of insight and judgment. There are innumerable possibilities for psychoanalytic outreach—from the arts to education to corporations.

In this article, however, I’m going to describe just one arena for psychoanalytic outreach—one you may not be familiar with and may not expect. In the very weird, Byzantine modern health care environment, psychoanalysis can be used as “the canary in the coal mine”—that biological early warning system that sensed the build up of poison gases deep in the coal mines of 100 years ago, alerting the endangered miners they needed to drop everything and run. Why do we function as an early warning system? Because our core values, which create the absolute requirements of the work we do, the work we know to be so helpful to patients, are at serious odds with the trends in health care policy that will affect us all, as clinicians and patients, whether we like it or not. There are three core psychoanalytic values that I want to track as we confront some frightening trends in health care policy:

1. Privacy—we know that the privacy of communications between therapist and patient must be absolutely reliable for patients to dare to tell us the truth about themselves and their world. As a corollary to privacy, the therapy has to be protected from outside interference.

2. Individuality (individualization of treatment)—we know that psychoanalytic work is absolutely individualized. That is its strength. The uniqueness of the patient and the clinician gel in some ineffable way to make change possible.

3. Centrality of the relationship—we know better than any other group with a clinical task that the relationship between patient and therapist or analyst is central to the treatment. It is also central to treatment success in just about all other clinical encounters, but we know about it.

Alarmingly, the trends in health care policy are aimed to vastly diminish or damage exactly these core values: privacy, uniqueness of the treatment plan, and the availability and strength of a healing relationship.

The health care trends I am about to report may be unfamiliar to many of you. But I can assure you they are well on their way to being established in this country, both by government regulation and private insurers, hospitals, and other entities. There is some news here that is quite horrifying. But my intention is to offer some hope about how psychoanalysts, using a model of active political outreach, advocacy and lobbying, and emphasizing the innate values of our profession, may be able to influence these trends.

Before I get to specific health care policy issues, I want to share my nightmare vision of the modern medical-industrial complex. This term seems to have emerged around 1980, sparked by the rise of a new, for profit health care industry. It hasn’t been used that much lately, but I find it extremely apt as I struggle to understand this brave new world.

In the old days, in which we still imagine ourselves to be most of the time, there was a clinician (physician, psychologist, physical therapist, etc.) or a facility (hospital, nursing home) and a patient, and often some sort of third party payer or insurance company to foot some of the bill. Now there are a multitude of business types and organizations taking a big bite of the $2 trillion dollars spent annually on “health care” in the United States. They also control a large part of the experience of the clinician and patient. These entities range from data brokers that buy and sell health care information (such as exactly how many of exactly which drugs I prescribe each week), to outsourced reviewers, hospital conglomerates, lobbying groups, pharmaceutical companies, trade associations (one example: The Software and Technology Vendors Association, or SATVA, which particularly serves behavioral health systems) innumerable government agencies and countless other categories of business, both nonprofit and for profit.

The new medical industrial complex has its own way of thinking and speaking. Here is a sentence I took from a government Web site on privacy and Health information technology:

A critical portion of the required NHIN [National Health Information Network] prototype deliverables is the development of security models that directly address systems architecture needs.
for securing and maintaining the confidentiality of health data.\textsuperscript{2}

What strikes me in the language of this quote, which is quite typical of the vast majority of similar Web sites and documents, is the note of dehumanized sterility. There is no mention of the patient or clinician, their relationship, or their needs for privacy.

Here’s another quote I could not resist including. After a reasonable beginning, to wit, “Mental health information is potentially stigmatizing and requires rigorous protection to protect patient privacy and give patients the confidence to share extremely personal information,” American Psychiatric Association spokesman on “informatics,” Robert Plovnick, immediately continues,

As for any discipline that addresses sensitive healthcare issues, a critical requirement for certified psychiatry EHR software would be access rules that are granular to the data element level. Certification would encourage standards development to ensure that software includes this critical functionality.

What, as analysts, do we think about this kind of language and communication?

These official comments were submitted by the American Psychiatric Association to a group called the Certification Commission for Healthcare Information Technology (CCHIT) which is looking into whether there are special requirements for electronic medical records in the mental health field.\textsuperscript{3}

Now, turning to three specific policy issues. They are:

1. Electronic Medical Records
2. Pay for Performance
3. Evidence Based Medicine

\textbf{Electronic Medical Records}

The federal government, hospital systems, academic medicine, professional associations and many other parts of the medical industrial complex are pushing for the establishment of a universal and “interoperable” electronic medical record. The key word is “interoperable”—that is, your records are meant to be accessible at every health care facility and to every health care entity at every level. Ideally, according to powerful proponents of Health IT, this system would not have an “opt out” feature. That is, even if you didn’t want your medical or mental health information included, you wouldn’t have an opt out choice. Those advocating for the system also wanted to override state privacy protections where they are more restrictive. Participation in the electronic records could easily be linked to payment for practitioners. The value of the data that would be thus obtained is allegedly inestimable—both for good, and for profit. The constantly reiterated justification is that this system would improve quality of care and help control costs. But this is what happened when Jim Pyles, the American Psychoanalytic Association’s lobbyist, and I went to testify before the Department of Health and Human Service’s National Committee on Vital and Health Statistics Subcommittee on Privacy and Confidentiality in 2005. We asked the subcommittee looking at privacy implications in a study on implementation of the plan what the evidence is to support these claims of cost control and quality improvement. We discovered—at the same moment they did—there are not any convincing studies. That is, there is no hard empirical evidence for project costs savings and quality improvement.\textsuperscript{4} The implementation cost for the national electronic health records is billions, maybe tens of billions of dollars.

We have positive knowledge that there is no way whatsoever to guarantee the privacy and security of such a system. Privacy breeches at the Veterans Administration stunned the country last year. At Johns Hopkins in January, personal data on 135K employees and patients was lost when a contractor didn’t return backup computer tapes and countless companies such as TJ Maxx have had similar massive data leaks. Also in January, 2007, a CD containing health data going back to 2003, covering 75,000 individuals insured by Wellpoint, was accidentally shipped to a private residence. It was found in a box of audio equipment two months later. Most astonishingly, this CD, shipped by UPS from a subcontractor of a subcontractor of Wellpoint, had been purposefully stripped of privacy protections such as passwords and encryption.\textsuperscript{5}

As discouraging as these stories are, and as fast as the electronic health record train is rolling, we have been able to make a difference. My organization, the American Psychoanalytic Association (APsaA) has had a vigorous and effective lobbying effort regarding patient privacy. Working with our allies, taking an analytic focus that says

\textsuperscript{2} Go to www.hhs.gov/healthit/privacy/
\textsuperscript{3} Official comments submitted by Robert Plovnick, MD MS, Informatics and Performance Measure Specialist, representing the American Psychiatric Association, to the CCHIT inquiry into “Expansion of CCHIT Certification to Specialties—Environmental Scan Data Report and Draft Expansion Roadmap. (answer A.3.1)


that privacy can never be balanced against expediency, and with the change in control of the Congress last year, we’ve had an impact. There is considerable hope that the final information technology legislation that Congress passes will include reasonable privacy protections, as opposed to none. APsaA has developed a set of 6 privacy principles which we use in our lobbying on Capitol Hill. These can be accessed on our Web site.$^6$

We have determined that the single most critical priority is to preserve the patient’s trust that his or her health information will be used only as authorized. We know this: if the right to privacy is not protected the information will simply not exist. Patients will avoid health care, and they won’t tell the truth.

**Pay for Performance**

The Electronic Medical Record is a key precursor to the next scheme, Pay for Performance. As far as I know this applies mainly to physicians, at least for now. Pay for Performance is the wicked spawn of a broader health policy trend called clinical practice guidelines, which detail “standards of care” for particular symptoms or disorders. Government and other payers and entities have developed a variety of practice parameters that are or will be tied to reimbursement incentives for physicians. One list I saw had about 115 measures, and included specific directives about patient care—such things as a yearly pap smear, certain parameters for monitoring appropriate blood tests for diabetics at particular intervals, etcetera. The only mental health related parameter on that list was that every patient presenting with depression (major?) be placed (immediately) on an antidepressant.

At first glance, Pay for Performance schemes have some appeal to physicians, not just health care technocrats. They’re seen as ensuring a minimal quality of care and allowing doctors to monitor their own performance vis-à-vis accepted practice standards. The idea is that the doctor who follows the standards (and employs electronic records to allow her work to be tracked) gets paid more by the third party payer.

Here are just some of the problems with Pay for Performance:

- Care is standardized and routinized, not individualized.
- Minority and poor communities are often less compliant with treatment, and therefore doctors working with this population will be penalized.
- It is often patient compliance that is being measured rather than physician skill or thinking. The patient has to meet the compliance parameter—come for a follow up appointment, get a test, etcetera.
- There is something deeply disturbing about a third party providing financial incentives for a doctor to make specific, cookbook driven medical decisions. This seems to me to introduce an outside corrupting factor into the clinical relationship, which could have tremendous unforeseen consequences. The whole nature of the doctor-patient relationship is changed. This dire alternation of the clinical relationship isn’t new—it began over two decades ago when managed care company’s profits rather than clinical need determined the amount and type of treatment a patient received. Recall the Orwellian term “medical necessity” which was used as a befuddling euphemism for “what we’re willing to pay for.”

A study reported in the *Journal of the American Medical Association* in 2005 reported that despite $2 billion in expenditures by the Center for Medicare and Medicaid Services to promote use of performance guidelines, there was no correlation between quality improvement and programs or expenditures.$^7$

**Evidence Based Medicine**

The third and final health care trend I want to discuss is Evidence Based Medicine. In mental health fields this is sometimes called “evidence based therapy” and the principle is the same. This grand idea is a decade or so old, and a growing force. The idea is that practitioners should only be “doing things” for which there is “evidence.”

Evidence is almost always construed to mean *randomized controlled studies*. Obviously this creates a huge problem for any treatment that relies on an understanding of the individual for the development of a unique treatment plan. Psychotherapy, psychoanalysis, pain management, and acupuncture are obviously problems in this kind of system, but we know that every treatment regimen should be individualized, no matter what the disease or type of doctor.

Here are some scary and true stories:

- There was a movement by some members of the Division of Clinical Psychology (Division 12) of the American Psychological Association to press the APA to take the position that if a

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psychologist sees someone who comes with a problem for which there exists an "evidence-based" therapy ("evidence" being defined narrowly as randomized controlled trials) and treats that person with any other approach, the psychologist would be deemed unethical and would be vulnerable to malpractice action. So people coming to analytically oriented practitioners for anxiety disorders, for example, would be able to bring charges that the therapist was not using "best practices." While this movement was successfully halted by the APA, it isn’t dead.

- Last month, a colleague of mine in Wisconsin had a patient in analysis and got a call from a reviewer for the patient’s insurance company, who said that unless the analyst could provide him with a placebo controlled randomized study proving that psychoanalysis worked, coverage would be stopped, which it was.

A number of analysts are trying to respond to this challenge. APsaa has some materials on our Web site about empirical evidence for psychoanalytic treatment efficacy and construct validity. A recent landmark study by Milrod et al., published in the American Journal of Psychiatry (February, 2007), demonstrated the effectiveness of psychoanalytically informed manualized treatment of panic disorder in a randomized control study. All these efforts are worthwhile, but in the end our work does not lend itself to these sorts of studies. It’s like trying to play baseball using the football rulebook.

Let me tell you about a now famous challenge to evidence based medicine. This was a paper published in the British Medical Journal in 2003, titled “Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomized controlled trials.” The authors did an extensive search of the literature and found that there were no randomized controlled studies proving that parachutes are a successful intervention in conditions of gravitational challenge. In fact, observational data suggested that parachute use itself has been associated with morbidity and mortality. The authors conclude: “We think that everyone might benefit if the most radical protagonists of evidence based medicine organized and participated in a double blind, randomized, placebo controlled, crossover trial of the parachute.”

Another interesting thing about evidence based medicine: we have discovered that there is no empirical evidence that it improves cost or quality of care. As you recall, evidence that the electronic medical record will improve quality and control costs is also missing.

These three trends are tied tightly together. Pay for performance is dependent on standards derived from evidence based medicine. Evidence based medicine and pay for performance cannot be implemented without electronic medical records. The enormous cost of establishing electronic medical records cannot be justified without inventing uses for the data (thus EBM and P4P). Although the linkages seem obvious, I have been unable to find any paper (either scholarly, journalistic, or policy) that links the three. To me, this suggests there is a serious deficit in the systemic thinking within modern healthcare policy or a hidden agenda.

Let me close with a call to action and a message of hope. As analysts, we understand more about the healing relationship, the absolute necessity of privacy, and the uniqueness of each patient and his or her treatment than any other group involved in health care. We can speak up on these issues as analysts in the press (write letters to the editor!). We can get involved in our associations’ lobbying efforts. We can educate congressmen and senators as well as state legislators about these issues. We should support the campaigns of politicians who are in the forefront of fighting for the privacy and other patient rights.

Our strongest allies on Capitol Hill are, on the House side: Ed Markey, Massachusetts; Lois Capps, California; Frank Pallone, New Jersey; Pete Stark, California; Lloyd Doggett, Texas; John Dingell, Michigan; Patrick Kennedy, Rhode Island; and Ron Paul, Texas (the only Republican on the list). On the Senate side, our strongest allies have been Patrick Leahy, Vermont; Ted Kennedy, Massachusetts; and Debbie Stabenow, Michigan, a social worker. Hillary Clinton had sponsored a Health IT bill not favorable to patient privacy but since seems to be coming around.

There are two other fine groups I can recommend that would welcome your involvement. One is Patient Privacy Rights (www.patientprivacyrights.org), an activist group campaigning for patient privacy via media, courts, and legislatures. The second is the Citizens’ Council on Health Care (www.cchonline.org), a patient/consumer advocacy group with strong privacy focus.

The 2008 political campaigns just gearing up are an important opportunity for us to influence potential candidates and platforms. The best way to talk to politicians about these policies is to cite specific anecdotes about your patients or your practice. Or, point out the consequences of these policies on the politician’s own privacy and mental health care! You can follow APsaa’s political advocacy efforts on our Web site at www.apsa.org.

Prudence Gourguechon
prudygourguechon@gmail.com

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MAKING STRIDES AGAINST TERRORISM IN THE CAUCASUS

NINA CERFOLIO, MD

Filled with anxiety, we prepare to drive across the border from Nazran, Ingushetia to Grozny, the capital of Chechnya. It was August 20, 2005, and we’d already spent five days in the North Caucasus. The region comprises seven ethnic homelands within the Russian Federation; it is a mosaic with more than 50 languages spoken. We need to pass through three Russian army checkpoints. At each stand at least three foreboding Russian guards, dressed with helmets and vests, and armed with Kalichnikovs. The men are huge, as if they had been selected from casting with the goal of intimidation. It works! After scrutinizing us, and our passports, they shrug and wave us through.

Dick Traum, the President of the Achilles Track Club, and I, a medical doctor who once ran a psychiatric emergency room and is currently in private practice, set out with the goal of starting an Achilles Chapter in war-torn Chechnya. No stranger to remote territory, we have members in other locations like Bhutan and Bosnia. Achilles has brought dozens of athletes from remote areas to participate in the NYC marathon and to receive medical care. Achilles is a not-for-profit running club for people with all kinds of disabilities. Membership in Achilles has been a life-changing event for many who have lost a limb, or are blind or battling chronic illness. I was born legally blind in my right eye due to a post-lenticular cataract. While based in Manhattan, our organization is worldwide with members in more than 70 countries.

We begin the ride in two police cars on an old dirt “highway” that leads to Grozny. It had been closed a week earlier because of heavy sniper fire. Our escorts drive at speeds of 70 to 100 miles per hour with 4 to 10 feet between the two police cars. With every click of the speedometer, the tension grows. When possible, they drive in different lanes. The idea is to reduce the chance of snipers and land mines. The trip makes me rethink the wisdom of coming. Here are two New Yorkers, who are not only putting our lives on the line, but those of our hosts, to bust into a war zone and start a program to help disabled and able-bodied people learn to run.

As we leave the third checkpoint, we pass a fortress that housed the Russian army and large tanks crowned with armed soldiers rolled by. The tension was suffocating. Our local escorts—two young, Chechen policemen, scrappy compared to the Russians—greeted us with grim expressions. Americans are prime targets for kidnappers. We didn’t find out until later that simply by escorting us, they were putting their lives at risk.

We hope our visit to Chechnya will transcend cultural barriers and be a step towards peace. Clearly, there is a need as more than 30,000 children are victims of the war or land mines. They experience not only war on a daily basis, but terrorism, kidnappings, and isolation from the rest of the world. The Consolidated Appeals Process (CAP) estimates 90% of the people living in Chechnya will never leave, and more than 2,000 children under the age of three will die each year as a result of inadequate medical care. Despite receiving aid from numerous organizations, such as the humanitarian organization “Voice of the Mountain” through the United Nations, the Red Cross, and the Canadian Embassy, the means to provide these young children with medical care is still lacking.

Block after city block in Grozny is a ravaged wasteland scarred with the detritus of ferocious bombings. The former press house is a collapsed crater of rubble. In some of the few buildings left standing, there are gaping maws, sagging foundation: all are bullet-riddled. The blown out windows reveal women drying clothes on a line. It is in this squalor that an estimated 90,000 to 190,000 Chechens make their home. How fitting that the Russian word for sad, “groozny,” is almost identical to the capital’s name. When the USSR collapsed in 1991, Grozny was an esteemed destination for the enlightened from the North Caucasus. It is hard to imagine a once bustling modern city of education and culture. Now, people walk the streets, prideful of what little they had.

Nothing could have prepared me for entering a war zone. It is too confusing and surreal to make sense of the death and destruction. For instance, tiny red flags wave in the wind celebrating the one-year anniversary of President Kadirov’s death by a Chechen bomb explosion. Even though Kadirov was a Putin appointee, and western human rights groups condemned the election, he was embraced by the Chechens. All the destruction left me feeling confused and dazed.

When we flew from New York to Moscow, we met our host at the Moscow Airport. Hana Demeterova, a Czech humanitarian, is a passionate crusader for the Chechens, functioned as our interpreter. Hana is project coordinator for the International Charity Foundation LIBA. Its main activity is the development of health centers in the North Caucasus outside of Chechnya. This is especially important for the Chechen children living in war who feel abandoned by the community. These centers, called “Schools in the North” through the United Nations, the Red Cross, and the Canadian Embassy, the means to provide these young children with medical care is still lacking.


2 Checiner, Robert. Russia Splitting Headache-A Brief History of Chechnya.
Nature,” provide Chechen children an opportunity to experience a peaceful environment. Here the children receive sorely needed medical and psychological attention.

Our group boarded an old Soviet plane from Moscow and landed at Nalchik, Karbardino-Balkaria where we met our Chechen hosts, Alik Galayev, a deputy minister of Chechnya for “Unusual Situations,” who looked much older than his 49 years, and his brother, Ahmed Galayev, a handsome Chechen businessman. We were driven to Nazran, Ingushetia, the last republic in the foothills of the Caucasus before Chechnya.

En route, we successfully negotiated two roadblocks; local Ingush policemen run the first. After checking our passports, we were told to return because their computer is not working. The translation: we forgot to tip. Our Chechen hosts remained unfazed. After providing the rubles, the computer buzzed to life. They explained that this is customary and equivalent to tolls on roads in the United States. During the second roadblock, while Russian policemen are checking passports, Hana asked me if I was scared. Having developed a thick skin for stress as a child, my automatic response was, “No.” However, while back home in New York, I reflected on the possibility of kidnapping and wondered why I wasn’t more fearful.

Next we waited for permission to enter Nazran, Ingushetia. This city has also become a breeding ground for kidnappers, assassins, and bombers. It was a bizarre juxtaposition, amidst all the desolation, to catch a glimpse of young, stylish Muslim women, wearing westernized A-cut, mid-calf length skirts. They carefully negotiated the unpaved roads wearing high heels, their heads covered in dark monotone scarves, completing their daily errands. In this modern world, where disasters and destruction occur regularly, there are still transglobal standards, like fashion, held firmly in place.

Finally, Dick and I were interviewed by an FSB (Russian intelligence service) agent in Nazran. He spoke fluent English, with a slight accent. He was tall, fair-haired, and perceptive. After a 45-minute interrogation, he wished us good fortune on our mission and indicated that we are perhaps the third and fourth Americans allowed into the area during the past year.

Home base for us during the stay was a general’s house in Nazran, about an hour drive from Grozny. Fortified by 20-foot gates, the home stood out among the bucolic landscape. Jana Galayev, the Chechen businessman’s wife, a quiet, submissive, affable woman, greeted us. Despite language and cultural differences, Jana showered us with incredible generosity, kindness, and tenderness. She cooked and cleaned, but chose not to socialize with us at dinner. I was fortunate to spend time with four Chechen girls, family and friends, between the ages of five and eight. They taught me some Russian by drawing pictures to represent words. In addition, I learned a number of ethnic dances. Their joy and passion was contagious, but I wondered whether these girls would eventually be broken of their independent spirit. Upon our departure, they gave me jewelry and other trinkets.

On the third day, we visited one of the many Chechen refugee camps in Ingushetia. It is estimated that more than half the Chechen population live in refugee camps. It was a blistering afternoon, but the lingering despair was far worse. The foul smell of human waste permeated the air. In a lonely-looking farm field, under electric wires, were old, abandoned, Soviet train cars that were home to more than three thousand Chechens. Past feeling lost and uprooted, these refugees were left behind, discarded and forgotten by the world. There was no sanitation, and predictably a high rate of infection. We were introduced to the chief of the refugee camp. He told us his 13-year-old daughter had a viral infection and was unable to fight it. Gradually she had developed viral congestive heart failure and was trying to obtain medical care. He told us that the refugees complained of chronic headaches, which they believed were caused by being in the proximity of the electric wires.

At another Chechen refuge camp, Dick met Makka, a 15-year-old blind girl. She lost her vision at age nine; she was playing outside her house when a car bomb exploded. She did not know why she was going blind; irrespective of the reason, she had no hope for help. The medical resources to provide treatment were lacking. Upon learning we could offer medical intervention, she was taken by Getagozov Akhmed, the deputy minister of sports of Ingushetia, to a hospital. Her medical assessment revealed that a corneal transplant might restore her vision.

We met four emaciated Chechen boys who were part of a local winning soccer team. One was a 17-year-old Chechen, Alichan Osmanov, who had lost his left leg and hand to a land mine while, ironically, playing soccer. He told us he currently lives with his mother; the Russian army kidnapped his father. In a shy, humble demeanor, he explained his love of computers, but there is no possibility of a career. Despite appearing depressed and underfed, he wanted to play soccer. We brought sneakers and shirts for him and other members of their team.

At our home base, on the fifth day, over vodka, we spent time with Getagozov Akhmed, the Ingush sports commissioner of Nazran. He told us he was one of the many Ingush police and security forces targeted in a devastating overnight assault by Russian military tanks in June 2004. More than 90 men were killed. The sports


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commissioner was lucky; he was only hospitalized for a few months after a bullet collapsed his lung.

That evening, while having dinner, we heard a loud explosion from outside our gate. We later learned it was an assassination attempt on Ingush’s prime minister, Ibragim Malsagov. The two roadside bombs killed his driver and wounded two others. The prime minister was hospitalized with wounds in his hand and leg. The two explosives, placed 10 meters apart, detonated within 10 seconds of each other as the prime minister’s motorcade passed. This was the latest sign of growing violence across the North Caucasus. By coincidence, we had been scheduled to meet the prime minister the next day.

The backbone of Chechnya culture, Adat is an unwritten moral code of behavior in Chechnya. One element of adat is a hospitality that insists on the inviolability of the guest. Adat governs Chechen moral tradition and human relationships. Orthodox Islam has always denounced terrorism. Not surprisingly, all this has suffered in the war. Since the earliest days, Chechens look to adat to distinguish right from wrong. Chechens feel betrayed, forgotten, and broken by the world.

During the years of war, young men calling themselves Wahhabis imported a new code. Wahhabism is a strict form of fundamental Islam. They believe those who do not practice their form of Islam are heathens and enemies. It originated in Saudi Arabia and has been carried to Chechnya with no respect of adat. The danger is that the most impressionable of the Chechen people—the children—will fall prey to Wahhabism and violence. They love their Chechen heritage, but without intervention, these children are vulnerable to becoming future terrorists.

By changing the environment of violence, humiliation and lack of opportunity, it is possible to begin to change the present trends of terrorism. Toward this goal, we could only take one small step. We organized a 5 kilometer race from Nazran to Magas, Ingushetia. It took place two weeks after we left. More than 200 Chechens, including invalid children and refugees, would run for Hope and Possibility on September 11, 2005. The race conducted annually in New York, is named in honor of the Achilles Board Chair, Trisha Meili, who was attacked, brutally raped, and left for dead in New York Central Park in 1987. Her book is titled, I Am the Central Park Jogger: A Story of Hope and Possibility. This race marked the first event for Achilles in the North Caucasus and the first time a Muslim Republic banded together to run in defiance of terrorism.

It was a privilege to have glimpsed life in Chechnya. In psychiatry, we often use countertransference as a way of further understanding our patients. Countertransference refers to the mood and feelings our patient induces in ourselves. One way of learning about yourself and a culture is by looking inside. The feelings I went through were similar to those expressed by the Chechens. The horrific experience of being in a war zone accounted for my lingering feelings of anger and confusion. Chechens feel deeply hurt, misunderstood, and abandoned by the world. It was even more frustrating to learn that federal authorities were eager to link their fight against militants in the North Caucasus with the international struggle against terror. In my experience, most of the Chechens we met denounced terrorism. Russian Government critics say a flawed Kremlin ethnic policy and corruption among regional leaders are major causes of violence.

It is my belief that we as human beings have shared destinies. Where we go is inter-linked with what others do. If we live in blissful ignorance, we allow Chechens to become more hopeless and vulnerable to the preaching of terrorism. By engaging with the Chechens, we begin to develop a common understanding. We are all vulnerable. Reaching out to one another, we begin the process of eliminating hopelessness. Hopelessness and despair breed terrorists. If we want peace, we cannot ignore the disenfranchised. Despite extreme poverty, unemployment and isolation, Chechen’s indomitable spirit will not go away. In order to prevent the next generation of terrorists, we need to find, individually and in groups, the courage and passion to demonstrate they are not alone and that we care.

My experience on this mission taught me how inspiring and exhilarating it is to feel one can rise above unimaginable horror and find a connection to something greater.

Nina Cerfolio
ninacerfi@nyc.rr.com

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ON THE PLEASURE IN PLAY: THE POETRY OF BILLY COLLINS

HENRY M. SEIDEN, PhD, ABPP

Since Freud and through Winnicott and a long list of distinguished others, psychoanalysts have paid serious attention to play—both to children’s play and to its various adult forms like wit and humor and jokes and playfulness in art and in language. But that same attention has often had a reductive quality—and had a way of taking all the fun out of it. To read poetry (the playful use of language in its highest form) is to be reminded: to take play only as a code to be cracked is to miss a vital pleasure. And the question of whether this is a derivative pleasure (derivative of anxiety and/or libidinal urges and/or relational striving and/or whatever) is beside the point. The joy is essential to the meaning.

Here’s a good example of play where the serious can’t be separated from the funny. Billy Collins is a recent Poet Laureate of the United States and much honored and celebrated. He is immensely popular for a poet. By one report, his half dozen or so books have sold over 500,000 copies when most poets are lucky if a book sells 2,000. A serious poet, he was recently named winner of the Poetry Foundation’s first Mark Twain Prize for Humor in Poetry. He is a master of the sweet, gentle, quintessentially playful—but at the same time accurately illuminating and emotionally telling—report on ordinary experience.

When I say “ordinary experience” I mean ordinary upper middle class experience. I suspect that his large popularity—and some of the criticism he gets for being “too easy”—grows out of the fact that Collins’s poetry does not come out of the more typical concerns of contemporary poets. His is not a voice of alienation, of a disenfranchised minority, of rage, despair or anomie, of social or political engagement. (Although, more power to those voices!) Indeed, Collins plumbs, and plays with, the sweet, sad moments of his own (and his likely reader’s) dailyness: a walk by the lake with his dog, a pot of tea on his writing table, the fish and asparagus for dinner, the experience of teaching and of writing, memories of a middle class childhood.

Here’s Collins playing with a familiar emotional situation (one, of course, entirely familiar to psychoanalysts) in a surprising way.

No Time¹

In a rush this weekday morning,
I tap the horn as I speed past the cemetery
where my parents are buried
side by side beneath a slab of smooth granite.

Then, all day, I think of him rising up
to give me that look
of knowing disapproval
while my mother calmly tells him to lie back down.

Collins’ special genius is to make of the outer world an inner one. His poems are reports on moments in the life of the mind—the mind in play with the ordinary reality around it. In No Time, his parents (and ours), although gone and buried, continue to be, now and forever, who they always were. Of course this is absurd. And of course, it’s true. There’s a funny and deeply pleasurable accuracy in the way he captures both the truth and the absurdity.

Interestingly, it’s a serious pleasure: this is much more than silly. A good joke has to hurt a little. Time passes, the poem reminds us, while we’re driving by the cemetery. Even the sweet life passes. Even those of us lucky enough to have a busy and successful life have lost and will lose the people we love—people we love regardless of their failings and foibles and, maybe, because of them. The whole important psychodrama of our lives just slides away, condenses, becomes a little comedy and then not even that.

Death is a base note in Collins’ writing; and often it’s in the treble. But even death can be the mind’s plaything. In a poem called “Writing in the Afterlife” (in Poetry, 2002), Collins imagines himself crossing the mythical Acheron, the ancient Greeks’ river of death—and imagines Charon, the ferryman, as a writing teacher! He writes about how he himself always imagined the afterlife...but how could anyone have guessed

that as soon as we arrived
we would be asked to describe this place
and to include as much detail as possible—

¹“No Time” was published in Poetry magazine in 2000; it is printed with permission of the Poetry Foundation. “Writing in the Afterlife” can be found in its entirety, along with other poems of Billy Collins, on Poetry magazine’s Web site: www.poetrymagazine.org.
not just the water, he insists,
rather the oily, fathomless, rat-happy water, not simply the shackles, but the rusty, iron, ankle-shredding shackles—and that our next assignment would be
to jot down, off the tops of our heads, our thoughts and feelings about being dead, not really an assignment, the man rotating the oar keeps telling us—
think of it more as an exercise, he groans, think of writing as a process, a never-ending, infernal process....

This is the world of a tweed-jacketed English professor who has attended, and taught, a thousand writing classes: how he plays with the received advice! Delicious how he comes to the conclusion that writing is “a never-ending infernal process”! He’s right, about writing of course—and you can picture him in a slow four o’clock class finding his inspiration for this one.

Well how about us? How about psychoanalysis—with its own received advice—as an “interminable” and never-ending infernal process? Who among us, patient or analyst, hasn’t known the interminability and known it ruefully and best during the last late session on a winter Thursday night? Who hasn’t sat (or lay) there thinking: this must be what forever feels like.


Henry Seiden
hmseiden@verizon.net
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Ivan Miller’s new book, Balanced Choice: A Common Sense Cure for the U.S. Health Care Systems, is one of the most hopeful happenings I have seen on the healthcare scene since BMC (before managed care). It is designed to simplify and improve services for consumers, allow professionals to practice and innovate unencumbered by managed care, and dramatically reduce and stabilize employers’ costs for insurance premiums. It is for all healthcare, not just mental health. It does not attempt to patch up our presently broken approaches to paying for healthcare. “Balanced Choice makes health insurance obsolete only by completely replacing it.” (p. 103). When you first read this book, you realize it is truly a breath of fresh air in the stale, dank, dimly lit room that the financing of U.S. healthcare has become. When you read it a second time, you begin to realize how truly creative and ingenious the model really is.

We humans seem to want to understand new concepts in relation to those we already know. Is this a single payer model with government controls? Not really, but somewhat. Is this a market driven model of free enterprise? Yes, but not entirely. Dr. Miller has masterfully melded the best of both models into a new and robust being.

Balanced Choice is a nonprofit, national healthcare financing plan that covers everyone. It is designed first and foremost to deliver quality healthcare services to the public, not to generate profits for an insurance or managed care company. It offers two options to consumers and professionals: the Standard Plan and the Independent Plan. The patient and the professional decide together which plan to use, and the decision can be changed if circumstances change. The Standard Plan operates very much like Medicare with a small co-pay but is more comprehensive. The first two visits each year to a primary care physician or...
an emergency room are free of any co-pay. The Standard Plan pays a set rate for each procedure and pays enough to attract quality professionals. No one is left out because of inability to pay. All are covered. If a patient can’t pay the co-pay, they can apply to Balanced Choice to pay it for them.

The Independent Plan allows professionals to set their own fee schedules with a base amount paid by Balanced Choice and the difference or gap paid by the patient. For example, if the professional’s fee is $115 and Balanced Choice pays $80, the patient would pay the $35 gap. In this way, professionals are encouraged to improve and innovate, and if the public recognizes value they will pay a higher fee. This might include benefits such as special expertise, innovative or advanced treatments, special office hours, or a reputation for experience or excellence. These two Balanced Choice options also apply to pharmaceutical, hospital, and specialty costs.

If these two options were left to operate on their own, it would undoubtedly lead to a two tier healthcare system, one for the wealthy, and another for the poor. Balanced Choice addresses this potential inequity by using a creative concept called the “Mandatory Funding Split” whereby 60% of funds are always available for the Standard Plan (SP) and 40% for the Independent Plan (IP). A Balanced Choice Governing Board is responsible for setting and adjusting reimbursement rates to keep these expenditures in balance. This is not unlike what the Federal Reserve Board does with interest rates to establish parameters and balance in our economy to prevent the detrimental effects of extremes. For example, if more than 40% of Balanced Choice funds are being spent on the Independent Plan because it is being chosen an inordinate amount of the time, the Board would decrease reimbursement rates for that Plan, thereby increasing the gap that patients pay to induce more to use the Standard Plan. Or if more than 60% are being spent on the SP, the Board would increase reimbursements for the IP, thus reducing the gap patients pay and inducing more to select the IP. Keeping the IP vibrant and robust is vital to innovation and improvements in the field through a competitive market. Other interesting management scenarios are described in the book.

This discussion of the financial model leads naturally to the question of how the Balanced Choice plan will be paid for. Dr. Miller describes how since World War II increasing numbers and varieties of healthcare services have been paid for by insurance premiums paid by employers. We have come to expect most of our healthcare to be paid for by insurance. This dynamic along with insurers discovering there were huge profits to be made by for-profit insurance companies, has led to an escalation of the cost of premiums to employers and to individuals. Our colleague, Dr. Kenneth L Salzman of Lansing, MI, has recently observed that insurance has become obsolete as a way to pay for healthcare because

... the insurance model operates on the principle that the risk of relatively rare adverse occurrences within a group can be spread among the many members of the group, reducing the impact of the adverse occurrence on any given member... When, however, the adverse occurrences include routine care, ongoing maintenance, medications and such, the frequency rises to essentially meet the population numbers and there is no way to spread any risk. (personal communication)

Managed care has been introduced to control costs and ensure profits to the insurance company while pretending to improve service delivery. This leaves us with 47 million people uninsured in our country. That is equivalent to 94 cities with the population of Washington, D.C. proper with no health insurance. The inequities are enormous, and some would say criminal, in a country that can afford to provide healthcare coverage for all if it is done right. Part of doing it right is to maximize the funds available for direct patient care and minimize administrative overhead, utilization review, advertising, marketing, sales, pricey real estate, and profit. The author describes how we are already using sufficient funds to provide coverage for all, and when Balanced Choice redirects the $258 billion saved administratively it provides $108 billion to cover the uninsured and $100 billion to reduce employers’ contributions.

Additional funding comes from a variety of sources including current Medicare and Medicaid funds. Employees contributions will not increase and will carry the security of stable healthcare even if they become unemployed or change jobs. Employers’ contributions will be reduced and stabilized, which facilitates their budgeting and planning. Out-of-pocket expenses, co-payments, and gap payments will continue to be part of the funding picture.

Cost containment is accomplished in several other ways in addition to the operation of market forces, the Mandatory Funding Split and gap payments. As Dr. Miller says, “What is needed is better information, not more management” (p. 130). Balanced Choice provides this by establishing a Consumer Health Advocacy Organization patterned somewhat after Consumer Reports magazine to give patients and professionals comparison information about quality, outcomes, and costs to use in their discussions together about the various options available for pharmaceuticals, lab and imaging tests, referrals to specialists, treatment options, and other such decisions. This collaborative process between patient and professional...
emphasizes the importance of personal responsibility for one’s healthcare decisions and one’s investment of their own time and money. A context of personal responsibility and being an active participant in treatment has been shown to have positive implications for maintaining health as well as for promoting healing and recovery. Consumers are enlisted additionally in the cost containment process by being rewarded with a refund if they discover an overcharge in professionals’ billings to Balanced Choice.

Furthermore, cost is contained by reducing administrative overhead in the offices of professionals and in hospitals. Less time, expense, and personnel costs are required than when dealing with multiple insurers, HMOs, and PPOs each with their own procedures, requirements and systems for managing claims to say nothing of the hours and dollars saved in dealing with utilization reviewers. Reducing overhead allows professionals the option of operating the Independent Plan to generate more profit or to reduce the gap payment to appeal to more patients. Moreover, Balanced Choice plans to pay within 10 days, further reducing costs for professionals, instead of holding payment for 30-60 days to generate interest for an insurance company.

Coming out of his 34 years of experience as a healthcare professional and his recent 13 years of intensive work, study and consulting in healthcare finance, Dr. Miller provides a clear and readable chapter on the historical perspective of how we have ended up with our currently broken healthcare system. This knowledge along with his description of the various approaches to healthcare funding—free market, insurance driven, managed care, and single payer systems and their strengths and liabilities—helps empower all of us in our work for change. Now we can add Balanced Choice to the list of models. In addition to setting the stage for understanding Balanced Choice and how truly unique it is, this excellent chapter could stand alone as a brief exposition on the dynamics of healthcare finance and economics. While it won’t make you an expert, it will make you more aware of what you are supporting and less likely to be deceived.

Balanced Choice also offers consumers the benefit of a real choice of professionals, not just those who are on an HMO list. Not having to be on a “panel” not only saves professionals the fees and phony credentialing process some HMOs use, it relieves them of being caught in the inherent conflict of interest between serving the client and serving the insurance company.

Dr. Miller concludes with two strategically placed chapters. One ably addresses the skeptical questions that may occur to you as you read the book and helps to cement the case for Balanced Choice. He also readily acknowledges and lists some of the many important questions yet to be addressed, including the need for mathematical modeling of the system. This is not yet a finished product and requires the work of many hands to make it so, including yours.

The other chapter is a five-phase plan for reforming our health care system; it is a kind of blueprint for implementing this powerful Balanced Choice model. At this point you begin to see that this really can work because it addresses the core interests of three major power groups in the United States: consumers, employers, and professionals. The concerted efforts of all three can overcome the tremendous resistance that is certain to occur by the insurance lobby. And the magnitude of that resistance, by the way, will be further evidence of the power of this plan.

So, I encourage you to review the Web site, www.balancedchoice.org and download the first chapter or read the book, which you can order there or from Amazon. The book is highly readable, clearly written, and non-technical in nature. Virtually any chapter can be read alone and be understood. The only change I would suggest is to replace the term “provider” with “professional.” Managed care efforts over the years referred to us as “providers” which subtly reduces our experience and expertise to that of internet providers and dry cleaners. However, this is a minor issue I would quickly abandon in order to make a gain with the magnitude of implementing Balanced Choice.

Somebody recently asked how he could enroll for this Balanced Choice coverage. I had to tell them they couldn’t yet. There is much work to do and you can help. This is a great opportunity to become a founding member of Balanced Choice and, if you wish, to put your hands and heart to work in this grassroots effort to bring Balanced Choice to life in the United States for yourself, your clients, your loved ones, and the nation.

Keith Cook, Waterville, ME
kmcook@midmaine.com
Even for someone for whom “the symptom is not the whole story” (2006), Renik’s words are true: “symptom relief remains the criterion by which analytic work is validated” (p. 25). We are all “behaviorists” in the sense of taking the patient and the symptoms seriously because ultimately we want the patient to correct the symptoms. But our insistence is that patients will change with understanding and knowledge of their symptoms’ significance and meaning. Even though insight doesn’t cure, it is the prerequisite for cure—not just for symptom removal—because our rational human nature needs reasons to act and change. Without ever losing sight of this principle, Renik invites us to embark on a journey that touches on many psychoanalytic ports, such as being honest with our clients, being open to self-disclosure, keeping the therapy relationship real, acknowledging impasses, and many others. For each of these topics he presents lively and brief clinical vignettes and explains his methods contrasting “traditional” with “practical psychoanalysis.” His language and style are consistently uncomplicated and clear, unlike much psychoanalytic literature, providing another contrast between “traditional” and “practical.”

In presenting the traditional teachings, he often corrects the understanding of what Freud meant and intended but without citing specific texts. Why not mention where in Freud’s writings Renik’s corrections can be validated? (Is this, perhaps, to make the book more accessible to nonprofessionals?) For instance, Renik considers the Oedipus complex not to be a “universal, pivotal phase of normal psychosexual development, relevant to the understanding of every patient” (p. 154), as Freud believed, “but rather . . . a consequence of certain not uncommon family problems that can have an impact upon a child’s experience” (ibid.); however, he does not give us the concrete Freudian source. He laments that psychoanalysis has become impractical—“an esoteric practice that promotes a self-involved escape from real life” (p.1)—and implies that practical psychoanalysis will counteract that misperception.

Renik is exceptional in focusing sharply on practice using simple English to communicate his ideas: “Practical clinical psychoanalysis is a treatment that aims to help the patient feel less distress and more satisfaction in daily life through improved understanding on how his or her mind works” (p. 3, italics mine). The book is packed with sane clinical advice coming from Renick’s long experience as a clinician and as a Training and Supervising Analyst at the San Francisco Psychoanalytic Society. His attitude is similar to Erich Fromm’s, whose last book (1980) was a loving critique with passionate appreciation of the Master, similar in motivation to The Art of Listening (1994) (made up posthumously out of notes from lectures and conferences), in which Fromm explained how to practice psychoanalysis. Other authors share Renik’s efforts to make psychoanalysis practical and relevant. Thus Solomon (2006), explaining Karen Horney’s approach, accommodates psychoanalytic treatment to the restrictions of today’s world. From this perspective Renik joins a respectable group whose pioneer might well be considered Theodor Reik (1948) with his masterful “third ear.”

Among many other topics discussed by Renik, transference is especially interesting to me, having been influenced in Buenos Aires in the 1950s by Racker who also had reservations about the traditional view of transference and who presented his objections in the unique way of considering countertransference an unavoidable manifestation of the therapist’s humanness (Racker, 1953, 1954). In this and other topics, I miss in Renick’s book, besides the lack of references, a comprehensive index that, I hope, will be added to the next issues. Fromm (1994) called transference “about the most significant problem in human life” (p. 118); and, considering the importance
of the therapeutic relationship that always becomes transferential, he objects strongly, among other things, to the use of the couch as distorting the reality of the human encounter (Fromm, 1980, pp. 38-39). Joining the rebels, Renik avoids emphasis on “transference” as such and stresses the “encounter that takes place within ordinary, everyday reality. The reality between analyst and patient is no different from any other interpersonal relationship, except that an unusual degree of candor is called for” (p.64). But he clarifies that “every aspect and every moment of an analyst’s activity is thoroughly saturated by countertransference” (p. 82). A very Rackernian statement, indeed! And he ends his comments on transference with an unequivocal statement: “It is precisely because the treatment relationship is essentially like any other that the patient has an opportunity, by examining his or her participation in the treatment relationship, to learn about his or her participation in interpersonal relationships generally” (p. 64). Renik’s dealing with transference is an example of his refreshing and uncomplicated attitude in the practice of psychotherapy.

The effort to update psychoanalysis, started even in Freud’s time and strong in the last few decades continues to be welcome because it contributes to the conviction among people in general and especially nonpsychoanalyst practitioners to whom I addressed myself (Araoz, 2006) that psychoanalysis is tremendously relevant and useful in our times. In the recent reform tradition where we could include Kohut, Masterson, Kernberg and many others, Renik’s powerful and practical book is an invitation to emphasize the solid truths we have in common and to stop wasting time and energy fighting among ourselves, weakening our position in the process, especially in the perception of nonpsychoanalysts. Our zeal for the analytic truth, Renik seems to say, cannot allow us to hurt our cause, standing like a firing squad in a circle. He believes that “the most rigorous form of psychotherapy,” (p. 83) must be available through practical psychoanalysis so that therapists and patients can benefit from it. And it is more important to irradiate psychoanalytic attitudes and principles centralized in the unconscious and its importance in being human than to attain a uniform model of therapeutic practice. From his thinking it follows that there is a clear distinction between behavior therapy (focusing on the symptom) and psychodynamic therapy (focusing on the individual and the meaning the symptom has for him or her). Renik is a liberator because he expands the view of psychoanalytic praxis, allowing the individual clinician to truly use his or her own self while doing psychotherapy: even not following the “traditional” psychoanalytic model.

Because of this attitude, many may consider Renik dangerous, including orthodox psychoanalysts. But so were Reik, Ferenzi, Fromm, Racker, Horney and many more whom time has vindicated. And the same may be said of others, currently considered heretics by some, like Spotnitz (1985) and Meadow (2003), founders of modern psychoanalysis and of the militant National Association for the Advancement of Psychoanalysis, whom history has not yet evaluated. Renik states, “practical psychoanalysis, with any patient, aims to confer maximum therapeutic benefit as efficiently as possible” (p. 179). From everything that he explains, this must be understood in terms of accommodating to the changes of the times and especially to the patient’s needs, truly and realistically being there for the client with flexible technique and schedules as well as honestly caring for the patient.

References

Daniel Araoz
draraoz@optonline.net

Christine C. Kieffer, PhD

The papers in this small but compelling volume compose a masterwork by European psychoanalyst, Haydee Faimberg, who has been examining and refining her ideas for the last 30 years. While trained in Argentina, Dr. Faimberg moved to Paris in the 1970s, where she is a training and supervising psychoanalyst of the Paris Psychoanalytical Society. While the author is an influential shaper of psychoanalytic thought and practice on the European and South American scene through the International Psychoanalytic Association, she is not yet well known in North America, a state of affairs which will change once American psychoanalysts begin to read this rich and provocative book. It is my feeling that Faimberg’s book is one of few recently published works that truly offers a new perspective on psychopathology and also provides us with new tools for understanding therapeutic action. It is likely that Faimberg’s highly original perspective has been enhanced by her immersion in several psychoanalytic cultures, because she blends theoretical perspectives from Argentina and Europe.

The book may be divided into three sections, the core of which are chapters 1, 3, 5 & 6, in which the author first summarizes how narcissistic links that pass between generations unfold within the analytic encounter, through the engagement of the patient’s private language—including both what the patient says and cannot say. The other part of this core involves an examination of the narcissistic dimension of the Oedipal configuration, with a resulting reinterpretation of the Oedipal myth. The second section (chapters 2, 7 & 8) focuses on a method of “listening to listening,” with an emphasis on nachtraglichkeit or après coup. The third section of the book examines the nature of countertransference responses that are engendered by this kind of approach.

Faimberg begins her book by posing the following question: “How can two people talk about something when one of them (the patient) does not think it concerns him, and the other (the analyst) is in ignorance of it? Complementarily, how can a patient be involved in a history that belongs to someone else?” Thus “the telescoping of generations” entails a particular form of alienated identification with a “secret history” which does not belong to the patient’s generation. The analyst must listen carefully to learn of this history, which may be enacted in the consultation room as much (if not more) through a process of engagement and a mode of discourse as through a disclosure of particular content. That is, the patient, as a child, has been loaded with a negative identification—with all in the parent that has not been accepted within him/herself, as if the parent has said, “You will be my not-me” (p. 10). These alienated identifications have been transmitted through the mechanisms of intrusion and appropriation, that is, the parents cannot love this child without appropriating his identity for themselves and they cannot acknowledge his independence without hating him and “subjecting him to their own history of hatred” (p. 11). Thus the child is utilized by the parent in the service of narcissistic regulation through acts of either appropriation or exclusion. However, since the parents themselves are enacting a mode of narcissistic identifications with which they themselves have been infused, Faimberg maintains that this type of identificatory process requires an understanding of the traumatic history of three generations.

Faimberg maintains that this mode of alienated identification cannot be fully appreciated without understanding it within the context of the Oedipal configuration, which usually does not come to the forefront until a process of narcissistic dis-identification has been undertaken. The narcissistic dimension of the Oedipal configuration is described by Faimberg as coming about when parents unconsciously transmit to their children the mode of narcissistic functioning that they themselves utilized in attempting to resolve their own intrapsychic conflicts. That is, each patient has internalized the way in which his or her parents both did and did not understand...
their sexuality.

The second section of Faimberg’s book is devoted to an exploration of clinical technique in listening to the manifestations of narcissistic resistance in the session, with particular attention paid to the manner in which the ego resistances are put up during the analysis when the ego is faced with the realization of not being the center and the master of its world. The author maintains that the ego “refuses to accept the wound inflicted by the Oedipus conflict” (p. 20). This sort of listening requires a particularly delicate attunement, as the analyst enters into a trial identification with the patient, allowing herself to be inhabited by his relationship with his internal parents, including its enigmatic gaps and silences, which reverberate endlessly though unarticulated. Faimberg’s theater of attunement includes both clinical observation as well as self-observation as she listens to her responses, including her own silences and the gaps in her knowing, also giving articulation to the “unthought knowns” (Bollas, 1989) that emerge from this mode of inquiry. The author cautions us that our own narcissistic resistances as analysts, particularly the notion that we must be omniscient, will restrict our openness to this material, and that this is particularly true for the ego threat posed by emergent material that threatens the cohesiveness and “omniscience” of our favored theory.

Faimberg asserts that an important way in which the child resolves the Oedipal conflict is to create an internal Oedipal configuration in which he relinquishes a sense of agency in return for being loved. Subjectivity is a dangerous position in this configuration because “it is only hate that defines otherness” (p. 21). Thus the intersubjective stasis that has been achieved and that has led to symptoms in the patient has been achieved at the expense of a strong and cohesive sense of self, although it serves the purpose of narcissistic regulation of the internal parents, which has telescoped from the preceding generation of grandparents. Faimberg maintains that the narcissistic modality and the unconscious identifications in which three generations are telescoped may be found in every analysis. Therefore, she believes that she has discovered a universal form of developmental sequence and psychopathology.

Another element in Faimberg’s work that resonates with current movements in American psychoanalysis, particularly Relational and Intersubjective psychoanalysis, is her understanding of therapeutic action. Throughout her book the author maintains that psychoanalysis is not only based on the painstaking work of reconstruction of the past but also construction. Her work, concerned as it is with the temporal aspects of treatment, is much occupied with the anticipatory and the forward movement of transference and its interpretation. Faimberg points out that the idea of “construction” in itself contains a paradox that forms the crux of creative work in psychoanalysis: it is an activity that, by definition both looks back on the past, and at the same time reworks it (note, in particular, her treatment of nachtraglichkeit and après coup in chapters 3 and 7). Certainly, Winnicott (1958) is one of the forerunners of the current focus on construction, with his emphasis on play and creativity in both child development and therapeutic action, and, more recently, Summers (2005) has elaborated upon Winnicott’s concept of the “spontaneous gesture” in developing his own theory of therapeutic action. Among self psychologists, Marian Tolpin (2002) also has focused on the importance of the “forward edge” of development over the “trailing edge,” both in thinking about self development and in examining what is mutative about the analytic encounter. Tolpin privileges the role of anticipation of “new tendrils of growth” in helping the patient to resume development that had been derailed by narcissistic injury, encouraging analysts to emphasize this dimension in making interpretations. So, while Faimberg’s emphasis on construction may not, at first glance, seem novel, her explanation of the role of nachtraglichkeit—and the analyst’s interpretive contribution—demonstrates how the paradox of reconstruction and construction in psychoanalysis can be brought to the forefront of treatment, creating a dialectic tension that may be utilized creatively in the service of freeing the patient from the narcissistic conflicts that transmit trauma across generations.

The author also takes up an important dimension of the Oedipal configuration that is often neglected: the Laius Complex. While the child has an inevitable narcissistic struggle in the working through of Oedipal conflicts, if there is a narcissistic, parricidal father to contend with, in order to appease and win the approval of this father, the child must sacrifice his own subjectivity, including a disavowal of this traumatic loss. (In the case of the opposite sex parent, there may be a narcissistic eroticization that the child also must contend with.) In reading Faimberg’s poignant description of the plight of the child whose development has been impinged upon because of the sacrifice of subjectivity and agency in return for love, and given her references to the individual analyst’s narcissistic resistances to listening to the patient, it evoked for me aspects of current struggles in organizational psychoanalysis, particularly with respect to the training of candidates and succession within psychoanalytic institutes. As the many cogent critics of psychoanalysis as an organizational structure have pointed out—including Emmanuel Berman (2002), Jurgen Reeder (2004) and Otto Kernberg (2006)—psychoanalytic training, more often than not, has required a submission to idols over the encouragement of autonomy and creativity in its candidates and faculty alike. Moreover, the “graying of psychoanalysis” with its resistances to facilitating the
Psychoanalytic Books


Charles J. Most, PsyD

Robert Waska takes us on an intimate journey that is not often so meaningfully shared or struggled with on such a personal level. The journey is to provide effective psychoanalytic treatment to emotionally challenging individuals experiencing borderline, narcissistic, and psychotic states of being. Dr. Waska places particular emphasis upon those cases that would normally be viewed as failures. He challenges our training institutes and us to understand the chaotic and dynamic situations that are established in the analytic setting with these patients and to maintain appropriate treatment. He posits that the unique signature and the cornerstone of all psychoanalytic treatment is the analysis of transference and resistance (acting out) to the analysis of transference. Other factors are certainly the transference-countertransference relationship, the interpretive process and the exploration of phantasies, objection-relational defensive systems, use of the couch and frequency. He places particular attention to those patients who come to us through Employee Assistance Programs: session limited insurance plans and those patients who cannot sustain frequency or traditional psychoanalytic guidelines. This very interesting and thought provoking journey is narrated through the lens of a Kleinian psychoanalyst with particular emphasis on the intrapsychic and interpersonal aspects of the paranoid-schizoid position.

For the Kleinian psychoanalyst, the paranoid-schizoid and depressive positions are developmental levels of experiencing life and are pivotal points of how they organize clinical material as it unfolds within the interpersonal contexts of the analytic experience. The paranoid-schizoid position is the earliest state of experiencing life, when the infant has no ability to conceptualize an internal image of a whole person but instead relates to part objects, such as the breast as opposed to the concept of the whole mothering figure. This position is often thought of as a pre-Oedipal or two person experience. There is no ambivalence within this stage, but rather a representational split into good (gratifying) and bad (frustrating) part objects. The good object is experienced as ideal and omnipotently satisfying and the bad object is experienced as persecutory. One of the aims of the infant is to acquire, possess, and identify with the ideal part objects and to project and keep at bay both the bad part objects and his own destructive impulses. Splitting, projective identification, denial, and idealization are the primary defensive means that the infant uses to cope with annihilation anxieties or utter destruction/death of oneself. The Kleinian lens looks to analyze through the transference-countertransference matrix, unconscious phantasies, and the dynamic internal world made up of self and object representations operating within a matrix of drives, defenses, and internal bargains between self and object or parts of self and parts of objects. Transference and countertransference are present in all analytic relationships from the first phone contact. In the Kleinian analysis, the transference is highlighted, explored and interpreted in terms of anxiety and defense, with particular emphasis on the positional anxieties (paranoid-schizoid/persecutory anxiety, depressive anxiety and feelings of devastation). Interpretative emphasis is on the here and now relationship between analyst-patient, the importance of understanding the content of the anxiety, the understanding of projective identification and of acting in the transference, and the many ways in which the patient experiences dependency, envy, love and hate. The general premise is theory guides us toward an understanding of behavior, moods, interpersonal interactions, and the unconscious. The better one understands the unconscious processes by which an individual organizes himself, the better chance we have of assisting that person and offering the best possible treatment for a specific individual. This book offers a general theoretical framework to allow the reader to understand how the Kleinian lens is focused on the internal and intrapsychic relations, which produce repetitious patterns of interpersonal interactions. Regarding...
difficult patients that Waska describes, their egos are fragmented and lacking in enough good objects. Their egos are often overwhelmed with persecuting bad objects and rely on excessive splitting and projective identification, idealization, and manic reparations that create a vicious cycle. In these patients, persecution is their primary anxiety, which is lived out interpersonally, intrapsychically, and primarily for the analyst, within the relational matrix.

Each patient, through the relational matrix, is understood as an individual with a personal profile, special and unique set of phantasies, anxieties, and defenses that emerge within the transference-countertransference matrix. The cases presented in this book emphasize the fragmented and affectively charged clinical climates that are an outgrowth of specific paranoid-schizoid struggles and phantasies. Waska believes that maintaining the analytic approach offers the best means of helping our patients make significant changes in their lives. Sometimes these clinical “storms” take the form of a brief, chaotic slice of someone’s life as one patient “cried and raged, pleading with me to tell her what to do. I was supportive and let her know I thought she must be very upset and was obviously overwhelmed by all these events. Also, I responded by addressing the transference. In all her stories, she was the victim. It sounded like this might have become the character plot . . . hours before her third session . . . she cancelled . . .” (p. 39).

It is these types of vignettes, Waska asks us to reflect and attempt to understand the persecutory and manic ways these difficult patients experience their relationships with others and us. The strength of this book is to travel with Waska as we explore the interactions he has with his patients who take control of the analytic situation and make them brief and unproductive. For some patients, our curiosity and observations are experienced as persecutions and attacks and oftentimes immobilize parts of our interpretive approach. The many case vignettes provided in intimate detail allow us to observe how underlying object relations and defensive patterns shape and force the treatment process into certain patterns and how even under extraordinarily difficult clinical conditions, a genuine psychoanalytic experience can emerge and provide the patient with something positive.

For effective treatment to emerge, Waska repeats his credo in the analytic focus: being the “degrees of interest and exploration and interpersonal/intrapsychic stance we take in relation to the transference, the defenses, the patient’s unconscious phantasies and the themes within them, the countertransference phenomenon, and the method of psychological repetition that plays out in the patient’s object-relations world (pp. 52-53). Each and every patient requires us to listen and communicate our focus on the basic principles of transference, defense, phantasy, and the unconscious process. He reminds us psychoanalysis is a discipline built on common sense, communication, honesty, compassion, and exploration; it calls for applying a flexible model to difficult situations rather than a predetermined model of the mind and procedures. Waska promotes flexibility and posits that at times psychoanalysis, psychotherapy, or supportive work is needed at certain times in the treatment. The case material Waska presents, challenges us to maintain an analytic focus. He provides examples of difficulties, such as abrupt terminations, frequency issues, acting out, countertransference issues, diagnosis, and external factors such as EAP programs, insurance limits and financial issues. One major position throughout this book is such work is “difficult but worth the effort.” “Although it is taxing, confusing, and frustrating, I am invested in working with patients who are so paranoid, narcissistic, or borderline that their treatment cannot always be sustained . . . but I notice valuable work taking place some of the time.” (p. 76) Some patients are so paranoid, narcissistic or borderline and at times aggressive, treatment is impossible to sustain and most break off the process before a true course of psychoanalytic therapy can be maintained, and yet Dr. Waska illustrates how valuable work can take place some of the time with such patients. If the psychoanalyst can assist the patient to identify and integrate some of their split-off, projected, and denied aspects of their ego, then valuable work can take place even though the clinician realizes that we never reach the ideal.

Waska always brings us back to theory to assist our formulations during these difficult clinical storms. He sites Klein’s views that difficult patients often rely on primitive methods of relating, which is organized around splitting, manic defenses, and projective identification. Life, death, and survival preoccupy these patients. Excessive hostility, experience of angry, attacking objects ready to devour them, and losses of contact with good objects are some of the basic experiences of our difficult patients. He proposes the analyst always engage the patient with the analytic instrument, respect, curiosity, and interpretation of the transference. These patients often have experienced ongoing traumatic events in their childhoods and did not have anyone to help them make sense of their situations or protect them. This often leads to sever states of angry hopelessness and manic states of omnipotent defenses. So often, large parts of their intrapsychic life are based around avoiding and defending loss, persecution and primitive guilt. They often want to be given to; they refuse to give and flee treatment because they do not feel safe enough to work through their phantasies with the analyst. Often, in treating these types of individuals, transference becomes real, instead of an as-if experience and they experience us as truly unhelpful, critical, and a distant enemy. Waska presents many interesting and frustrating case illustrations, which offer us a
transition of succeeding generations into the power structure contributes to its own stultification and ultimate destruction, which is the other side of the dimension that Faimberg so eloquently describes.

In summary, I highly recommend this extraordinarily erudite, lucid, and evocative text to both seasoned clinicians and students alike. I know that Faimberg’s work has had an appreciable impact upon my thinking about analytic work and child development, and that I will incorporate this volume into my teaching.

**References**


Christine C. Kieffer, CCKPHD@aol.com

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rare and intimate glimpse into the day-to-day clinical work of a Kleinian psychoanalyst. With each and every case, Waska meets his patients in his capacity as a psychoanalyst and from a Kleinian-Freudian model. This translates into an interpretive process that emphasizes focusing on the transference as well as the countertransference, valuing the moment-to-moment developments in the analytic relationship, understanding the patient’s phantasy life, and searching for the unconscious meaning and experience of external reality situations (regardless of the diagnosis, setting, or frequency). He takes into account that neither patient nor psychoanalyst is ever completely finished with his or her own internal and interpersonal struggles. We can, however, accept the jigsaw puzzle of what make us special and unique and continue to strive toward gradual improvement, integration, and pleasure of our lives.

The last part of this wonderful journey into the workings of a Kleinians psychoanalyst’s day to day practice offers the reader with a message that all candidates and psychoanalysts should discuss and think about. Why do we spend so much time, money, and resources to become a psychoanalyst and what do we offer that is different from our nonpsychoanalytic colleagues? Our patients are being treated by someone trained as a psychoanalyst, so that they are receiving a different type and level of care than a patient would with another mental health professional. Waska advocates for our training to include more work with these difficult types of patients and for us to be able to maintain our psychoanalytic focus, especially during the clinical storms. If we can speak to those anxieties within the paranoid-schizoid and depressive positions, our ability to effect change will improve. Waska presents a sound argument as he postulates that an actual psychoanalytic practice involves the essential elements of the transference-countertransference relationship, the interpretive process, and the exploration of phantasies, object-relational defensive systems, and unconscious world views. We do things differently from other nonanalytic mental health professions as we locate and interpret the transference whenever possible. This is our unique signature and we do it because we believe it is the most meaningful and lasting way to effect positive change in an individual.

I strongly recommend this book to anyone interested in working with real people with real problems. The real solutions are not magical, and, as Dr. Waska clearly states, don’t always work. Our psychoanalytic focus and signature is the best we have at this time and the best we have to do research into reaching and effecting change with our patients.

Charles J. Most

cjmpsyd@aol.com

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Ferenczi’s “confusion of tongues” (1980/1933) spoke to differences between adults and children. The metaphor could easily be applied to a much broader range of issues in today’s psychoanalysis. Ample grounds for confusion were provided by Freud. As we know, he used the very term psychoanalysis to describe at least three different enterprises: a theory of mind, a theory of psychopathology, and a treatment method. Many of our seemingly basic terms are similarly used in so many ways even in one language, let alone the many into which Freud’s work has been translated. The ways in which we speak with one another include cultural, linguistic, and substantive differences often difficult to untangle. A considerable literature has addressed definitional matters, but the present state of affairs has gone, it seems, beyond mere confusion to Babel.

It is easy to decry this situation, and those concerned with psychoanalysis as a science (as was Freud), may be among those most troubled by it. To offer an alternative perspective, the very subject matter staked out by the founder is so complex in its nature—encompassing the multiple dimensions of human nature—that this century of definitional confusion has been both necessary and heuristic. The human mind/brain comprises trillions of synapses, with a factorial algorithm of possible meanings approaching infinity. Psychoanalytic psychology created a new approach to its exploration and discovery. Our “Babel” is a necessary stage for dealing with such complexity.

Toward this end, clinical psychoanalysts and research psychoanalysts should welcome what has been called “applied psychoanalysis,” if only to extend the reach of phenomena subject to analytic scrutiny. Freud’s Requiem is a most worthy contribution.

Cited in a recent Newsday article and favorably reviewed in the New York Times, this is a book whose popularity is good for psychoanalysis. That Freud’s name should be associated with the Catholic Mass for the repose of souls may seem incongruous, as he was, famously, a Godless Jew. But Matthew von Unwerth demonstrates throughout this almost poetic work Freud’s preoccupation with mortality and his attempts to come to grips with it, not only personally but also scientifically. This book is simultaneously about psychoanalysis, the first psychoanalyst, science and art, poetic inspiration, psychoanalytic methodologies, and the dilemma of human existence.

Trained in literature, von Unwerth has been a librarian at the New York Psychoanalytic Society and Institute for a decade. More recently, he is in clinical psychoanalytic training. His literary background melds with his attraction to psychoanalytic theory to inform and inspire this book.

Stimulated by Freud’s 1915 essay, “On Transience” (provided as an appendix in the current volume), von Unwerth deals with the essay’s theme, and with Freud’s concurrent thinking that would be revealed in “Mourning and Melancholia” (1917). Using episodes from the lives of Freud, Rainer Maria Rilke, and Lou Andreas-Salome (these latter two reasonably presumed to be the characters referred to in Freud’s essay), von Unwerth weaves psychoanalytic theory, poetry, and biography to grapple with the domains of art and science, epistemology, and mortality.

I will now provide a summary of what is to be found in this book. The writing is much more engaging than this overview.

Freud has often been cast as a pessimist. In contrast to the poet in the essay who experiences the transience of beauty as depressing, Freud argues that its very transience provides a scarcity value that is inspiring. Freud is here an optimist; those who cannot mourn are depressed. Andreas-Salome introduced Rilke to Freud, and also recommended analysis for the then-blocked poet. She soon retracted her advice, fearing that treatment would stifle his creativity—a sad but not uncommon view, even today.

Freud’s psychoanalysis promoted rationality over inspiration (the oceanic feeling). Freud respected poetic intuition and loved poetry, but could not connect...
emotionally to it, or to Rilke. Freud’s art appreciation is intellectual; he did not consider himself creative. For Freud, art is irrational and related to psychosis; he cared not at all for music.

Andreas-Salome is considered the most important female German writer of her time. She was a lover of great men (Nietzsche, Jung, Rilke) and their biographer, and she became a psychoanalyst and a member of Freud’s Wednesday group. Rilke’s writing block is undone without analysis and the literary achievements that follow are major. Andreas-Salome is able to mourn Rilke’s early death, in part by writing about him.

Much of this book describes Freud’s neurotic object-relations and their relationship to his ideas and to the history of the psychoanalytic movement. An adolescent crush leads to a rejection of emotionality; Freud commits himself to science, but his work redraws boundaries between art and life. Self-analysis poses an obvious scientific problem (objectivity); yet Freud writes often about artists and writers. Freud identifies with Ulysses, and Goethe is a major hero for him. Establishment science rejects Freud while art embraces him; Freud would disagree with both judgments.

Von Unwerth deals with Freud’s smoking and his cancer, his collection of antiquities, his love for his dogs, his Lamarckianism, and his being a political reactionary, yet engages neither in Freud-bashing nor hagiography. He moves fluidly from each topic back to his two central themes: death as a preoccupation for Freud and mourning as the alternative to depression.

Von Unwerth attempts in this book to unite art and science. Like Freud and others before him, his success is limited. Unlike Freud, he does not engage in theory-construction, although his grasp of psychoanalytic theory is impressive. With artistic flair, he engages our interest in the details of his presentation and in his themes.

Along with Hartmann (1964/1944), I view psychoanalysis as an overarching general psychology. I count the “standard” psychoanalytic treatment situation also to be one “application” of the general theory. I believe that psychoanalytic knowledge may be derived from the couch, from standard research paradigms, and from biography, literature and other sources of human endeavor. The state of our knowledge, although extensive after a century of exploration, remains limited, and our pluralism can seem like a Babel of confusion. Von Unwerth’s voice is an important new voice, and this book is a good read as well.

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Jeff Golland
E-mail: jgolland@att.net

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In this engaging, readable, and highly original book, Carlo Strenger offers some thought provoking ideas about the place of psychoanalysis in the context of a fast changing world. Strenger has taken psychoanalytic thinking from its origin with Sigmund Freud into the contemporary Internet world. With this journey he has offered some unique thoughts about how we as a species have changed and how psychoanalysis has changed and must change in order to remain relevant. During a presentation given in Chicago, Strenger (2006), who was a featured speaker, indicated that there have been two major changes in human consciousness: the first was the industrial revolution which transported us from creating everything by hand to being able to utilize the machine for increased productivity; the second was the Internet, which has truly made us a global village. During Strenger’s enlightening presentation he proposed that the Internet not only changes the rapidity with which we can communicate across all ethnic, racial, and geographical divides but also changes the relationship between parents and children. During the baby boom generation we relied on our parents to take us to the library, and we interacted with the adults in our life as drivers, teachers, and sources of information. During Strenger’s lecture he indicated that today’s children will not need their parents for transportation to the library—with the push of a button they can access any information they need on the Internet. Furthermore, the young are able to access the Internet in ways that the adults who are raising them are not, thereby dramatically changing the balance of power. In The Designed Self, Strenger has further extended this philosophy of the cultural divide to focus on psychoanalysis. He challenges us to acknowledge the significant changes that have taken place in society over the decades since Freud and provides a model for contemporary psychoanalysis which respects the past and psychoanalytic history, while landing us squarely in the 21st century. The author chronicles his therapeutic encounters with five highly gifted young adults for whom the idea of authenticity, which was associated with the previous baby boom generation, was supplanted in the contemporary generation (which he calls generation X) by the need to experiment endlessly with the self. Strenger paid close attention to the dark side of generation X’s sense of creating themselves and need to use themselves and their self-creation as a final goal. Strenger proposed that generation X’s perpetual self-experimentation is constantly reinforced by the media and in the cases that he presented, came to encompass everything from body shape, to gender identity, to hair color, to career choice. Strenger allowed us to get to know his patients who rejected all that their parents represented, including their culture, and discussed generation X’s need to embrace a “nobrow” culture, which rejects any delineation between popular culture and genuine culture. These generation X patients were totally consumed by the project of shaping themselves, bringing the same intensity that their parents felt in attempting to shape the society in which they lived; this self-shaping became a source of chronically high excitement. During this excellent and thought provoking book Strenger’s analytic inquiries revealed generation X’s hunger, which was termed “fatherlessness,” and the need for clearly felt authority. This lack of direction resulted in a terror of aging that coexists with post adolescent norms of sexual attractiveness. Generation X’s fear of financial failure and fear that they will never be able to achieve both the ideals promoted by the media and the extremes of the lives of individuals such as Donald Trump and Bill Gates, has resulted in a sense of financial failure that has plagued those who felt they fell short of the well publicized success stories of their cultural icons. Generation Xers are in a quandary between wanting to be part of an ethnic identity and wanting to be part of the global village.

In the chapters that compose the book (The Self as Perpetual Experiment; Nobrow: Forming an Identity
in Urban Culture; The Bobo Dilemma; Failing Fathers, Failing Sons; Finding Ethnic Identity and a Place in Western Society; and Psychoanalysis in the Age of the Designed Self), Strenger tells the story of his encounter with five extraordinarily talented people whose ages range between early-20s and mid-30s. Each has a unique biography and carries the unconscious memory of interactions with his or her parents; each was born with the potential struggle to realize his or her self, but all of them were also shaped by the cultural forces that surrounded their adolescence and early adulthood. In this book Strenger attempts to capture their individuality by his descriptions but also places each of them within the cultural context of the last two decades. In exploring the interrelationships among recent cultural changes and the process of identity formation in generation Xers, Strenger investigates the shaping of personality by the impact of cultural experience and psychological development. His milieu for investigation is Israeli urban society, where ethnic and cultural tensions have long had significant impact on young adults. Strenger argues that the entire culture of generation X is very different from that in which psychoanalysis evolved and even from that with which the middle-aged analytic panel of either gender of today is familiar. In The Designed Self Strenger utilizes compelling clinical examples and wide ranging scholarship to put forth his vision of psychoanalysis that takes into account the generation of today but maintains connection with the traditions expressed by Freud.

Two theorists whom he explores in depth are Eigen and Phillips (p. 141). Strenger discusses Eigen’s papers in which Bion’s thought on catastrophe, the black hole, and the pain of regaining psychic truths are explored. The author celebrates Eigen’s ability to transform affective experience into written language and views Eigen’s work as an answer to one of the pervasive problems of many contemporary patients, which is the disappearance of the sense of selfhood and the demonization of the sacred. Strenger appreciates Eigen’s strong sense of the sacred and his insistence that if one does not have a focus of numinous experience, one will of necessity relinquish the possibility of being truly alive (145). Eigen’s work is celebrated with his thoughts about possibility and his hypothesis that if one “stays with the pain” long enough, joy may emerge. Even pain is preferable to psychic deadness, and suffering pain can open the release, which is due to aliveness and joy.

In contrast, another psychoanalytic theorist celebrated by Strenger is Adam Philips (p. 147). Strenger views Philips as one of the most original and prolific psychoanalytic writers of the last several years with his proposal that “if psychoanalysis cannot tell people how to live, it should still be able to make people feel better, but often in unexpected ways.” Philips’ work is epicurean and attempts to liberate psychoanalysis and psychoanalysts from the fear instilled by psychoanalytic tradition. Philips takes the psychoanalytic establishment to task for a variety of sins including pomposity and the insistence that there is a true essence of psychoanalysis. His concern is that psychoanalysis is constantly dealing with itself instead of wondering about human beings. In his view (p. 148), psychoanalytic institutions are so concerned with the purity of psychoanalysis that they have become sources of authoritarian indoctrination rather than practices of emancipatory liberation, which he views as both dangerous and useless to patients. Strenger quotes Philips in positing that the desirable outcome of an analytic encounter is not a well-analyzed person but a coefficient of eroticism. In the end the purpose of analysis according to Philips is “how interesting is it to live this person’s life.” Strenger quotes Philips (p. 151) in depicting a celebratory stance toward the very unexplainability of who we are. We should celebrate our strangeness and cherish the quirkiness of our life trajectories; people should take a wholehearted interest in themselves and celebrate existence. Strenger views both Eigen and Philips as two interesting alternatives to the Stoic model of psychoanalysis that has been dominant since

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Freud and believes that it is essential for psychoanalysis to be able to develop a voice in a world that has lost many of the certainties of the past. He feels that it is essential to find new ways of making us interesting to ourselves as human beings rather than becoming obsessed with purity of technique and adherence to tradition.

The epilogue of this highly intellectual and beautifully researched book concludes with Strenger’s requiem to the dream of metaphysical depth (p. 174). The author provides us with his personal dream analysis and leads us to his own conclusion that it is possible to get rid of the very notion of metaphysical depth without having to give up the idea of a deep self that is essential to psychoanalysis. Strenger clarifies in this book that he is not judging generation X and cherishes and respects the individual patients that he has written about. He clarifies that he does not feel that generation X is a less valuable generation than any other, but illuminates his hypothesis that previous generations deconstructed metaphysical images, metaphors, and modes of thought and left us with postmodern flatness. Generation X has grown up into the cultural reality that they have to deal with, and Strenger states that he recoils from neoconservative reactions that try to return to something that is irretrievably dead and he is afraid of the fundamentalist attempts to restore certainties that are and should be left behind. Strenger (p. 173) feels that the global culture forming the background to the individual case studies in this book has done away with depth. Contemporary western culture has gotten rid of a large number of taboos, and the young people Strenger worked with had to find their way in a space more open than any social space that has ever existed. The young people he presented had difficulty living with so much freedom. Strenger feels (p. 163) that psychoanalysis has a significant place and function in the culture of the Designed Self. The patients presented were able to enter adulthood with enormous opportunities and possibilities for experimentation, but the pressure placed on these young people in the culture of the Designed Self was enormous. “If there are so many possibilities then those who do not make use of this space have no one to blame but themselves.” According to the author, the obsession with success that permeates the culture of the Designed Self can easily lead to a sense of loss of self. It is noted that the incidence of depression and anxiety disorder has quadrupled since the 1970s, which the author partially attributes to the inundation with images of success combined with the decline of the social support structures that help people feel at home in the world. It is postulated that the focus on the self and the lack of a sense of community and continuity with earlier generations robs humans of the resources necessary to sustain themselves psychologically.

In Strenger’s view psychoanalysis does not offer quick fixes for symptoms that lead to a fast track to success, but insists on listening to the messages that these symptoms carry. Psychoanalysis attempts to facilitate processes of transformation that allow for the self complexity to be lived rather than suppressed. According to Strenger, psychoanalysis today is becoming a loosely connected culture of forming the self, a humanistic undertaking organized around a ritualized interaction between two people (p. 129). Recent changes have resulted in an ecumenical atmosphere that allows for communication across styles of work. In Strenger’s opinion (p. 134), one of the central arguments of the book is that contemporary urban culture has moved from existentialism and humanistic psychology to a more radical ethic, which places high demands on members of urban culture. An interesting aside made by Strenger (p. 135) is that most natural sciences value novelty and require that citations in physics, biology, and chemistry be as recent as possible. It was interesting to note that the period of observation that is utilized by modern Freudians, Kleinians, Winnicottians, Bionians, and self-psychologists emphasizes the continuity of their work with the major figures of the psychoanalytic tradition, rendering psychoanalysis unique among the social sciences in that almost every publication contains references to a few radical and clinical works, some of which were written more than a century ago.

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Marilyn Newman Metzl
marilynmetzl@sbcglobal.net
Psychoanalytic Books


Jay Frankel, PhD

Like a sculptor who can see the form hidden within the block of stone, Sheldon Bach—most recently in his third book on narcissism, *Getting from Here to There: Analytic Love, Analytic Process*—opens our eyes to the underlying structure and dynamics of narcissistic disorders. Bach’s observations and formulations are presented in an accessible, engaging and deceptively simple way, but they reflect precision of observation, clarity and sophistication of thought, deep empathy for patients, and genuine clinical wisdom. Indeed, Bach’s formulations are closely grounded in clinical observation. He is clearly gifted as a healer, scientist, and teacher.

The book is a distillation, synthesis, and further development of Bach’s earlier discoveries about narcissistic disorders. As one makes one’s way through the book, reading Bach’s observations and formulations about one or another aspect of the functioning of people suffering from narcissistic disorders, the internal coherence of his overall framework becomes increasingly clear. Bach points us to the truly defining elements of narcissistic pathology and development—he focuses on the essentials without oversimplifying, giving us an elegantly described phenomenology of narcissistic disorders. And he brings in findings from studies in related areas such as attachment, mother-infant attunement, separation-individuation, and cognitive neurobiology that bolster the framework he has developed over the years. His gentle erudition permeates the book.

But he also goes further in describing his clinical method than he has previously done. His method is faultlessly grounded in his understanding of the development and pathology of these disorders.

Finally, Bach speaks to a truth about what clinical work can sometimes become—and may sometimes need to become—that is out of synch with our society’s prevailing objectivizing ethos; it’s a truth that we may seek to avoid. It is at this point that Bach’s clinical wisdom meets up with his courage to follow the truth as he sees it. What follows is a brief summary of Bach’s findings and ideas.

**Development and psychopathology of narcissistic disorders**

In the preface to his book, Bach tells us that states of consciousness—their permutations, transformations, integration and disintegration—have been a lifelong interest for him. Indeed, beginning with his first (1977) contribution to the study of narcissistic disorders, which forms the basis of the first chapter of his first book, *Narcissistic States and Therapeutic Process* (1985), the closely observed, thoughtful explication of states of consciousness has, in my reading, been the thread around which Dr. Bach’s very important contributions to our understanding of the development, pathology, and treatment of narcissistic disorders are organized.

*Getting from Here to There* begins with a chapter “On Being Forgotten and Forgetting Oneself.” Bach places the developmental miscue of not being held in mind by the primary caregiver, when this is a chronic situation, as the characteristic central, cumulative trauma in the genesis of narcissistic pathology. “Our own feelings of aliveness,” Bach says, are sustained partly “by feeling that we exist and are remembered in the minds of others” (p. 2). People who suffer from a narcissistic disorder, in contrast, “cannot feel continually alive in the present because as children they did not feel continually remembered and alive in the minds of their primary caretakers” (p. 2). They were forgotten—not held in mind as an abiding, “living presence” (p. 132), with a basic attitude by the caregiver of “sympathetic resonance” (p. 132).

Such people are also likely to have a deficit in what Bach has termed “evocative constancy”—“the capacity to hold on to the object representation when the object is absent, or to hold onto the self-representation when the object is not there to reflect and reinforce it” (p. 23). Having been forgotten, such people become deficient in their own capacity to remember themselves and others in a vital, fully engaged way. Evocative constancy, Bach indicates, is the basis for “the establishment of stable representations and reliable self- and object constancy” (p. 3).

It is not only the feeling of aliveness and the ability to keep oneself and others in mind that depend on being remembered, but the ability to use one’s mind
in a full and integrated way. Over the course of this first chapter and within the book, Bach goes on to describe the “narcissistic thought disorder” (p. 20), or “narcissistic state of consciousness” (p. 20), that results from being forgotten. This state of consciousness is notable especially for the rigidity and lack of continuity in various dimensions of thinking—the lack of capacity to encompass ambiguity, complexity and multiple perspectives that creates “either-or” thinking; the lack of ability to balance, shift between, and integrate “the great polarities of psychic life, such as self and other, subjectivity and objectivity, attachment and separation, activity and passivity, and pleasure and unpleasure” (p. 18) as well as love and hate, engagement and disengagement, and concrete and abstract perspectives on experience; the lack of a sense that the present moment is linked to the past and the future; the lack of a sense of a process that governs how things happen; and ultimately the lack of a sense that experiences have meaning and that other people, and the world itself, can be trusted. Patients with narcissistic pathology are often engaged in frantic oscillations between what feel like discontinuous and contradictory points of experience. Being held in mind in an abiding way by another is what allows people to develop the capacity to hold in mind other states than the one they are in, and to integrate their present experience with other kinds of experiences they have had.

Bach places this forgetting, by the parents of narcissistically disordered patients, within the broader context of their failure to become engaged in the interpenetration of affects between themselves and their child, and thus their failure to foster the child’s transitional space (Winnicott, 1953). These are the states in which the child becomes able to tolerate and then to integrate contradictory experiences and to develop a sense of personal continuity, and which are the foundation for the level of attunement by the mother necessary for the child to develop evocative constancy.

Additionally, Bach sees the lack of such interpenetration and attunement as the cause of “severe emotional dysregulation” (p. 21)—another characteristic problem of those suffering from narcissistic disorders. He writes, “it often seems as if their emotional thermostats were malfunctioning or nonexistent, which was consistent with their overall problems of self- and mutual regulation” (p. 21), and cites research in cognitive neurobiology showing that the mother’s misattunement and emotional reactions affect the child’s brain functioning. Bach’s discussion of regulation emphasizes his view that the psychological and the somatic and inextricable.

Bach notes that events other than the caregiver’s chronic failure of attunement to the child based on the caregiver’s own difficulties can also underlie narcissistic disorders. These events include a child being “so extremely high- or low-drive that few mothers could have responded adequately, or because in some other way child and mother are essentially mismatched” (p. 77) as well as “loss of the self through childhood illness, traumatic disillusionment, overwhelming anxiety, and so forth” (p. 24).

Bach pays special attention, most notably in chapters 2 and 8, to one of the polarities of psychic life that poses great difficulties for people with narcissistic disorders: the difficulty shifting between and integrating subjective awareness—where we are totally immersed in our own thoughts, feelings, and actions, and nothing else exists for us—and objective self-awareness, where we observe ourselves in a more distanced way, as one person among people. The difficulty integrating these polarities is closely related both to the two manifest presentations of narcissistic pathology—overinflated and deflated—and to the sadomasochistic object relations characteristic of narcissistic pathology.

Overinflated narcissistic pathology reflects an exaggeration of subjective awareness to the detriment of seeing oneself as one person among many, and thus forms the basis for a sadistic orientation to other people. Others are devalued, and one’s need for them denied; there is a hypomanic affective tone. Deflated narcissistic pathology, on the other hand, involves an exaggeration of objective self-awareness, a devaluation of one’s own experience, depressive feeling, and a masochistic engagement of other people. In treatment, overinflated narcissistic pathology results in a mirroring transference (Kohut, 1971), where the analyst is a part-object whose function is essentially to admire and affirm the patient. Conversely, deflated narcissistic pathology creates an idealizing transference.
Bach goes further in this book than in his earlier work in Treating narcissistic disorders. He notes that latent within each of these manifest presentations of narcissistic pathology lies the other form, which will eventually emerge in treatment.

In an earlier book (1994), Bach described how the sadomasochistic fantasies inherent in narcissistic disorders may or may not emerge in frankly sexual forms, but will certainly shape the underlying structure of their object relations—a theme he returns to in chapter 7 of Getting from Here to There. This, too, he ties to “parental nonrecognition, emotional absence, or a lack of mutual pleasure between parent and child [which] force the child to flee to the sadomasochistic drives in an effort to deny the loss and to buttress a failing sense of self” (1994, p. 5, also see p. 4). Sadomasochistic object relations are seen by Bach as arising in the context of being socialized largely through coercion, “terror and fear of abandonment” (p. 98), resulting in someone seeking out pain rather than pleasure in interactions with other people—this is what is familiar (p. 101) and as constituting “a defense against and an attempt to repair some traumatic loss that has not been adequately mourned” (p. 24). The sadistic and masochistic object-relational alternatives are attempts to undo the inner insecurities upon which narcissistic disorders are based: as Bach tells us, the sadist, in his maltreatment of the other, reassures himself that “I can do anything I want to you—I can beat you or torture you forever—but you’ll never be able to leave me!” (p. 27); the masochist essentially offers: “Do anything you want to me—beat me or kill me if you must—but don’t ever leave me” (p. 27). Both sadist and masochist use others in the instrumental way they experienced themselves as having been used in their own childhoods. The centrality of sadomasochism in narcissistic object relations is one of Bach’s most important contributions.

In this book, Bach also refers briefly (p. 18) to a subject he has dealt with at greater length in his earlier books: fantasies, other than sadomasochistic ones, frequently found in people with narcissistic disorders. These fantasies include the “narcissistic cocoon . . . fantasies of implosion and explosion . . . fantasies about a double, an imaginary companion, a wise baby, or an androgyne . . . or fantasies of escape into another world” (p. 18). Like sadomasochistic fantasies, all of these fantasies function, in one way or another, to soothe and help regulate narcissistic distress.

**Treatment of Narcissistic Disorders**

Bach goes further in this book than in his earlier work in describing his treatment methods, in specific and concrete terms. And indeed, his treatment methods flow seamlessly from his understanding of the development and pathology of narcissistic disorders, allowing Bach to describe a compelling analytic treatment method for a disorder for which many analysts have questioned the value of analytic treatment.

On the most general level, Bach proposes that psychoanalysis—frequent, and using the couch—is the treatment of choice for narcissistic disorders, because it addresses the regulatory issues underlying narcissistic symptomatology, as well as creating the necessary conditions for an adequate reworking of disturbances in the organization of subjectivity and object relations, and thus for healing. Taking issue with the practice of medicating symptoms frequently found in narcissistic disorders, such as the depression that may result from the narcissistically disordered person’s difficulties in regulating his or her affects, Bach says, “a great many people with analytically treatable narcissistic disorders are still being diagnosed as unipolar or bipolar and treated only with medication, which may help their behavior but not their basic regulatory issues or their problems with relating to others. . . . Fortunately, when these patients do get into a good analysis where they begin to trust the analyst and become able to use him or her as a transitional or selfobject, then they often become emotionally and cognitively regulated, with or without medication” (p. 21)—and “with greater precision and fewer side effects” (p. 32; also see p. 51). Bach also believes that “These patients respond very nicely to psychoanalysis but sometimes less easily to [less frequent] psychotherapy, because in many psychotherapies the appropriately deep, primitive transferences either cannot be achieved or else cannot be adequately managed” (p. 29-30).

In terms of how the specifics of the analytic setting address regulatory issues, and ultimately the patient’s trust, Bach reminds us that “analysts have for decades been providing their patients with ‘hidden’ psychobiological regulators such as a couch, some pillows and a soothing sensory environment. In my own practice I usually try to adjust the consulting room to each patient’s preferences about temperature, ventilation, sound, lighting, pillows, blankets, furniture arrangement, and so forth, within the bounds of my possibilities . . . . This policy applies to scheduling as well, which I try to keep flexible if I can do so without generating too much countertransference. Some patients simply need a longer time to get started, and I try to accommodate them whenever possible . . . . I also arrange for the clock to be visible to both the patient and to me . . . . Many of these apparently inconsequential adjustments of the analytic environment may be thought of as paralleling the hidden biological regulators of early
attachment such as the warmth, texture, and tactile, auditory, and vestibular stimulation . . .” (pp. 25-26). And on the most basic level, “the analyst is always there and usually on time” (p. 37).

Regulation in the analytic setting is also fostered through obtaining a history of regulation. “I try in the first sessions with these patients to get both an overview of the dynamic picture and a history of the early dysregulation with which it is so often intertwined. . . . I find that working in this way from the very beginning is a great help in dealing with transference disruptions, in understanding and managing them, and in arriving at the better regulated interaction that is the foundation of basic trust” (p. 39).

At the beginning of therapy, because of the patient’s difficulty in regulating emotional reactivity and interpersonal relationships, Bach sees the patient’s “attachment to the treatment [as] our primary goal” (p. 27). Bach’s basic way of doing this is to try “to enter into the experiential world of the patient . . . which requires leaving behind, as far as possible, one’s own fears, memories, values, and desires. . . . a tall order under any circumstances” (p. 129). “Remaining in the patient’s world is the road to attachment, [and] making an ‘objective’ comment or interpretation [is] the road to separation,” which should generally be avoided (p. 27).

Even if the patient is unable to engage in mutual collaboration, and at first most of these patients are not, we are always collaborating with them by going along with their vision of reality even when they reject ours . . . . We must defer to the patient’s vision of reality until he becomes able to tolerate our presence and psychic reality in the room with him. . . . By this means we enter the patient’s phenomenal world.” (p. 36). “The best place to be most of the time is as close to the patient’s experiential world as possible. (p. 39)

One goal of this kind of engagement of the patient is for the patient to become able to create transitional space—the medium in which a child, and later a patient, learns to integrate polarities and to develop a sense of continuity and linkage. The transitional object, Bach reminds us, is “a safe haven of attachment to the object and a means of separation from that very object. It is both a link to the past as it was and a way of carrying and transforming this past into the emerging future. It is a way of remaining immersed in subjectivity while also being a path toward objectifying the world . . . . It is only when this does not occur, as in pathology, that one finds a radical splitting and an obsessive alternation between the frozen dichotomies of subjectivity and objectivity, of self and other, which seem unable to oscillate fluidly, to integrate, or to reach some homeostasis” (p. 118). It is in the transitional area, Bach says, that “dichotomy, ambiguity, and paradox can be acknowledged and contained” (p. 76), that “trust becomes possible” (p. 94) and that “playing together becomes possible” (p. 94). Thus in the treatment of narcissistic disorders, “the creation or recreation of an adequate transitional space is essential” (p. 70).

Inseparable from the kind of heightened attention that is part and parcel of a mother’s emotionally holding a child—and an analyst’s holding a patient—in mind as a “living presence,” and from the mother’s or analyst’s own participation in the transitional space that the child or patient creates, is what Bach calls “the reliably consistent interpenetration and mutual regulation of affects and gestural communications in the . . . dyad” (p. 19). Indeed, Bach says that transitional space “evolves largely through the interpenetration of affects and states of consciousness”
attunement needed for mother and child to metabolize each other’s affects and perceptions (p. 76) and for mother to contain and manage the baby’s states and “help the baby feel he is alive in her mind” (p. 78), is based in such a state of interpenetration. This atmosphere of high attunement, interpenetration, and transitionality is the medium, Bach tells us, in which “meaning and trust originate” (p. 19). As is clear from some of these quotes, the atmosphere of interpenetration and transitionality is also the medium for the mutual regulation between mother and child—and between analyst and patient—that forms the foundation for someone learning to regulate his or her own affective and attenotional states.

Bach recommends certain modifications of technique (p. 45) to foster the patient’s sense of being remembered by the analyst and being able to hold herself in her own mind in a more continuous way, including: holding, accepting projections, lending oneself to enactments without interpreting them for a considerable time, and verbal and bodily expressions of empathy and attunement. He also suggests that with a patient who has difficulty with reflective self-awareness, it may be easier to approach the understanding of her thoughts and actions from the perspective of their self-regulatory function.

Bach says: “As the patient begins to use the analyst in this narcissistic way and the analyst lends himself to this usage while elastically maintaining the overall framework, we begin to see the development of analytic trust, of a transitional area, and of mutual regulatory processes” (p. 28). “In the ordinary course of events a patient will eventually begin to take distance on his own subjectivity and to develop reflective self-awareness, which can then be taken as one sign that interpretations have now become usable” (p. 27). The analyst can then move towards “the regular employment of classical interpretive techniques” (p. 28).

A primary clinical problem is establishing trust. “We do this by making the analytic consulting room a safe and reliable space and by being absolutely truthful with the patient about everything that occurs in this space and that happens between us” (p. 36). When things go wrong, “we analyze our own reactions as well as the patient’s, for there is no way that a patient who mistrusts everything will trust us at all if we insist on leaving ourselves out of the equation. There is a way of being absolutely straight with the patient without indulging in confessions, apologia, or gross parameters” (p. 36). Bach emphasizes the importance of countertransference analysis, due to the constant affective communication between patient and analyst (p. 92).

There is an additional reason for the analyst to be open. Separating oneself from a shared pathological family worldview or state of consciousness is a necessary therapeutic task for many patients. Such a family worldview often involves a prohibition on questioning of family attitudes and on thinking about or noticing certain things that happen in the family (chap. 4). “To help such patient recognize the parental pathology and to help them separate from it is one of the most difficult clinical problems we face” (p. 64), Bach says. Thus it is important that the patient be able to question, and have access to, the analyst’s thought processes, if he is to become able to achieve true independence.

I allow the patient to witness my mind at work in the process of free-associating or making formulations . . . . It is especially useful for such patients to experience the analyst as he tries to deal with doubt and ambiguity, or as he tries to hold two ideas or two roles in mind at the same time, for it opens up the possibility of the patients doing the same. . . . since I am implicitly asking my patients to trust me with their minds, I struggle to attain a position where I can trust them with my own mind and feel that I have nothing to hide from them. (p. 63)

In this regard, Bach says that “the therapeutic dyad [is] a reworking of the original dyad in which the continuing goal of each participant [is] to understand how the mind and body of the other person really worked” (p. 53).

Bach says “while direct verbal communication may sometimes not be necessary to initiate important change, I believe that to understand consciously and eventually to formulate these changes in a verbal and symbolic manner always adds an essential extra dimension to a psychoanalysis” (p. xix). One aspect of this is that “since . . . transference reactions are so often accompanied by intense rage and other blinding emotions . . . the analyst is at a great advantage if the subject has already been raised and discussed in its historical context” (p. 38).

Despite the analyst’s attempts to protect the patient’s attachment to the treatment and to support the patient’s trust, there will inevitably be disruptions in the attunement and connection between patient and analyst. Following Ferenczi (1933) and Kohut (1971), Bach sees a central therapeutic role for these disruptions. “Each episode of attempted alliance, its disruption, and the repair of the alliance raises the mutual trust to a higher level . . . . Each episode of mismatch, disruption, and repair is also an ongoing process of regulation of the dyadic system . . . . Analytic trust is based on and grows with successful mutual regulation” (p. 36-37).
Because of the traumatic losses that underlie narcissistic disorders, Bach also links the process of reintegration to a process of mourning. In this regard, he cites Kris’ (1984) concept of “divergent conflicts of ambivalence” which involve an inability to reconcile the basic polarities of life. “For these patients at this stage the mutative process is often not verbal interpretation of drive-defense or convergent conflicts, but rather a prolonged process of mourning and reintegration that entails a mindful interpenetrative oscillation between these polarities” (p. 24).

**Love**

It is in his final chapter that Bach takes a new, especially personal, and somewhat daring step, saying what some analysts believe in their heart of hearts about the core of therapeutic change: that it is based upon love (and cf. Steingart’s, 1995, discussion of analytic love). Bach cites Freud’s statement that “The secret of therapy is to cure by love” (p. 126), and says that “Many of the technical terms and concepts of psychoanalysis can be seen as part of a programmatic effort to specify the parameters of love in an experience-distant language” (p. 126). What Bach means by love is “the sense of knowing, appreciating, and admiring without carnal knowledge or seductive feelings but in essentially the same way one appreciates the body and flesh of one’s closest friends or one’s own children in their entirety” (pp. 129-130). Bach believes that the effects of paying a particular kind of very close attention to the patient—characterized by the analyst holding the patient as a “living presence” in his mind as well as by a sense of “basic trust” of, and a “sympathetic resonance” (p. 132) with, the patient—“can be very profound indeed, for the person with whom you are thus connected, whether patient or friend or lover, begins to feel held together by your attention and to feel that more and more parts of himself are becoming meaningfully interconnected” (p.133). When such a connection with the patient is achieved, “the most curious things begin to happen. After a while you find yourself totally emotionally involved in the process . . . caught up in a process that is larger than yourself. A part of you is still able to observe professionally, to reflect and exercise control, but another part is hopelessly entangled, and you simply cannot help it. You have, to speak quite frankly, fallen in love with your patient” (p. 133). In this way, analytic love provides the medium for the “mutual assimilation and interpenetration” (p. xix) that may have been lacking during early childhood and that is required for the analytic reworking of this early deficiency.

One might wonder whether an analytic stance that does not include at least the effort to attune oneself to the patient in the way that makes analytic love more likely, is—drawing on the set of options that forms the title of Bach’s second book, The Language of Perversion and the Language of Love (1994)—a perverse analytic stance, in that such an approach embodies a less-than full embrace of the other person: that is, a part-object view of the patient. We may further wonder whether the same healing processes set in motion by analytic love, that naturally address the deficits in narcissistic functioning that Bach describes, can occur in the absence of analytic love? I think Bach would say that they cannot.

The kind of analytic love that Bach talks about is

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the opposite of the parental forgetting he describes at the beginning of the book, which he places as the root of many of these patients’ difficulties. The first and last chapters form bookends to this work. Indeed, analytic love seems to gather together many of the elements Bach believes are essential in the treatment of narcissistic disorders: the analyst holding the patient in mind as a “living presence,” with “sympathetic resonance” and “basic trust”; giving oneself over to the patient’s world; openness; and the high degree of attunement and interpenetration that facilitate mutual regulation and trust. Analytic love is also a kind of play, which is a form of shared transitionality and which carries an ever-resilient potential for mutual recognition: an achievement that all of us would hope for our narcissistically troubled patients.

CONCLUSION
Bach at one and the same time humanizes and operationalizes our understanding of narcissistic disorders. He has great empathy with people’s struggles and compassion for their pain, yet describes these struggles with precision and clarity. His observations and formulations are accessible and convincing. His clinical vignettes not only illustrate his points persuasively, but also give us a vivid and three-dimensional sense of the dynamic struggles of human beings in pain. In my experience, the book’s observations, formulations, and vignettes all enrich enormously the possibilities to listen to our patients more closely and actively, with greater compassion and clarity, and find new dimensions of meaning in what they say and do.

Bach draws upon ideas of like-minded analytic thinkers, integrating them into his own approach: Balint’s (1968) clinical avoidance of signs of the analyst’s separateness from the patient and allowing the patient the kind of object relationship the patient feels he or she needs, without interpretation or challenge; Kohut’s (1971) concept of self-object transferences, enriched with Bach’s own formulations about subjective and objective self-awareness and sadomasochistic object relations; Winnicott’s (1953) idea of transitionality, not only as a route to the development of the self and the embrace of outer reality, but more specifically as the medium in which the rigid dichotomizing of the narcissistic state of consciousness and deficits in the ability to self-regulate can be resolved.

To sum up Bach’s formulations in the most schematic way: the mother’s sustained attunement to her child, and seeing the child as a person in his or her own right, foster an interpenetration of affect and a healthy experience of transitionality in the child. These conditions, in turn, facilitate the child’s healthy development in many areas—feeling alive, being able to keep oneself and others in mind in a vital way, being able to regulate one’s own affects and to trust other people.

In contrast, many aspects of narcissistic disorders that Bach has delineated—dichotomous thinking, sadomasochistic object relations, overinflated or deflated self-experience, idealizing or mirroring tendencies, typical narcissistic fantasies—seem to reflect attempts, using primitive and rigid defenses, to compensate for deficits in these areas of development and thus to gain self-control and stability. These compensatory efforts compromise affect, thinking, self-experience, and object relations.

Bach’s approach to treatment flows directly from this understanding: through various means, to create a containing and responsive environment that will lead to an interpenetration of affects, transitional space and, with luck, analytic love—a medium, in other words, that contains the essential developmental experiences the patient lacked in childhood. Such a medium will likely facilitate the growth of the patient’s trust, feelings of aliveness, self- and object constancy, and more adequate ways of regulating her own affective states, and allow the patient to let go of rigid, defensive attempts to compensate for earlier deficits.

REFERENCES

Jay Frankel
Email: jaybfrankel@gmail.com
What transpires in the minds of violent criminals? Do their actions follow from uncontrollable impulses or simply reflect an absence of moral feeling? Abby Stein’s (2007) response is that violence is “...the inevitable outcome of severely damaging early interpersonal relationships” (p. 38). Her work as a forensic psychologist and Adjunct Associate Professor at the John Jay Criminal Justice program at City University of New York leads her to conclude that violence is shaped by massive trauma and dissociation. She seamlessly integrates psychoanalytic theory and her clinical work into a unique understanding of violent offenders. However, by according dissociation a central etiological role, Stein also makes a significant contribution to the current debate about this mechanism within contemporary psychoanalysis. Her sensitivity to the indicants of dissociated moral feeling in individuals widely regarded as conscienceless has important clinical and philosophical implications.

Stein’s central argument may be parsed into two interlocking premises: (a) As a result of severe childhood trauma, violent offenders are more vulnerable to pathological dissociation; (b) Pathological dissociation produces a distinctive mental state described by the term “psychosomnia”, a chronic, dream-like mode of experience resulting from an incapacity for linguistic representation. Psychosomnia undermines critical reflection and integrated moral appraisal, thus increasing the likelihood of enactment.

Whereas many criminologists understand violent action as expressing impulses no longer satisfied within the offender’s elaborate fantasy life, Stein views their imaginative capacities as impoverished and inarticulate. Without any facility for reflective self-awareness, they experience affects as intolerable tension states pressing for discharge. Violent enactment thus voices dissociated victimization, communicating unthinkable trauma through disclaimed action. The real legacy of abuse is a lust for attachment rather than for sexual gratification. The perversity of this pursuit destroys the possibility of secure and satisfying attachment.

There is wide agreement among trauma specialists with regard to Stein’s first point: severe abuse produces dissociation. The prevalence of the former in violent offenders correlates with the alarmingly high incidence of the latter. But Stein does not rest her conclusions exclusively on statistical induction. She uncovers powerful evidence of dissociation in their narratives. One sadistic killer recounted his crimes in the following way: “I knew what happened when I woke up but I did not know if it happened for real or was imagined” (p.97). For Stein, dissociation increases the likelihood of violent enactment by preventing the offender’s “victimacy ... [from being] ... seamlessly woven into expressive discourse” (p.25). Unassimilated, but highly charged experiences are destined for “the comforting pulse of gesture” (p. 25). Although one must remain vigilant to their wish to evade punishment, Stein notes the frequency with which they forego opportunities for denial in speaking about their deeds. She interprets this surprising phenomenon to mean that punishment is an integral element of criminal narratives, providing comfort, containment, and moral authority that cannot be generated internally.

Although relational theorists largely regard dissociation normatively and as a dimensional variable, Stein very clearly speaks of dissociative experiences falling at the pathological end of this spectrum. Indeed, some of her patients might well meet the diagnostic criteria for Dissociative Identity Disorder, thus indirectly supporting the claim that pathological dissociation is categorically distinct from other forms of so-called dissociative experience. There is substantial evidence supporting the view that pathological dissociation occurs rarely outside of severe psychopathology and bears little relationship to
normal experiences of compartmentalization, detachment, selective inattention, and/or imaginative absorption (Waller et al., 1996 & 1997). Therefore, many forms of expectable dissociation do not preclude linguistic representation. That I do not formulate or permit certain experiences into awareness does not mean they cannot be formulated or symbolized.

If the absence of formulation is the sine qua non of dissociation (Stern, 1997), then much of everyday experience is dissociated. However, it is more likely that pathological dissociation reflects the inability to bridge disparate states of mind. Stein suggests that violent offenders learn to dissociate facilely to diminish the subjective experience of agency and to by-pass moral culpability. The multiplicity of which Stein speaks is real multiplicity; pathological dissociation renders the subjective experience of who did what to whom uncertain.

In framing these questions, Stein follows the thinking of Grossman (1993) who explicitly links disavowal to an inconsistent commitment to truth. He uses the term “perverse attitude to reality” (p. 422) to denote a mode of experience in which one sees and knows, but facilely “turn[s] down the volume on reality” (p. 422) when it is advantageous to do so. Similar to psychosomnia, the perverse attitude allows one to gratify forbidden wishes without experiencing conflict. However, in this perspective, agency is maintained. Although one may not experience it as such, one makes choices and decisions about one’s actions. Stein does not jettison the concept completely, but sees the concept of agency as more ambiguous. She describes it as “ping-ponged” (p. 121) between dissociated aspects of the self. She avers that what is enacted is “at least partially conscious” (p. 116), but implies that agency is diminished by dissociation.

What is not discussed by Stein, but is of vital importance to psychoanalysis, is how one reconciles a fundamentally dissociative model with one that is agentic. Because relational theorists regard consciousness as the product of effortful construction, the idea that some mental contents remain outside awareness is not problematic. Experience, like personal identity, exists only by virtue of verbal formulation. What is not formulated creatively in language never reaches awareness. But, understanding the form and content of experience to be determined exclusively by the interpersonal field rather than by the individual necessarily diminishes agency. As Mills (2005) contends, this leaves relational theorists in the unenviable position of choosing between a nontranscendental self, understood as a reflection of these influences, or a materialistic one. Neither alternative is appealing. To speak of splitting or dissociation employed for the purposes of defense implicates agency. It implicates a self that is distinct from the influences of language, culture, and/or the interpersonal field—a self, in other words, that decides and chooses. Stein says as much when she notes that “offenders work hard to exploit their natural tendency for dissociative reverie” (p. 24). In embracing what comes naturally or results from trauma, offenders powerfully express agency.

Upon reflection, enactment instantiates processes of two different kinds: those that cannot be (or have not yet been) thought and those that are defensively excluded. Although both are separated from conscious experience and identity, the former bespeaks an agent that guides, directs, appraises, and defends, whether consciously or unconsciously. Dissociation deletes these experiences. But there’s a catch: it does not obliterate agency as such, but rather the subjective experience of it. One no longer perceives oneself to be the author of one’s actions; intention and will are felt to be distributed among multiple selves and self-states, or, in the extreme, are experienced as someone else’s. One need look no further than phenomena like highway hypnosis and the modularity of cognition more generally to appreciate the relatively minor role played by consciousness in the drama of agency (Naso, 2007). This is the deeper sense of Mills argument as well as relational theorists like Greenberg (2005). Although dissociated, the powerful and sustained impact of agency nevertheless may be discerned.

The liabilities of a dimensional view are most apparent when one confronts the problem of deception, an essential element of immoral action. Deception is a prominent feature of criminal narratives and coextensive with intention. If Stein is correct in understanding criminal acts as the perverse effort to mollify a murderous superego, it is only because they express multiple intentions, including, but not limited to, the desire to conceal uncomfortable truths from the self and others. This intention is not reducible to expectable, nonpathological dissociation. To disentangle victimization from victimizing, dissociation as a subjective experience from the self-serving disavowal of deception, one must pay greater attention to moral agency.

At a deeper level, Stein’s analysis suggests that, by undermining the capacity for verbal representation, dissociation creates a kind of premoral internal world that obscures the connections between action and intention. What cannot be said cannot be avowed or connected to who one is. By precluding speech, dissociation also undermines the possibility of moral integration by perpetuating the illusion that one is a victim of forces beyond one’s control. So, it reinforces the perception that one is not implicated morally in what one does, leaving one with only a vague and indistinct connection to one’s immoral actions.

Stein gives us a highly intelligent, depth
EMOTIONS AND STONES: TWO WAYS OF KNOWING.

Given our conversations with colleagues and fellow subway riders, this collection of essays wins the prize for this year’s most intriguing book. More than any other spotted in our hands, it provokes the “What’s in that book?” question. It does so for good reasons. The chapters cover sites as numerous and varied as the Basilica of the Mission Delores in San Francisco, Freud at the Acropolis, the Jewish Museum Berlin, the Bauhaus, Frank Gehry buildings, and Bettelheim’s Orthogenic School. The writers depict a variety of enticing topics that fuse the psychological and the architectural like Klein’s phantasy, “emotion in the stone,” analytic space, and the architectural uncanny.

Because it best fits the likely readers’ expectations, the easiest place to begin a characterization of the book is its psychobiographical third section—a multi-faceted exploration of Frank Lloyd Wright that reveals the value of attention to the psychological characteristics of the person who creates the art. James William Anderson, an analyst and psychobiographer, takes us from the architect’s beginnings through his early career to his heights as an acclaimed but controversial architect. For Anderson, Wright expresses his personality as he creates remarkable buildings that reflect his exalted self and simultaneously silence his degraded self. For Jerome Winer, an analyst and psychiatrist, key is the architect’s psychic organization—one that craved freedom—and its manifestation in his distaste for “boxes” and desire for bridging the human and natural world. Lastly, Robert Twombly, professor of architectural history, considers Wright’s life alongside that of Alfred Loos’s, and shows how their contrasting interpretations of the modern era were reflected in their respective arrangements of interior space. While Loos embraced the individuality that modernity brought about, Wright held on dearly to unity and “idealized memory.” What is created and who created it become inextricably intertwined.

The three essays sketch an articulate portrait of Wright’s complexities, and exemplify the many ways and benefits of studying an individual life. By presenting Wright historically, artistically, and psychodynamically, these pieces provide depth to an understanding of Wright’s life, situate him in his particular context, and shed light on his creativity.

Perhaps less expected but certainly as effective are the three other sections of the text. In two of these, the emphasis is put on the subjective and experiential—what the analyst, architect, patient, and building visitor encounter and experience. Psychoanalysts reflect on basilicas, design, and other aspects of the built environment, while architects and scholars of architecture offer their own speculations on the experience of therapy and other psychoanalytic topics. In the final section, the authors integrate psychoanalytic with historical and cultural approaches.

The architecturally inspired psychoanalysts of the book’s initial chapters address how the spaces we occupy each day become starting points for psychological inquiry. In the engaging chapter that opens the book by Robert Harris, who is also a sculptor, we find a wonderful example of how fully and deeply a person can see and experience a building. Harris moves from the building details of a basilica in San Francisco to his feelings about these and his general engagement with architecture, including what others have observed and written about it. We remain on the level of the very personal in Phil Lebovitz’s piece about the houses that four architects have designed for themselves. He describes the interplay between architects’ inner worlds, personalities, and houses. Starting with the personal and then moving to patients and finally to theoretical concerns, F. Robert Rodman, the biographer of D.W. Winnicott, reveals the links between that theorist’s ideas about the self and what buildings do for us in our lives.

Even our dream world relates to our experience of buildings. As Eugene Mahon writes in “Dreams of Architecture and the Architecture of Dreams,” when buildings...
and edifices find their way into our dreams, we are forced to ask questions about the structure of our own mind, how what is “out there” has become internalized. Similarly, Stephen M. Sonnenberg in “An Enhanced Awareness of Architecture and Design,” argues that Freud was led to a remarkable introspection and self-analysis by his experiences at the Acropolis, no ordinary physical space. Sonnenberg visits the Neue Synagoge in Berlin to stimulate his own analytic efforts. The impetus is what a particular aspect of the building provokes, what Cecil Balmond termed the “informal,” a characteristic of a structure that lends the viewer to unconventional, surprising thinking.

The architectural scholars who consider the book’s dual topics deal with a number of ways in which psychoanalytic approaches to architecture can yield new realities. For Steve Pile, a professor of geography, architectural space becomes a possible site where our desires are made consistent with our lives. Elizabeth Danze, an architect and professor of architecture, takes a more particular look at space and reminds us in “An Architect’s View of Introspective Space: The Analytic Vessel” that the physical space in which therapy occurs can affect what happens between analyst and analysand through the placement of objects and the design of the room. Both Peggy Deamer, also an architect and professor of architecture, and Stephen Kite, professor of architectural planning and landscape in the United Kingdom, discuss the work of the English art and architecture critic Adrian Stokes who had an analysis with Melanie Klein and who applied her ideas to architecture. Kite’s deals with Stokes’ discussion of “oneness” with a work of art, an idea that resonates throughout the book as a whole. The aesthetic moment takes precedence as the artist temporarily loses her or his self, moving beyond the self’s borders, to the “otherness” of what has been created, in an act of unity. Those experiencing art, and not only those creating it, become enveloped and absorbed, too. The focus on the self that has been so central to the field of psychology for decades is reconsidered here: What is out there, outside the self, and why are we concerned with it? For some architects, the realm between the subject and the space outside has long been of paramount importance.

Bringing us to a deep consideration of how architects have the potential to engage Freud’s method, Juliet Flower MacCannell, professor emerita of English and comparative literature and co-chair of the California Psychoanalytic Circle, treats space as equally important to time in Freud’s work. She shows how Freud in his well-known case of the “Wolfman” reorganized his patient’s dream space into a “construction,” where time and place blend together. By doing so, Freud was able to help his patient rearticulate the assemblages of his dream and fantasies in a new light. MacCannell goes on from here in her complex but well worth the ride conceptual journey to consider what a Freudian revolution in the framing of space would look like architecturally. She finds this revolution in the innovative and enigmatic work of the contemporary architect Emilio Ambasz, which so distorts space and time that it provokes a new way of thinking about our world, our futures, and ourselves.

Representing historical and cultural perspectives, historian Peter Loewenberg underscores in his essay on the Bauhaus the importance of safe playspaces for artists. Drawing on Winnicott’s theory of the sphere of transitional space, the author claims that for the artists the Bauhaus served as an extension of that precious sphere between mother and child where symbol formation initially occurs. The comfort that such a community afforded the artists contributed to the radical ideas that emerged from the Bauhaus school. Ruxandra Ion, drawing on training in medicine, anthropology, and clinical psychology, and the analyst James William Anderson jump further back in history, tracing the myth circulating around the Romanian Monastery of the Arges. The tragic tale of the monastery’s construction has long served a function in Romania, the authors argue, which is what all stories that surround buildings must retain to ensure immortality of the buildings. Thus not only a building’s structure but its history, too, is entangled in the psychological. “The question,” the authors write, “is not whether buildings have meaning for those who use them but rather how to get at such meaning.”

Freud once remarked that the study of art is more conducive to the discovery of psychological insights than is the myopic focus adapted in attempts to mimic the natural sciences. With “Tracking Emotion in the Stone: An Essay on Psychoanalysis and Architecture,” Peter Homans, professor emeritus of psychology and religious studies, and Diane Jonte-Pace, also a professor of religious studies and Freud scholar, remind us that psychoanalysis and modern architecture grew up together. They offer a most engaging metaphor for the new relationship between psychoanalysis and architecture and the interpretation of human affairs that it enables. Using an image of house painting, they write that the earliest interpretations of pieces of art through psychoanalytic frameworks applied concepts in a way that one might apply paint to a wall. Now, in our postmodern time, in which psychoanalytic notions are part of our shared cultural air, the subject matter that we seek to observe and interpret includes the psychological interpretations that have already been made by architects/artists and historians.:

The house, in a sense, is already painted in psychological hues—the housepainters have psychological paints and tools at hand. This situation necessitates a new stance in the project of psychoanalytic “interpretation.” (p. 261-262)
Not since Heinz Kohut’s theory of the self arrived on the analytic scene in the 1970s and early 1980s has there been a more significant contribution to self psychology than Crayton Rowe’s Treating the Basic Self. This is a treasure that expands Kohut’s original theory with the unveiling of a newly discovered selfobject that Rowe titles the undifferentiated selfobject, and which he defines “as the fundamental experience of knowing that there will be unknown, nonspecific happenings that will occur throughout life that will be challenging, uplifting, and self-enhancing no matter the positive or negative nature of our current circumstances” (p. 21). He explains that this discovery came about while treating certain traumatized adult and child patients whom he recognized were fixated on narrowly focused psychic pursuits that were unresolvable.

This book is uncommonly readable and takes so little for granted that it can be read by beginners as well as experienced clinicians, by self psychologists and analysts of different theoretical persuasions, as well as by clinicians outside the analytic community. Do not mistake, however, its ease of language for simplicity of thought. This book’s subject matter is provocative and challenging. The first few chapters offer a succinct but clear review of Heinz Kohut’s early discoveries of the self, detailing the struggles to understand his now famous case of Ms. F whose criticisms of him for derailing her analysis resulted in his dramatic shift in listening from an outsider’s point of view to that of the empathically immersed observer. It was from this perspective that he made his radical discovery of the selfobject, which Kohut (1984) later defined “as that dimension of our experience of another person that relates to this person’s functions in shoring up our self” (p. 49). In other words Kohut (1971) recognized that to his patient he was not a person per se but merely serving vital but impersonal functions of mirroring, idealization, or twinship.

Rowe then expands on his concept of the undifferentiated selfobject, pointing out that even though it’s innate like the others, it differs because it is provider-free. For example, who has not peeked in on a very young infant alone in her crib, babbling excitedly, as she scans for new and different sights and colors? Or, who has not observed a young toddler, oblivious but determined, rummaging through a pantry of pots and pans searching for the unfamiliar and the novel? From his clinical observation, Rowe concludes that parental recognition of this fundamental selfobject need is essential for the further development of the mirroring, idealizing, and twinship selfobject needs. On the other hand, when this recognition is limited or unavailable, not only are these other selfobject needs blocked, but the self becomes fixated upon the undifferentiated selfobject as the primary source of self-enhancement and self-sustenance.

For those with questions or doubts, Rowe’s case material offers illuminating and reassuring answers that make the theory come alive. In a series of eight socioeconomically diverse and clinically stimulating case examples, he takes us along on a journey of empathic immersion as he unveils in minute but graphic detail his new transference. With a style and format where nothing is held back, he brings each case to life so authentically and, at times, humorously, that you feel as though you are there with him in the consultation room. His uncanny attunement to his readers as well as his patients, his revealing of his moment-to-moment thinking during the treatment, his open admission of countertransference reactions and their resolution, his many technical recommendations sprinkled throughout each case, and his skillful portrayal of the empathic steps that led to his understandings are so scientifically fascinating and clinically relevant they may inspire the curious clinician to experiment with his own difficult and intractable cases.

All the cases in this volume are equally important because they shed light on the relevance of the
undifferentiated selfobject to a wide range of pathological symptoms such as homelessness, addiction, compulsivity, and ADHD as well as to normal development. For this reason I recommend that each case be read and closely studied. However, space allows me only to touch upon the significant nodal points of the initial case of Ms. C, an actively suicidal middle-aged woman, whose analysis led Rowe to his discovery of the undifferentiated selfobject transference.

Her wish to kill herself was not revealed at first—something that made Rowe wonder if she had, would he have ever continued. Yet, he never had any regrets because of the significance of what he was to learn. It was only after months of treatment and an unsuccessful suicidal attempt that he came to appreciate the intense level of childhood abuse that led her by age 12 to become narrowly fixated on the “self-sustaining experience of anticipating unknown endless possibilities that awaited her only after death” (p. 42). That was a secret she cherished and had refused to divulge to any therapist before because it was her essential source of self-sustenance. However, Rowe’s uncanny ability to remain immersed in her experience allowed her to divulge its deeper meaning, namely, that her repetitive suicidal behavior (she had five attempts prior to this treatment) and her need for self-destructive behavior were a sine qua non of maintaining the life-giving force of anticipating the “unknown” that death alone held. Eventually, she worked through her deep mistrust, her lowered self-esteem, and her conviction that only through death and destruction could she attain something more sustaining. In other words Ms. C gradually came to trust “that she could experience the enrichment of the unknown while she was still alive” (p. 43).

In conclusion I am reminded of an essay I read back in high school, “Of Studies,” by Francis Bacon, in which he writes: “Some books are to be tasted, others to be swallowed, and some few are to be chewed and digested: That is some books are to be read only in parts; others to be read, but cursorily, and some few to be read wholly, and with diligence and attention.” I cannot dictate how, if at all, anyone might choose to read this book, but for my tastes, it is one of those few rare gems that need to be read “with diligence and attention.”

References

David MacIsaac
drmacisaac@aol.com
The Psychodynamic Diagnostic Manual (PDM) is the result of a unique collaboration among the major psychoanalytic organizations. The PDM covers adults, children, adolescents, and infants and systematically describes:

- Healthy and disordered personality functioning
- Individual profiles of mental functioning, including patterns of relating, comprehending, and expressing feelings, coping with stress and anxiety, observing one’s own emotions and behaviors, and forming moral judgments
- Symptom patterns, including differences in each individual’s personal or subjective experience of his or her symptoms

For the past two years a task force selected by presidents of the psychoanalytic organizations listed above systematized the descriptions of both the deeper and surface levels of an individual’s personality, emotional and social functioning, and symptom patterns, emphasizing individual variations as well as commonalities. The PDM describes the whole person and complements the DSM and ICD efforts in cataloguing symptoms and behaviors.

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CE credits are available for taking the ABPP examination. Please feel free to contact me, jreppen@datagram.com, or our Academy administrator Jane Kerner, j.kerner@comcast.net, or Dolores Morris, PhD, ABPP, President, American Board of Psychoanalysis in Psychology (the examining board), domorris@worldnet.att.net, for further information.

References

Ronald C. Naso
rnaso@snet.net
Impressions and Reflections on the 2007 National Multicultural Conference and Summit in Seattle

Ming-Hui Daniel Hsu

I attended the 2007 National Multicultural Conference and Summit (NMCS) in Seattle, WA during January 24-26. For those who do not know, NMCS is hosted by four APA divisions that share common interest in social justice of minority groups. These divisions are Counseling Psychology (Division 17), Women (Division 35), Lesbian, Gay, and Bisexual Issues (Division 44), and Ethnic Minority Issues (Division 45). Although not a host division, Division 39 also sponsored the Summit and is listed as one of the Benefactors.

As a student member of the Multicultural Concerns Committee, my goal of this report is to share my impression and reflection of this Summit, with the focus on two aspects that are more relevant to the members of Division 39: First, how people in the Summit approach social justice issues and what psychodynamic perspective can contribute to this dialogue. Second, how relevant multicultural psychology is to psychoanalysis. In conclusion, I will provide some recommendations on what Division 39 can do to deepen its involvement in multicultural psychology.

Social Justice and Psychodynamic Perspective

Social justice is a very important theme in the NMCS. Many presentations focused on the impact of prejudice and discrimination on minority groups. This year, the most important theme arguably is to be sensitive to the psychological pain of other minority group members, including those with multiple minority group memberships, while pursuing social justice of one’s minority group. In fact, three out of the four keynote speakers addressed this issue.

This emphasis on recognizing and examining the prejudice of oneself, in addition to the one of the society, in my view, reflects the maturation of the Summit¹. And this is where I think depth-oriented psychodynamic perspective can contribute to this dialogue. Psychodynamic-oriented psychologists could help people see that although members of minority groups suffer from external prejudice, they also suffer from internalized prejudice stemming from childhood experiences and from repetitions of these victimization. Furthermore, individuals are more likely to be sensitive to the pain of other minority group members when their own pain from the past is healed.

¹For those who do not know the history of the Summit, in the Town Hall meeting of last NMCS in 2005, there was some tension between sexual minority psychologists (mostly White) and racial/ethnic minority psychologists (mostly heterosexual).
An Annual Report is required of all APA Divisions. The report is requested by the Committee on Division and APA Relations (CODAPAR). Its purpose is to identify new division projects and initiatives and monitor division activities for compliance with the American Psychological Association’s bylaws, policies and rules. What follows is an excerpt of the 2006 Division 39 Annual Report submitted to APA. It is being reproduced here for review by the membership of the Division. The work of Division 39 continues to be creative, prolific and expansive and quite impressive.

Overview of the Structure of Division 39
The nine Sections of Division 39 reflect the Division’s complexity and its broad presence in the realm of psychoanalytic psychology. Within the field of psychology, Division 39 represents psychologists and other mental health professionals who identify themselves as having a major commitment to the study, practice and development of psychoanalysis and psychoanalytic psychotherapy. The sections of Division 39 serve to actualize the Division’s mandate and objectives specified in its By Laws. As such, Division 39 is committed to:

1. Broadening and enhancing scientific and public interest in the contributions of psychoanalysis to psychology
2. Encouraging and supporting educational programs and research having to do with the discipline of psychoanalysis and its applications to the public welfare
3. Informing the psychological community and the public of current theoretical and empirical developments in psychoanalysis by exchange of scientific ideas, meetings and publications
4. Establishment of the highest standards for the practice of psychoanalysis

New Programs and Initiatives
The year 2006 marked the end of the yearlong celebration of the 25th anniversary of Division 39. That occasion was significant in that it symbolized how the Division has continued the implementation of its organizational goals and objectives with the increase in its commitment to the study, practice and development of psychoanalysis in both applied and clinical psychology. During 2006, the Division had a considerable momentum in the scope of its contributions to psychoanalytic knowledge, to the science and practice of psychology and to supporting psychoanalytic education and research. In addition, the Division continued to support projects relating to the application of psychoanalytic theory and practice to the public welfare and to public information about mental health. The Division also continued its commitment to maintaining the highest standards of clinical practice for psychoanalytic psychotherapy and psychoanalysis.

The following new programs and initiatives were established by Division 39 in 2006:

A. Programs
1. During 2006, the 26th Annual Spring Meeting of Division 39 was held in Philadelphia, PA. The theme of this meeting was - “Love, Desire and Passions: Variety, Enigma and the Disruption of Psychoanalysis.” The meeting was well attended and provided the psychoanalytic community with a richly diverse program of events.
2. During 2006, the Division sponsored a program at the annual meeting of APA in New Orleans. The theme of this program was: “Psychoanalysis: A General Psychology.” The title choice was meant to reflect the view that psychoanalysis is a viable competitor with other models of human behavior. During the APA meeting, eight programs were cosponsored with other APA divisions (Theoretical and Philosophical {24}; State Associations {31}; Independent Practice {42}; Media {46}; Peace {48} and Psychopharmacology {55}). In addition, a member of the Division presented an ethics workshop as part of the APA Professional Development Workshop series.
3. The Division participated in the APA sponsored 2006 Expert Summit on Immigration held in San Antonio, Texas
   a. Division 39 sponsored a presentation by one of its early career psychologist members, Usha Tummala Narra. The paper was entitled: “When the Patient is the Institution.”
   b. The documentary “Looking North: Mexican Images of Immigration” completed by a member of Division 39, Ricardo Ainslie, was presented at the Summit.
4. The Division was a co-sponsor of the historical event “Freud’s Place in Our Minds” which was held on September 15, 2006. This event consisted of a symposium, “A Day of Reflection on Sigmund Freud’s Significance in the 21st Century,” which was held at the Embassy of Austria in Washington, D.C. The symposium was in commemoration of the
150th anniversary of the birth of Sigmund Freud. It was collaboratively planned and organized by the four major psychoanalytic organizations in North America: The American Academy of Psychoanalysis and Dynamic Psychiatry, The American Psychoanalytic Association, The National Membership Committee on Psychoanalysis in Clinical Social Work and Division 39. The Austrian Cultural Forum has posted the entire set of presentations of this event at: http://www.acfde.org/freud-symposium-transcripts/


6. The Division has made a commitment to develop a liaison with Division 19 (The Society for Military Psychology). Division 39 has arranged to sponsor two of its specialists in traumatology to the 2007 annual meeting of Division 19 (“Building a Better World: Improving Quality of Life and Productivity”). At that time, a symposium “The Aftermath of Combat: Understanding and Treating Traumatic Stress Syndromes” will be presented.

7. The Division has organized a two-part symposium, “Psychoanalytic Perspectives on Prejudice and Conflict: A Model for Applied Psychoanalysis for the 21st Century” for the 2007 Spring Meeting in Toronto. This program was co-sponsored by its Committee on Multicultural Concerns and Section IX (Social Responsibility). This program will consider the problem of prejudice and conflict in the Palestinian-Israeli encounter with a dialogue among Palestinian, Israeli, and North American Jewish and Arab psychoanalysts to cover narratives of history, dynamics and the current situation.

8. The Division supported the project of Section IX (Social Responsibility) in its online colloquia “Ideology and the Clinic,” which considered the ways that ideologies support unjust social systems and then shape individual psyches.

B. PUBLICATIONS

9. The Division continued its support of the Psychodynamic Diagnostic Manual (PDM). The PDM is a diagnostic framework that describes both the deeper and surface levels of an individual’s personality, emotional and social functioning, and symptom patterns. This work was a collaborative effort of the four major psychoanalytic organizations in North America (see # 4 above) as well as the International Psychoanalytical Association. The PDM was selected for a feature article in the Division Spotlight column of the Monitor on Psychology to be published in early 2007.

10. The Division joined a collaborative effort among the sponsors of the “Freud’s Place in Our Minds” event to pursue publication of the symposium proceedings in book format. To this end, a book contract is in the process of negotiation with Jason Aronson, Inc. The title of this book will be: Freud at 150: Twenty-first Century Essays on a Man of Genius.

11. The Division supported its Section III (Women, Gender and Psychoanalysis) in the publication by Routledge Press of Psychoanalytic Reflections on a Gender-free Case: Into the Void. This work is concerned with important areas of inquiry in feminist psychoanalysis.

12. The Division newsletter, Psychologist-Psychoanalyst, continues to be a rich resource for Division members and others in the mental health community. During 2006, the four issues were each a minimum of 80 pages in length. The newsletter reports on the functioning and activities of the Division. The content contains committee reports and articles relevant to the practice of the profession as well as articles regarding matters of interest to the membership and a calendar of events. During 2006, a plan was articulated to make the newsletter available to the general public and to increase web links to it from other psychoanalytic sites. The newsletter editor continues to increase its breadth and depth by enlarging the number of items accepted for publication.

13. The Division journal, Psychoanalytic Psychology, also continues to be a valuable resource for psychoanalytic clinicians and researchers globally, with theoretically diverse scholarly papers on clinical theory and technique. The Division has been involved in tracking the most popular articles downloaded from its journal and plans to use this information in future educational planning. With regard to the journal, during 2006, the process for the search for a new editor was instituted with a plan to change some aspects of the structure of the editor’s position. A Search Committee was established and possible candidates considered. The Division has worked closely with the APA Publications Office in this matter.
C. UNDERGRADUATE /GRADUATE EDUCATION AND EARLY CAREER PSYCHOLOGISTS

14. The Division has made a renewed commitment to the APA Education Directorate with the creation of the Task Force on Academic Careers. This task force will develop liaisons with the APA Education Directorate (such as the APA Center on Mentoring) and send members to attend the APA Education Leadership Conference. During the Division Board meeting in New Orleans at APA, the Division invited a representative from the APA Education Directorate to attend in order to update the Board on its ongoing programs.

15. The Division joined the “10,000 Minds Project: Outreach to Undergraduate Education” organized under the auspices of the American Psychoanalytic Association. This project is a focused outreach initiative the goal of which is to increase awareness of psychoanalytic ideas among undergraduate students. The project is directed by a task force of 20 professionals representing diverse fields in undergraduate education.

16. The Division continues to prioritize its Graduate Student Committee, the objective of which is to promote the interests of graduate students within the Division by creating and supporting opportunities for graduate students in a wide variety of developmental activities. At the present time, graduate students comprise over 10% of the membership of the Division. The Division follows the activities of the American Psychological Association of Graduate Students as a means to keep current with APA supported activities in this area. For the Division Spring meeting, graduate students were offered a reduced registration fee to attend the meeting. Several programs were organized for the 2006 Spring meeting for graduate students. These were: a) “The Dynamics of the Supervisory Exchange: An In Vivo Supervision and Discussion”; b) “Learning from Experience: Young Clinician’s Encounters with the Therapeutic Process”; c) “Thinking Toward More Life: Centrality and Marginality in Human Development” and d) From Oedipus Complex to Oedipal Complexity”. In addition, during 2006, this committee established a List Serv for graduate students of the Division.

17. The Education and Training Committee of the Division is contemplating augmenting its survey of the scope and nature of psychology training programs in North America with additional surveys of training programs in psychoanalysis available for early career psychologists. This committee organized the presentation at the 2006 spring meeting “Teaching Psychoanalysis to Clinical Doctoral Students in the Age of Managed Care and Short Term Treatment”.

18. The Division has continued to support the work of its Task Force on Early Career Psychologists. Along with the goals of APA in this area, Division 39 has identified the main concerns of early career psychologists as both professional and personal. Through the work of this task force, the Division has integrated the needs of early career professionals in its decision making. For the Division Spring meeting, early career psychologists were offered a reduced registration fee to attend the meeting. During the 2006 Spring meeting, the Task Force sponsored the invited roundtable discussion “Disruptions Repair and Development: Being and Becoming a Psychoanalytic Therapist”.

19. The Division has established the Joint Committee for Analytic Candidates whose mandate is to develop initiatives to assist psychologists who are participating in psychoanalytic training at independent institutes in North America and to encourage participation and membership by these individuals within the Division. In this regard, the Division has given its support to the Candidate, a newly formed online journal which is directed at the issues which psychoanalytic candidates encounter during their training. This publication will contribute to the needs of early career psychologists within the Division.

D. OUTREACH

20. The Division continued its support of its highly successful outreach project. This project is directed at the development of strategies to bring psychoanalytic psychology into the public domain. The web site of this project, www.Div39Outreach.org provides public education and outreach through an online database which lists ways in which members of the Division have brought their expertise to the community.

21. The Division organized an outreach effort to those who were affected by Hurricane Katrina
   a. Those members of the Division residing and practicing in affected areas were offered a waiver of membership fees
   b. For the APA meeting in New Orleans in 2006, the Division encouraged those of its members attending to bring school supplies and clothing to donate
   c. The Division supported participation by its members in the rebuilding effort organized by Habitat for Humanity
E. MATTERS RELATED TO APA
22. The Division has closely monitored the findings of the APA PENS Task Force. The Division has joined a coalition of 11 APA divisions united to form the Divisions for Social Justice (DSJ) which has been chaired by a member of the Division. In addition, the Division has appointed a Task Force on Basic Human Rights to study the issues considered.
23. The Division continued to support the APA State Leadership Conference in 2006 by sending a representative to the meeting in Washington, D.C.
24. The Division continues to maintain a commitment to nominations of Division members to APA Boards and Committees during each election cycle.
25. The Division established a Task Force on CIRP to increase its liaison with the APA Committee on International Relations in Psychology.
26. During 2006, the Division Board established the requirement that all of its Sections use the accountancy firm APA CBIZ for its fiscal management needs.
27. The Division continued to provide a forum for the APA Practice Directorate with regular meetings by the PD Executive Director during the APA Board meeting of the Division.
28. The Division has continued its support of the Psychoanalysis Synarchy Group, the entity representing the interests of psychoanalysis in North America in response to the proposed APA policy on specialty or proficiency certification in psychology.
29. The Division has continued support of the inception of the Division of Trauma Psychology (58).
30. The Division has made a commitment to the American Psychological Foundation to recommend more candidates for the Levinson Awards.
31. Division 39 continues to participate in the Psychoanalytic Consortium, a group composed of the 4 major psychoanalytic organizations (Division 39, the American Psychoanalytic Association, the American Academy of Psychoanalysis and Dynamic Psychiatry and the National Membership Committee on Psychoanalysis in Clinical Social Work.), which meets two times a year to share ideas and concerns about the practice of psychoanalysis.
32. The Division continued it support of the Psychoanalysis Synarchy Group, the entity representing the interests of psychoanalysis in North America in response to the proposed APA policy on specialty or proficiency certification in psychology.
33. The Division has continued its support of the Academy of Psychoanalysis, the membership group for members of the Division who have achieved Diplomate status in psychoanalysis through the American Board of Professional Psychology.
34. The Division enlarged and upgraded the focus of its Continuing Education Committee and its projects to expand topics in psychoanalysis as CE offerings to be made available to professionals within the mental health field
a. There was an initiation of CE credit availability for participants in the programs of the annual Spring meetings
b. There was improvement of the CE procedure to ensure a more “user friendly” process and increased marketability
c. There was an increased availability of online CE programs

G. MISCELLANEOUS ACTIVITIES
35. During 2006, the Division investigated a potential By Laws change to allow full membership for Allied Professional members with inclusion of voting rights. This issue became a consideration out of a growing consensus that the Division 39 By Laws are overly restrictive as they pertain to allied professional members.
36. The Multicultural Concerns Committee of the Division continues to represent the concerns of ethnic minority members of the Division. This committee closely follows the developments within the APA Committee on Ethnic Minority Affairs (CEMA) with the aim being to ensure that the specific interests and needs of individuals of diverse backgrounds are represented within Division 39. As with CEMA, the Multicultural Concerns Committee promotes cultural competency and sensitivity and encourages the recruitment and retention of diversity by the development of resources and engaging in advocacy to increase the awareness of multicultural issues within psychoanalysis.
37. The Division has continued support of its Committee on Sexualities and Gender Identities. The mission of
this committee is to promote the needs of Division 39 members with LGBT concerns and to provide all members interested in this topic with a voice in the affairs of the Division. During 2006, this committee sponsored a program at the Spring meeting of the Division “Ongoing Discussion Group: The Construction of Non-Normative Desire”

38. The Site Selection Committee of the Division has continued to have a diversity of regional sites for its annual spring meeting while encouraging the selection of sites which will ensure adequate revenue for the Division.

39. The Division has supported the recommendations of its Internet Committee. During 2006, a major goal was to streamline the Division web site with the addition of an online payment system for all Division activities (e.g., membership, spring meetings and online continuing education programs).

H. SPECIAL INITIATIVES

1. Diversity - Division 39 will continue its priority of matters relating to multicultural concerns with support of its Committee on Multicultural Concerns and its Committee on Sexualities and Gender Identities. This will be reflected in participation at events related to multiculturalism sponsored by APA, program time programming at the Spring meeting 2007 and APA program and inclusion of issues relevant to these areas in its newsletter and journal. In addition, discounted rates for participation in Division activities will continue to be offered to graduate students and early career psychologists.

2. Students and Early Career Psychologists - Division 39 will continue its priority of matters relating to early career psychologists with support of its Graduate Student Committee and Task Force on Early Career Psychologists. This will be reflected in participation at events related to early career psychologists sponsored by APA, program time programming at the Spring meeting 2007 and APA program and inclusion of issues relevant to these areas in its newsletter and journal. In addition, discounted rates for participation in Division activities will continue to be offered to graduate students and early career psychologists.

3. Mentoring - Division 39 will continue to support its Task Force for Academic Mentoring in its commitment to assist graduate students and early career professional who are interested in academic careers and psychoanalysis and who wish to pursue scholarship, teaching and clinical work informed by psychoanalysis within an academic career. This may involve the provision of one on one mentoring to such individuals by more experienced Division 39 members within academia, the creation of workshops and programs related to obtaining grant funding and journal publication within a psychoanalytic research framework and making psychoanalytic teaching and supervisor resources more accessible.
THE AFTERMATH OF COMBAT: UNDERSTANDING AND TREATING TRAUMATIC STRESS SYNDROMES

On March 1, 2007, on behalf of Division 39, we participated in the Annual Meeting of Division 19 (Military Psychology). This included attending their Executive Committee Meeting and presenting a symposium at the general meeting the next day. Our symposium addressed the challenges faced by mental health clinicians in providing mental health services to military personnel and their families during their deployment and after they return home. We focused on the clinical problem of PTSD and we emphasized a psychoanalytic perspective. We were invited to attend the Executive Committee Meeting Division 19 to exchange perspectives about the priorities of each of our respective Divisions.

We began the symposium presentation with a review of the history of PTSD, typical clinical manifestations and levels of severity, and treatment options using psychotherapeutic interventions. The symposium also considered how psychic trauma can affect recovery from combat wounds and physical illnesses with an emphasis upon the development and maintenance of chronic pain states. We also talked about community based interventions, the process of how the soldier becomes a civilian, helping families cope with the changes in the soldier after combat, understanding the response of families and children and workplace reentry. The program included illustrative clinical case presentations and encouraged audience participation. What follows are each of our impressions of our participation in this event.

DIVISION 19 BOARD MEETING: DIVISION 39 GETS A SEAT AT THEIR TABLE

On February 28, 2007, I was invited to attend the Board Meeting of the Division of Military Psychology (19) during their Annual Meeting as the next step in a dialogue and collaboration between our two Divisions. The visit allowed me to talk with members of Division 19 about some of our shared interests, such as psychodynamic work with military families and veterans, our interest in trauma, our wish to show how applicable psychodynamic principles are both in and out of the consulting room.

Our first meeting in August, 2006 had resulted in the planned co-sponsored panel at APA in San Francisco 2007 entitled, “Combat: The Aftermath for the Soldier and the Family”. At the Annual Meeting, I spoke about the SOFAR project (Strategic Outreach to Families of All Reservists), the pro bono project for support, psychotherapy, psychoeducation and prevention services to extended families of military reservists and National Guard who are deployed in Afghanistan, Iraq, and Kuwait, and the partnership of Division 39 with SOFAR.

Division 19 members, in response for their appreciation of our services to the military, were willing to discuss their thoughts and feelings about the proposal coming before APA Council in August to declare a moratorium on psychologists participating in interrogations of foreign detainees at sites where they lack the protection of the Geneva Convention. The Divisions for Social Justice (DSJ) is heading this effort which was authored originally by Neil Altman. I was able to convey our Division’s wish to offer the protection of a strong ethics code to psychologists who need support in situations that are ethically challenging. The members of Division 19 shared the many feelings which had been generated in them by this proposed moratorium. I appreciated the privilege of getting to look through the eyes of the people who would be directly impacted by this moratorium. I came away with one more example of the importance of trying to move out of a position of complementarity into a position of thirdness.

The next day, after our presentation at the Division 19 Annual Meeting, Marilyn and I were presented with Division 19 coins. Each military group has its own coin, which is offered to someone as a symbol of an unbreakable bond. While Division 39 does not have a coin to offer, I think the Division 19 Board understood we were offering the best we had, the ability to listen, to ability to make an alliance and the ability to understand the other.

PRESENTING AT DIVISION 19: HUMILITY AND NEW INSIGHTS

Our attendance at the Annual Meeting of Division 19 was a learning experience and humbling to me in many ways. This Annual Meeting was a congress of military psychologists from different branches of the armed forces and from diverse backgrounds. When we sat in on the next day, after our presentation at the Division 19 Annual Meeting, Marilyn and I were presented with Division 19 coins. Each military group has its own coin, which is offered to someone as a symbol of an unbreakable bond. While Division 39 does not have a coin to offer, I think the Division 19 Board understood we were offering the best we had, the ability to listen, to ability to make an alliance and the ability to understand the other.

CONTINUED ON PAGE 68
Task Force on Liaison to the APA Committee on International Relations in Psychology

Marilyn Jacobs, PhD, ABPP

Overview
The Division 39 Board has created a Task Force on APA CIRP. The objective of this task force is to bring the work of the APA CIRP to Division 39.

What is CIRP?
The APA Committee on International Relations in Psychology (CIRP) is a standing APA committee which is administered by the APA Office of International Affairs. The mandate of CIRP is “to increase contacts of all kinds between psychologists in the United States and their colleagues abroad”. Of historical note, CIRP was founded in 1944 to advise APA on the rehabilitation of psychological laboratories and libraries in post-World War II Europe. CIRP consists of nine elected and two ex-officio members (the APA chief staff officer and a designee of the International Union of Psychological Science). CIRP has formal liaison relationships with the International Union of Psychological Science, the International Association of Applied Psychology, and the National Academy of Science and with the APA main representative to the United Nations.

What is the Mission of CIRP?
As stated in the Rules and Procedures of the APA:

1. To encourage and support the free circulation of psychologists and of psychological ideas and information
2. To promote and assist attendance at international meeting and conferences; promote exposure to world psychological literature; support programs of international exchange of psychologists at all levels of academic and professional training
3. To promote inclusion of an international perspective in the teaching of psychology at all educational levels; increase sensitivity to cultural and linguistic variance at all levels of academic and professional training
4. To encourage the advancement of psychological knowledge that is relevant to international affairs and to encourage the application of that knowledge to the formulation of policy in international affairs
5. To monitor within the international context and take action in cases involving infringements of the rights of psychologists or abuse of psychological knowledge and techniques wherever these may occur, consistent with APA’s ethical principles
6. To apply psychological knowledge to the alleviation of psychological suffering attendant upon abuses of human rights
7. To initiate and maintain communication with international and regional organizations of psychologists, and with other national societies of psychology
8. To assess organizations of psychologists with other national and international associations of psychologists.

Current Focus of CIRP
The last five-year report of the APA Policy and Planning Board (2004) recommended that, “As the largest psychological organization in the world, APA should take the lead in making psychology an international presence”. It was concluded that the core functions of APA were to play “… a central role in making psychology not only a household word, but also a prominent force in global society”. In essence, APA is now committed to the promotion of global psychology, with the recognition that domestic multicultural issues involve a more diverse set of cultures and the belief that addressing domestic issues may be usefully informed by activities in other countries (and by psychology research from other countries).

It has been reported that at present, 60% of the psychologists in the world reside outside of the U.S. and the numbers outside the US are rapidly increasing. For example, in China 10 years ago there were ~4,000 psychologists; the number is currently increasing by ~3,000 a year. It has also been reported that there are areas of the world where there is a scarcity of psychologists (e.g., Africa, parts of Asia).

To actualize the recommendations of APA, CIRP has recently discussed a range of activities including the following:

1. Translation of Psychology Materials
2. International Educational Materials for psychologists
3. International Capacity Building
4. Faculty development and support
5. Partnerships with academic leaders
6. Make electronic products and materials available
7. Provide seed money for department-based projects
8. Act as coaches in international collaboration
9. Help other national associations build infrastructure
10. Help organize professional exchange visits for US psychologists
psychologists to go abroad
11. Serve as a clearinghouse for resource information
12. Explore an international program to partner senior/young psychologists
13. Offer matchmaking grants to universities to foster international exchange
14. Encourage and facilitate the development of psychology around the world

APA is one of four academic discipline organizations participating in a project to internationalize teaching at US higher educational institutions. The APA Board of Educational Affairs has established goals for internationalizing the undergraduate psychology curriculum.

A concern with human rights is an essential aspect of the commitment of CIRP, with a concern for migration, poverty, racism, xenophobia and issues of social justice. CIRP reviewed the proposed “Universal Ethical Principles for Psychologists” drafted by an ad hoc committee of several international psychology organizations including the International Union of Psychological Science, the International Association of Applied Psychology and the International Association of Cross Cultural Psychology. More information on APA CIRP can be found at the APA Office of International Affairs: http://www.apa.org/international/homepage.html

DIVISION 39 TASK FORCE ON APA CIRP
The goal of the Division 39 Task Force on APA CIRP is to develop programs in the spirit of the APA CIRP in Division 39. We are in the early process of formulating our objectives. We would like to include all interested members of our Division in this goal. Some of the potential directions which we have identified are: 1) underdeveloped populations and the underserved; 2) visiting lectureships for cross cultural exchange; and, 3) bridging with psychological associations in the third world who are interested in psychoanalysis. We also have considered organizing a symposium at the 2008 meeting of Division 39 in this area.

WE ARE ASKING FOR INPUT FROM ALL MEMBER
Please advise us of any international programs to which you have a connection and/or any ideas you might have on how we can advance this project. We are particularly interested in any work that we could use for our projected 2008 symposium.

Marilyn S. Jacobs, Chair
Marilyn N. Metzl
Richard Ruth
Gerald Stechler
Please send all correspondence to: mjacobspshd@gmail.com
LOCAL CHAPTER REPORTS: CHICAGO ASSOCIATION FOR PSYCHOANALYTIC PSYCHOLOGY

Chicago’s local chapter of DIV 39, CAPP (Chicago Association for Psychoanalytic Psychology) has been very active and productive this past year in bringing it’s members and the community into contact with a broad spectrum of psychoanalytic ideas. We’ve accomplished this in several different modalities of delivery. Through our Continuing Education programs, formal conferences, study groups, social events, and with outreach and referral programs, CAPP has continued to keep psychoanalytic theories, techniques, and philosophies alive and accessible to a diverse membership and the general public. We are particularly proud this year to announce that CAPP is 25 years old! We are planning a special celebration to commemorate the efforts of everyone past, present and future that have or will have contributed to our success.

In the service of a cooperative exchange of ideas and experience, our Continuing Education Program invites CAPP members to volunteer to present a topic of special interest or expertise to our membership (free of charge) and to the professional community (minimal fee). This year, we were privileged to have a very diverse collection of presentations. In January, 2006, Jay Eihorn presented valuable information and current research on ADHD and the meanings this has for psychoanalytic psychotherapy and assessment. In February, 2006 CAPP members Linda Rudy, Scott Pytluk, and Ron Rosenthal presented a panel discussion titled: “Crossing Over: Relational Dynamics in Cross Sexual Orientation Clinical Dyads” (previously presented at the 2005 Spring Meeting, and International Association for Relational Psychoanalysis and Psychotherapy Annual Conference, 2006). Their papers discussed various dynamics and conflicts encountered when patient and therapist are of different sexual orientations and genders. In November 2006, Christine Kieffer presented a paper on “Restitutive Selfobjet Fantasies of the ‘Entitled Victim.’” February 2007 brought Jim Anderson to the stage to talk about his inspirational interactions with Anna Freud and Helene Deutsch. Coming up this spring, Jesse Viner, Director of Yellowbrick, a specialized treatment center for emerging adults will talk about a developmental neuropsychoanalytic treatment model.

CAPP had also sponsored or co-sponsored several “mini” or informal conferences. These included a panel discussion at the Illinois Psychological Association’s annual fall conference, 2006 in which CAPP members Alice Bernstein (past president), Mary Connors and Peter Reiner discussed “How Attachment Theory, Object Relations Theory, and Current Research Form a Cohesive Whole.” President-elect Christine Kieffer participated in organizing and presenting at a “mini” conference co-sponsored by CAPP, Division 39, the Chicago Psychoanalytic Society, Institute for Clinical Social Work, and the Chicago School of Professional Psychology. The theme for the conference was “Working at the Edge of Chaos: Psychoanalytic Psychotherapy with Children, Adolescents, and Their Parents” which integrated object relations theory, Self Psychology, and Dynamic Systems theory. CAPP also sponsored a special program given by Gary Walls and Frank Summers on “Psychoanalysis and Torture” which was part of the very timely debate going on with regard to the interrogation of prisoners in time of war. This program attracted many attendees outside the membership, especially graduate students. Additional education opportunities are open to CAPP members via special programs/classes offered by the Chicago Center for Psychoanalysis with whom we enjoy a valuable collaborative relationship.

Traditionally, CAPP offers 2 annual conferences that are more formal and more academically rigorous in which invited speakers and discussants come together to present and explore current topics in psychoanalysis. Our spring, 2006 conference deviated somewhat from our regular format. CAPP president, (now past-president) Nancy Huntzinger wanted to bring in information that represented cutting edge research and integrative theory, along with clinical application. Rather than the usual half-day conference that included theory and case material, Allan Schore presented a full day seminar on his theory and research that integrates attachment theory, developmental neuroscience, and psychoanalysis, titled, “Connections, Ruptures, and Repair: Attachment Theory and Brain Research in Clinical Practice”. The conference was co-sponsored by the Illinois Society for Clinical Social Work. It was the most well attended conference thus far, drawing in a cross-disciplinary audience and bringing visibility to CAPP in the larger professional community. CAPP member Bernadette Berardi-Coletta, presented case material of her treatment of a patient survivor of childhood abuse and neglect, exhibiting a disorganized attachment history in a follow-up conference one month later titled, “Between Isolation and Existence.”

Current president, Pat McMahon continued the focus on integrative clinical issues at our annual
Psychoanalytic Psychotherapy at the Margins: The Case of Ana Ortega” that focused on the special challenges of working with a client in a community mental health setting. Discussants included CAPP members Mary Connors looking at the case from an attachment theory perspective, and Charles Turk, who took a Lacanian perspective. This spring, our annual Spring Conference will bring Darlene Bregman Ehrenberg to present her recent work on “The Vulnerability of Desire.”

Another important venue for sharing ideas and experiences is the various study groups offered by CAPP. We currently have three ongoing study groups, with two more forming. All groups are offered free of charge to members and leaders volunteer their services. We also offer a group specifically for graduate students to encourage burgeoning interest in psychoanalysis, and a new Early Careers group, to support new graduates (0 – 5 years) just becoming established in the professional community. Membership in these groups is encouraged but not required. We also offer a referral service that we are currently transitioning into an on-line service to provide greater access to the general public.

CAPP has had a great year. In a time when psychoanalysis seems in danger of becoming invisible and undervalued, we have strived to make our selves known and accessible. We have tried to establish collaborative relationships across disciplines and encourage students and newly graduated professionals to join us. We’ll continue to “put ourselves out there” in the best and most effective ways possible to promote our profession as viable and vitally active in both the bigger world of psychology and mental health, and among ourselves in support of our own work and ambitions.

**The Oklahoma Society for Psychoanalytic Studies**

G. Michael Kampschaefer, PsyD, ABPP

OSPS kicked off the nineteenth year of programs with a presentation by Dr. Gerald Stechler entitled “Ethics in Couples Therapy.” He followed up that evening presentation with a Saturday workshop on “Affect Based Couples Therapy.” In October, Oklahoma was fortunate to be able to host the first-ever visit by Dr. Charles Brenner, who gave both Friday evening and Saturday workshop presentations related to the release of his latest book, *Mind and Meaning*. In November, we hosted longtime teacher and colleague, Dr. Elliot Adler for an evening presentation entitled “Men Who Will Not Love.” OSPS finished out the fall season with a Christmas party and good cheer.

In January, we sponsored for the first time a panel presentation dealing with the subject of Comparative Psychoanalysis, titled “Clinical Conversation: A Case Study with Dialogue From Three Theoretical Perspectives.” The panel was comprised of Oklahoma psychoanalysts Anne Early (Object Relations), Stephen J. Miller (Ego Psychology), and Joseph Couch (American Relational). This was a very stimulating presentation that was among our most well attended events of the year.

For February’s program, psychoanalyst Sondra Shehab and her husband, Sam, hosted a wonderful presentation and discussion of the film, “West Beirut.” Then, in March, continuing a sort of “film season”, popular presenter Mary Ann Coates hosted viewings and discussions of the film “The Weeping Camel”. Over the years, OSPS has found film presentations and discussions to be among our most popular types of programs.

Finally, this year will close out with an April program by local therapist Jaime Buecker entitled “The Girl Behind the Eating Disorder: A Case Presentation,” and by a May program titled “The Professor and the Madman: Attempts to Escape an Internalized Object” given by one of our community’s true pioneers, Martha Jo Marsh, who courageously “blazed the trail” for psychoanalytic training in Oklahoma.

**SECTION REPORT: Section V Psychologist Psychoanalyst Clinicians**

**Johanna Krout Tabin, PhD, ABPP**

First Prize in the biennial graduate student essay contest went to David Livney (Chestnut Hill College) for “On Encountering the Unconscious: A More than Twice Told Tale.” Nina Katzander (Adelphi University) won second place with “The Collected Unconscious: First Year Encounters of a Graduate Student.” Both authors were honored at the Toronto Section V reception. Both essays are posted on the Section V Web site (www.sectionv.org). The latest addition to the Web site is a poem that is evoking comment about the psychoanalytic experience.

Plans for the Invited Panel in San Francisco extend from the program in Toronto on new understanding and a pioneering approach to victims of psychic trauma, led by Ghislaine Boulanger. Members Suzanne M. Gassner and Harvey M. Schwartz, who have also developed methods of treatment, will explore ways of understanding and helping victims from the standpoint of dissociative processes and control mastery theory. Mark Mellinger will be the discussant.
BOARD OF DIRECTORS MEETING MINUTES
SATURDAY, JANUARY 27, 2007
SHERATON SEATTLE HOTEL

PRESENT: N. McWilliams, President; D. Ramirez, Past President; D. Debiak, Secretary; M. McCary, Treasurer; Council Reps: J. Darwin, B. Karon, D. Morris, L. Wagner; K. Haley for L. Barbanel; Members-at-Large: M. Charles, M. Cresci, W. MacGillivray, H. Seiden, M. Metzl, J. Logue, J. Slavin, L. Zelnick; Section Reps: A. Brok, Sec I; J. Tabin for J. Bellison, Sec. II; E. Toronto, Sec III; D. Downing, Sec IV; R. Prince, Sec. V; T. Ungar, Sec. VII; G. Stechler, Sec VIII; F. Summers, Sec. IX; L. Rothschild, Membership Committee Chair; Leiani Crane, Committee Chair; M. Jacobs, Immediate Past Division 39 Secretary

CALL TO ORDER AND INTRODUCTIONS: Dr. Ramirez welcomed the members and officially passed the gavel to Dr. McWilliams. Dr. McWilliams called the meeting to order at 8:31 am PST. Members were asked to introduce themselves.

OPENING REMARKS AND REVIEW OF DIVISION INITIATIVES: Dr. McWilliams made opening remarks and welcomed the members. She announced that most of the committee chairs would remain the same. She will continue many of the initiatives of past presidents: including graduate students in committees, reaching out to the community, reaching out to early career psychologists, and continuing to work with and within APA. Her presidential initiatives involve encouraging and supporting psychoanalytic research, healing the rift between researchers and practitioners, and cooperating with other psychoanalytic organizations.

I. ATTENDANCE
A. Substitutions: Dr. Tabin for Dr. Bellinson (Section II Rep); Dr. Kaley for Dr. Barbanel
B. Absent: Dr. Kieffer (no substitute)

II. APPROVAL OF THE DRAFT MINUTES OF THE BOARD OF DIRECTORS MEETING, AUGUST 11, 2006

MOTION 1: To Approve the Draft Minutes of the Board of Directors Meeting of August 11, 2006 as amended. ACTION: Passed

III. TREASURER’S REPORT: DR. MCCARY
A. Draft Budget 2007 -- Dr. McCary reviewed the 2007 budget and explained several line items. She opened the floor to questions and answers.

MOTION 2: To Approve the 2007 Budget as submitted. ACTION: Passed

IV. ANNOUNCEMENTS
A. Multicultural Summit: Dr. Ramirez introduced Daniel Hsu to the Board. Mr. Hsu gave a brief summary of the Summit and his impressions of the meeting.
B. B. State Leadership Conference, March 3, 2007: Dr. Ramirez announced that he will be attending the State Leadership Conference in March.
C. Harry and Miriam Levinson Award Nominee: Dr. McWilliams explained that Division 39 is one of three organizations to nominate individuals for this award. She asked the board to support Dr. Ken Eisold for nomination for this award. Dr. Prince offered to write the letter of nomination.
D. PDM in the APA Monitor: Dr. Jacobs reported on a very positive article which appeared in the APA Monitor. 2006 Annual Report: Dr. Jacobs referred to the Annual Report distributed, which she has prepared for APA.

V. INTRODUCTION OF CAROL GOODHEART
Dr. Goodheart gave a brief presentation on her candidacy platform for APA President-Elect.

VI. OLD BUSINESS
A. Austrian Embassy Freud at 150 Event Proceedings Publication: Dr. Jacobs summarized the event in September and referred to her report included in the agenda packet. She announced that the Proceedings Book will be published and was a collaborative effort of the Psychoanalytic Consortium.
B. Division 39 at Division 19: Dr. Jacobs briefly summarized the meeting of a group of Division 39 members with Division 19. Dr. Jacobs included a report regarding this effort in the agenda packets.
C. 10,000 Minds Project: Dr. Ramirez reported that this project’s committee is moving forward in a very positive and effective direction. He discussed several activities this committee is either working on or has accomplished.
D. Education and Training Committee:
1. Psychoanalytic Internship Sites: Dr. Downing reported on the progress of an effort to post a list of psychoanalytic internship sites on the Division web
2. Model Syllabi: Dr. Downing is working with Dr. Zelnick to get the model syllabi loaded to the web site. He listed several of the syllabi that will be made available.

E. Consortium Report

1. Essential Privacy Principles for American Healthcare: Dr. Wagner distributed a written report for the board’s review.

2. ACPE Funding Request: Dr. Wagner reported that the ACPE asked the Consortium members for additional funding. The Consortium understands the importance of supporting ACPE. The Consortium asked the ACPE to develop a business plan before additional funding would be approved. Dr. Wagner reported that there have been several collaborative efforts amongst the member organizations. One of those efforts is having a representative from each member organization on the American Psychoanalytic Association’s committee on state licensure issues. Dr. Cresci represents Division 39 on this committee.

VII. New Business

A. Bylaws Revisions

1. Article IV, Section 3h (Publications Committee)

**Motion 2:** To approve the amendments to Article IV, Section 3h of the Bylaws as submitted, with changes from the author and accepted by the author of proposed change. 

**Action:** Deferred to the April Board Meeting and a task force will be appointed to clarify the proposed amendment.

2. Articles II and V (Membership and Elections)

**Motion 3:** To approve the revisions to Articles II and V of the Bylaws as submitted. 

**Action:** Deferred to the April Board Meeting and a task force will be appointed to clarify the proposed amendment.

3. Section II Bylaws Revision

**Motion 4:** To approve the revision of the Section II Bylaws as submitted. 

**Action:** Passed with one abstention

**Motion:** To move to Executive Session 

**Action:** Passed.

The Board closed Executive Session at 2 PM.

B. Section III Request

1. APA Guidelines for Treatment with Girls and Women: Dr. Toronto briefly summarized the guidelines and gave additional explanation of the request.

**Motion 5:** To approve the APA Guidelines for Treatment with Girls and Women developed by the Joint Task Force of Divisions 17 and 35. 

**Action:** Passed with 2 abstentions

C. Psychoanalytic Electronic Publishing (PEP) Proposal: Drs. McWilliams and Seiden summarized the proposal that has been negotiated with PEP. Dr. Seiden referred the members to the written report and proposal included in the agenda packets. Board discussion and questions followed. Dr. Seiden along with Drs. Ramirez and McCary were asked to continue negotiating with PEP to map out a more affordable and clear cost analysis.

D. Moratorium Resolution: Dr. Summers summarized the moratorium resolution and asked for Division support of the resolution.

**Motion 6:** The Division 39 Board supports the resolution of Neil Altman, Ph.D., calling for a moratorium on psychologists’ participation in interrogations. 

**Action:** Passed unanimously

E. Division Leadership Conference: Dr. Debiak and Dr. McCary attended the leadership conference at APA. They gave a brief summary of the types of seminars/workshops that were held.

VIII. Committee Reports

A. Program Committee: Dr. Darwin reported on the Toronto meeting and encouraged members to attend. She reported on spring meetings through 2014. Dr. Slavin voiced concern regarding the program assignments for the spring meeting. Dr. Darwin acknowledged that the logistics of scheduling programs is challenging.

B. Graduate Student Committee: Dr. Slavin reported that the graduate student committee is a very active committee. He stated that his co-chair, Matthew Whitehead, has been invaluable. He summarized the programming for the upcoming spring meeting, as well as marketing the meeting to graduate students.

C. Membership Committee: Dr. Rothschild referred to the written report included in the agenda packet. He summarized and expounded on several items in the
1. APA Members withholding dues to protest APA policy regarding psychologists’ participation in interrogations of foreign detainees. Dr. McWilliams held a discussion regarding this particular issue and explained that APA is taking the position that these members are withholding dues rather than resigning membership. Current APA policy is that members who do not pay dues aren’t dropped from APA membership until they are two years in arrears.

D. Nominations and Elections Committee: Dr. Ramirez reported that his committee is working to develop a slate of candidates in time to meet the deadline set by APA to turn in the slate. He noted that the Division lost one Council seat, which changes the number to be elected to that position from three to two.

E. Publications Committee
1. Psychoanalytic Psychology Editor Search: Dr. McWilliams reported that there was an excellent search committee in place and the call for nominations for editor is now out and accepting names. Dr. Maureen Murphy chairs the committee.

MOTION: To continue the Online CE program as described in the written report. ACTION: Passed unanimously

3. Possible collaborative projects with Jason Aronson: Dr. Seiden gave a summary of the collaborative projects that are being discussed with Jason Aronson publishers. Additionally, the publisher is considering offering a book publication prize.

F. Internet: Dr. Zelnick reported that this project is going well. He will work with the Publications Committee to consider a new, updated design of the web site.

G. Newsletter Report: Dr. MacGillivray referred members to the written report.

XII. Adjournment
There being no further business to come before the board the meeting was adjourned at 4 PM PST.

Secretary: Dennis Debiak, Psy.D.
Recorder: Ruth Helein
## 2007 Committee Members

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Dennis Debiak, PsyD
300 South Chester Road, Suite 106
Swarthmore, PA 19081
Phone: 610-690-2442
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Email: DDebiak@aol.com

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Austin, TX 78759
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Fax: 512-338-4752
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DIVISION 39 OFFICE
Ruth Helein-Director
2615 Amesbury Road
Winston Salem, NC 27103
Phone: 336-768-1113
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