FROM THE PRESIDENT

JONATHAN H. SLAVIN, PHD

TIMELINESS AND TIMELESSNESS

There is a well known (to some) passage in the Talmud that goes like this: “After the destruction of the (Jewish) Temple in Jerusalem (in 70 A.D.) Rabbi Yohanan Ben Zakkai set up an academy for the study of Torah in the town of Yavneh.”

What does this have to do with our situation today and with this column? Read on, and I will try to suggest the continued timeliness and relevance of this nearly 2000 year old passage.

I write this column about two weeks before the Spring meeting of Division 39 in New York. The reception at our Spring meeting will have occurred exactly seven months to the day after the September 11 attack. Scenes of horror—and for some of our members in New York and Washington, DC, experiences of terror—have assaulted us for the past seven months. As I write, the violence in the Middle East has spiraled into nearly full-scale war.

By the time you get this newsletter, our meetings will be over, and no one can predict what will happen in the several weeks it will take for this column to make its way into print and into your mail, but perhaps once again the world will have been changed. In that sense, a quarterly newsletter, written a couple of weeks before it goes to press, and then bulk mailed to you for delivery weeks later, is hardly timely (something that will be remedied as our new Internet site is constructed, enabling the newsletter and other updates to be immediately available). But for now, what I write may be hopelessly out of date the moment it gets e-mailed to the editor. Rarely, in our lives, have we experienced such a rapid and shifting sense of how the world is.

Since September 11th—and subsequently, in our visions of extraordinary religious militancy, suicidal attacks, suicide bombers, war and retaliation—we have seen many efforts to understand a world that many of us had come to experience as relatively benign. But I wonder if that benign experience is something of an anomaly, an epiphenomenon, in a longer view of things. The world has not always been benign. Some of our members fought in World War II, Korea and Vietnam. Some are refugees from oppression and the Holocaust. Some grew up in the context of the Cold War, with the background tension of nuclear threat. Some of us may remember the Cuban missile crisis and the horrifying realization, in that moment, that nuclear destruction was not simply a vague possibility that we read about in newspapers.

THE WAY LIFE SHOULD BE

If you drive north from Boston and cross the Maine line you encounter a sign which says, “Welcome to Maine: The Way Life Should Be.” One can feel the tension flowing from one’s body as the sign greets you with its anticipation of a relaxed, unhurried, soul soothing vacation. With the collapse of the Soviet Union, and a decade of remarkable prosperity for much of the Western world, daily life took on a different hue. While it wasn’t quite a Maine vacation, we didn’t worry about our safety, except perhaps on the highways. We were lulled into a vision of the world, and of life, as essentially benign, carrying only the joys and sorrows that we “expect” to experience. This was life as it should be, or should have been, filled with ordinary struggles, as well as moments of satisfaction and happiness.

All that seemed to change, for Americans, on September 11th. I believe the trauma of the experience of September 11th has yet to be fully described. It was not simply the immediate horror and viciousness of this attack that proved so traumatic. It was also an attack on the way we had come to see the world—as we thought it ought to be.

What does this have to do with psychoanalysis? A century ago, Freud began to expand his vision of psychoanalysis. While he continued to develop and change his clinical, technical and metapsychological theories, he took on much bigger issues regarding the nature of human experience. He applied psychoanalytic ideas to literature
HOPE: CONTEMPORARY PSYCHOANALYSIS’ PASSION FOR THE POSSIBLE

Hope is an essential yet often neglected aspect of analytic theory and technique. Considering the events of the recent past it is vital, now more than ever, to explore how contemporary psychoanalysts work with their patients to hold and maintain hope and psychic possibility. Paradoxically, the ability to lose hope or mourn through the recognition of loss and limitation is a necessary part of the analyst and patient’s journey towards creating a new and more positive psychological future. We invite papers that convey different theoretical and technical views of the progressive and limiting uses of hope in the analytic experience. Also welcome are presentations that illuminate what is essentially hopeful and possible in contemporary psychoanalysis from any perspective or area of study.

Keynote Speaker: Steven H. Cooper, Ph.D.
Author of “Objects of Hope: Exploring Possibility and Limit in Psychoanalysis”

DEADLINE FOR SUBMISSIONS: POSTMARKED BY SEPTEMBER 4, 2002

For each submission include:

- Four copies of the proposal with TITLE ONLY (Omitting names). NO FAX SUBMISSIONS PLEASE.
- Cover page containing: Your name(s), address, e-mail and/or fax, title of submission, and for each author her/his primary affiliation and a One-Page Curriculum Vitae.

Additional requirements for specific presentation types:

- FOR PANELS: Four copies of (a) A 50-word overview of the panel, (b) A 350-word abstract for each paper. Panels are 110 minutes in length. We strongly recommend limiting panels to three presenters or two presenters and a discussant to allow for a minimum of 20 minutes of audience participation.
- FOR PAPERS: Four copies of a 350-word abstract. Paper sessions are 50 minutes in length with 15 minutes of the allotted time reserved for audience participation.
- FOR MEET THE AUTHOR: Four copies of a 150-word overview With Name(s) Included. 50-minute format.
- FOR CONVERSATION HOURS: Specify in 150 words the issues to be addressed in this informal 50-minute format.
- FOR POSTER SESSIONS: Graduate and undergraduate students are encouraged to present their psychoanalytically relevant research. Submit four copies of a 150-word abstract. 120 minute format.

*** PLEASE NOTE: ***

1. All presenters must register and pay for the Conference. NO EXCEPTIONS.
2. Only three (3) proposals per person will be accepted.
3. “Psychoanalytic Psychology” has the right of first acceptance for all papers and panels under the aegis of the Division of Psychoanalysis (39).
4. Please direct all questions regarding submissions to conference Co-Chairs:
   Linda C. Giacomo, Ph.D. (612) 872-1161 or LCGiacomo@msn.com
   Trisha A. Stark, Ph.D. (612) 374-4601, ext. 225 or Trishas@visi.com

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and art, to group processes, to religion, to the nature of human civilization, and in one of his final works (Moses and Monotheism), to the human construction of God.

For a good part of the twentieth century the application of psychoanalytic understandings to the human experience continued among some of Freud’s epigones and acolytes. But, apart from the contributions of Freud and Jung, it is not clear how much of a mark these have left in collective Western thinking. Ultimately, the effort to apply psychoanalytic insight outside of the clinical arena felt into disuse. Perhaps this came about because psychoanalysis itself was no longer the most exciting arena of intellectual ferment, no longer the new kid on the block. Perhaps the effort to apply psychoanalysis beyond the clinical arena overreached itself, reworking the ideas of the master, but saying little that was new.

But, a central question remained. Is psychoanalysis truly applicable to understanding everything about the human experience? This is a question I think we ask too infrequently when we venture beyond our area of hands on experience. Moreover, how many minds can truly aspire to take on the “big” questions? While I believe that if we don’t take risks in our thinking we gain nothing new, I think we in psychoanalysis are prone, perhaps more than in other fields, to want for a certain humility in what we think we know and don’t know.

Clinically, however, things have been different. Clinical psychoanalysis, despite its death proclaimed over and over again in the media, continues to develop, to remain alive and filled with excitement, controversy and new paradigms.

After September 11th, which shocked us traumatically and forced us to take notice of other views of life—including a view that exalted self destruction and the destruction of others—there has been of flurry of renewed efforts to expand the application psychoanalytic ideas beyond the clinical arena. Clearly, these ideas, published in newsletters, circulated on the Internet, presented at meetings, and no doubt soon to be published, were not simply a dispassionate effort at understanding. It was our response to trauma (as, no doubt, is this column). As psychoanalytic psychologists we are in the business of understanding. And when we were faced with something that seemed incomprehensible, we have tried to apply our ways of knowing the world, of making sense of it, to these phenomena.

But I am not sure how useful this effort has been, other than providing some sense of security, a feeling of knowing and understanding. Personally, I am a skeptic about the application of psychoanalytic perspectives too broadly. I wonder if our effort to apply psychoanalytic ideas beyond the consulting room is not only illusory, but may foreclose the deeper comprehension that can come only with incorporating knowledge from other fields in which we are not experts—history, economics, anthropology, politics, religion—and equally important, in keeping our questions and our uncertainty on the table without premature resolution, however uncomfortable that may be.

To the extent that our knowledge is useful, it is, I believe, because it is based in experience, real clinical experience, however muddy, unsystematic and complex this may sometimes seem. But how many of us have worked with a suicide bomber, lived in a refugee camp, faced daily humiliation, lived with a sense of constant fear and imprisonment in our daily activities, or even felt grateful to be searched by a guard carrying a submachine gun in order to get into a coffee shop, if we dared to go to one?

Of course, there are some things we know pretty well. One of them, which Freud understood in his earliest investigations, is that the essence of trauma is the experience of helplessness, a massive loss of personal agency, an experience of overwhelming entrapment and incomprehensibility. And one thing we may try to do when faced with this is to DO something to try to recover our experience of agency, to try to feel not completely helpless and meaningless in our lives.

And so we may write and speculate about the meaning of the events, which have so affected our feeling of predictability and control that comes with a more benign view of the world. But I wonder if the timeless wisdom of the Talmudic passage I cited at the beginning of this column might give us another, perhaps more humble, avenue for our efforts and needs. As I understand it, this passage suggests that even in the face of the most terrible destruction and loss, it is important, vital, the essence of life, to go on with life, and that the most important way to do this is to insure its continuity, the continuity of our values, belief and knowledge, through our own study and—in a way which is sure to challenge our sense of knowing and certainty—the education of those who follow.

In our own small, parochial way, in our small corner of the planet, this has been what the recent initiatives in Division 39 have been about: to revitalize the teaching and learning of psychoanalysis, both in form and substance, to insure its continuity, to provide the gift of the excitement we experience in this work to the next generation. It is in these efforts that we DO something, that we affirm life in
the face of darkness and provide for the possibility of growth for ourselves and those who follow us in the future.

I hope these comments are understood in that context and have not been themselves too overreaching. I welcome your reactions to these thoughts and will print those I can in the next newsletter.

Now for some mundane matters, still of importance to us in Division 39.

First, the warmest congratulations to Elaine Martin and her extraordinarily effective committee on the success of the program of the Spring Meeting. This program has it all. It is all of what is exciting and interesting in psychoanalysis today, from every point of view and vantage point.

In addition, we are especially grateful to the truly loving care demonstrated by Natalie Shear and her associate, Jen Grudza, who have had to deal with no end of challenges and last minute surprises no one could have anticipated. They dealt with them with grace, professionalism, creativity and even good humor. We are fortunate to be working with this group of professionals.

And, following up on some of my presidential initiatives, I would like to welcome Dennis Debiak as the new Chair of the Committee on Sexual Identity and Gay, Lesbian, Bisexual and Transgendered Issues. This committee, a long time in coming, was approved by the Board in January. And welcome to committee members Victor Bonfilio, Randi Kaufman, Bethany Riddle (Grad Student), John Rosario-Perez and Barbara Artson.

Welcome also to Margaret Fulton from Minnesota and Danielle Knafo from New York as co-chairs of the newly reconﬁgured Public Information Committee. They will be announcing their committee membership and plans for the year in the next newsletter. I know they bring the energy, fresh ideas and political savvy this job requires.

Finally, perhaps in keeping with the theme of this column, we have been able to deliver on the commitment I made to include graduate students on all of the Division’s committees. A list of these new members of our effort to involve students in the work of the Division and in our future follows below.

In the meantime, if you have plowed though this, thanks for reading.

Feel free to contact me at jslavin@aol.com

GRADUATE STUDENTS NEWLY APPOINTED TO DIVISION COMMITTEES

Claire Haiman, Rutgers: Education and Training Committee
Sera Morelli, Illinois School of Professional Psychology: Graduate Student Committee
Elisabeth Morray, Boston College: Graduate Student Committee
Denise Schieren, CW Post: Graduate Students Committee
Martha Temple, Rutgers: Internet Committee
Tal Lee, CWPost: Membership Committee
Lisa Orbé, Columbia: Multi-Cultural Committee
Lucy Takagi, Rutgers: Multi-Cultural Committee
Silvia Gosnell, Adelphi: Publications Committee
Karen Tilman, St. Johns: Ethics Committee
Lauren Noll, Adelphi: Infant Mental Health Committee
Bethany Riddle, Duquesne: Committee on Sexual Identity & LGBT Issues
Elizabeth Moran, California Institute of Integral Studies: Awards Committee
I hope that you will enjoy the many fine articles that were submitted for this issue. One important part of the mission of the newsletter is to keep members informed of the many activities and projects undertaken by the leadership of the Division. This issue has much to offer beginning with Laurie Wagner’s update on the Psychoanalytic Consortium and the development of accreditation institutions that will succeed the Consortium’s efforts. This issue also includes the minutes from the August Board Meeting. I know that it can be a daunting task to read meeting minutes but I encourage you to peruse some of the discussion and familiarize yourself at least with one important issue discussed at the board meeting: the future of communications in the age of e-mail and the Internet. (One of the grammatical conundrums to track over the last few years has been spelling of new words with e.g., “electronic mail” being shortened to “E-mail,” then to “e-mail”, and now, simply “e-mail.” The neologism Internet being downgraded to internet. Being conservative, I am holding out for e-mail and Internet. And you thought being an editor was a boring job!) In addition to these reports there are seven committee reports and four section reports.

As in the last issue, there have been a number of contributions from members writing about the events of September 11th and I think this is certainly a testimony to the trauma of these recent events that impel people to want to share their experience even as much of what is shared reflects how unspeakable our feelings and reactions are.

There are two Special Sections in this issue—On Research and On Couple Therapy. Our editors Ablon and Levy heavily edited the articles on gender and psychotherapy since they were so filled with information and data. The references were left off in order to save space as well. It was a difficult decision but anyone interested in reading the entire articles and/or receiving the reference lists should contact the authors who will be quite willing to share the information with our readers. Carolynn Maltas is the editor of the section On Couple Therapy and this is the conclusion of the series begun by Mary-Joan Gerson.

Once again there is an extensive book review selection and I think you will enjoy the range of books reviewed. Mary Pharis, Diane Gartland, Kay Saakvitne, Charles Spezzano, Nancy McWilliams and Spyros Orfanos are to be commended for being willing to write the reviews and endure my entreaties to get the books reviews in on time. (Since this issue was supposed to have ten reviews, those who resisted my pleas shall be nameless.) Later in the issue is an update I wrote on the National Coalition. If you are interested in purchasing any of the books reviewed here, or any books, please do the Coalition a good turn and order your books through the Coalition web site’s link to Amazon.com. Amazon makes a contribution to the Coalition for every book purchased.

There are two other contributions from members in this issue. Karen Zelan writes about her work with autistic children and Kenneth Isaacs shares his provocative views of psychoanalytic theory and ideas of cure and change. That’s it. Good reading!

Oh yeah! We received the candidate position statements in the mail this week. It is a privilege to run for office and a way to demonstrate commitment to service to psychoanalysis. Please do your part and read the candidates’ positions and vote when the ballots arrive in the mail.
Analytic press
THE PSYCHOANALYTIC CONSORTIUM AND THE ACCREDITATION COUNCIL FOR PSYCHOANALYTIC EDUCATION: THE FUTURE IS BRIGHT

LAUREL BASS WAGNER, PhD, CHAIR, CONSORTIUM COMMITTEE

Since agreeing upon and passing The Standards of Psychoanalytic Education, the Psychoanalytic Consortium has focused its efforts on the formation of the Accreditation Council for Psychoanalytic Education (ACPE) and defining membership criteria so that other organizations may join the Consortium. Given that the focus of work is now moving from the Psychoanalytic Consortium to the ACPE, the Consortium has begun to meet twice yearly rather than three or four times yearly, as the case has been in the past.

The ACPE has been incorporated, with Richard Fox, MD, Sheila Hafter Gray, MD, Crayton Rowe, MSW, and Nathan Stockhamer, PhD, as the original incorporators. These four incorporators, while each appointed by the Consortium component organization to which he/she belongs do not represent that organization as an incorporator. Their task is to incorporate ACPE and elect the first ACPE Board of Trustees, which will consist of twelve members. The Consortium’s four component organizations (The American Academy of Psychoanalysis, The American Psychoanalytic Association, The Division of Psychoanalysis, American Psychological Association and the National Membership Committee on Psychoanalysis in Clinical Social Work) will each nominate by July 1, 2002 at least three candidates to be considered by the ACPE incorporators for election to the ACPE Board of Trustees. The ACPE Board of Trustees will then have the task of drafting bylaws and developing a program to implement The Standards of Psychoanalytic Education. Public members, also, will be added to the ACPE Board of Trustees.

While the Psychoanalytic Consortium is facilitating the formation of the ACPE, the Consortium and the ACPE are completely separate entities. The members of the ACPE Board of Trustees will not represent any component organizations of the Psychoanalytic Consortium and will not be eligible to be representatives to the Psychoanalytic Consortium nor members of the governing bodies of the Consortium’s component organizations. This separation between the two organizations is essential in light of the bylaws of the American Academy of Psychoanalysis and the American Psychological Association, both of which prohibit their respective organizations from participating in accreditation. Those in Division 39 may recall that a similar issue arose regarding credentialing with the formation of ABPsAP in that the American Board of Psychoanalysis in Psychology was, and is, completely independent and separate from the Division of Psychoanalysis, while being started by leaders within Division 39. The experience of those members of Division 39 who toiled so hard at forming the now very successful ABPsAP is helpful to those of us representing Division 39 in the Consortium as we map out the formation of ACPE.

At the most recent Consortium meeting in February 2002 a motion was passed in which each component organization would give one dollar per member to the ACPE for seed money. This motion was contingent on the approval of the governing bodies of each of the component organizations. This money is necessary to help the ACPE get off the ground. The ACPE, of course, will need to find ways to generate money to sustain its operations, with the main operation being that of accrediting psychoanalytic institutes. Division 39’s Board of Directors will address this motion at the April 12, 2002 Board meeting.

The Standards of Psychoanalytic Education are historic-setting, for they represents an unprecedented meeting of the minds regarding psychoanalytic training standards by four major psychoanalytic organizations in the United States. The component organizations of the Consortium represent close to 10,000 mental health professionals (medicine, psychology and social work) and it is the position of the component organizations of the Consortium that psychoanalysis is an advanced specialization within the mental health professions. The Nursing profession was initially invited to join the Consortium, but declined to do so; nonetheless, a RN, with a PhD or a Master’s degree with Clinical Specialist certification is cited in The Standards of Psychoanalytic Education as a degree from which one can go on to specialize in psychoanalysis. The Standards of Psychoanalytic Education encompasses diverse training models and does not adhere to any particular psychoanalytic theoretical orientation. The Psychoanalytic Consortium walked a balance beam in agreeing upon standards of psychoanalytic education that recognize diversity in training while not being so inclusive that the standards set no standards at all.

Once the ACPE has a Board of Trustees, enacts its bylaws and begins the process of implementing The Standards of Psychoanalytic Education it, also, will be historic-setting. No such organization currently exists in psychoanalysis in the United States. No organization is recognized by the Department of Education (DOE) or the
Council for Higher Education Accreditation (CHEA) as an accrediting body for psychoanalytic training institutes. ACPE will be working with the Department of Education to be recognized as an external accrediting agency for psychoanalysis in the United States.

In the past other organizations have made applications or written letters of intention to the federal government to become an external accrediting body in psychoanalysis (e.g. NAAP, the American Psychoanalytic Association, the IPS), but all these attempts have failed. The ACPE is likely to succeed in this regard because of the painstaking work of the Psychoanalytic Consortium to reach a unanimous agreement regarding standards of psychoanalytic education. While three organizations, the American Psychoanalytic Association, the International Psychoanalytic Association and the American Board of Psychoanalysis (associated with NAAP) currently accredit institutes, they only accredit within their own organizations. None have the authority to accredit outside of their organizations. If it succeeds, ACPE will be in a unique position as the only organization with the ability and authority to provide external accreditation for psychoanalytic institutes. Many independent institutes have not sought accreditation and one of the reasons is because an organization such as the ACPE has never existed. It is exciting to contemplate what ACPE has to offer psychoanalysis once it becomes a fully functioning organization. Interest in the Consortium and the ACPE continues to grow. Three organizations, the Association of Autonomous Psychoanalytic Institutes (AAPI), the Council of Psychoanalytic Psychotherapists (CPP), and the Confederation of Independent Psychoanalytic Societies (IPS) are in the process of applying for membership in the Consortium.

Laurel Bass Wagner is Clinical Associate Professor of Psychology at the University of Texas Southwestern Medical School at Dallas and is in private practice in Dallas. In addition to serving as Past-president of the Division, Laurel will continue to serve as the Division’s representative to the Psychoanalytic Consortium.

Remembering Gertrude Blanck

Gertrude Blanck died on September 29th, 2001 after a long battle with cancer. Those of us who knew her well will miss her strong and lively presence, her shining intelligence and her unwavering love of psychoanalysis in all its varied dimensions. In addition to the sense of loss felt by her students, colleagues, friends, and family is the gap her absence leaves in the field of mental health, in psychoanalysis and beyond, for Trudy, as we called her, was in many different ways a pioneer.

One of the ways her innovative spirit found expression was in her attitude toward teaching and training. She, with her husband Rubin, long ago recognized that social workers had joined psychiatrists and psychologists in providing a large segment of the population with much needed psychotherapy. Together they formed an institute, which provided training for psychotherapists from all three of these disciplines. Back in 1969 when the Institute for the Study of Psychotherapy was formed, the interdisciplinary nature of its student body represented a break with tradition, but that was only the first step in the creation of an approach and attitude towards training that had no precedent. Trudy, psychoanalyst to the core in her own practice, recognized that psychoanalysis as a modality was not available or even appropriate to many of the patients treated by her students. While she was not unique in recognizing this fact she was determined and successful in finding a remedy. She developed a curriculum that while grounded in classical psychoanalytic theory, was expanded to include the contributions of the early ego psychologists, those gifted theoreticians who added the dimension of early normal development and object relations to psychoanalytic theory building. She was so skilled at extracting the absolute maximum in her study of theory, and was so creative at integrating various perspectives that her students were presented with a theoretical approach that was grounded, disciplined, yet highly flexible. And it fit the wide range of diagnostic entities found in an ever broadening patient population. Thus, she found a way of conceptualizing psychoanalytic psychotherapy as a specific treatment modality, exquisitely formulated, complex and highly adaptable.

How did she do this? By being a true scholar and thinker. By reading Freud with equal interest in his thinking and in the revisions of his thinking. By reading his followers and teasing out all that was valuable and novel and useful. By teaching her students from the vantage point of the evolution of psychoanalytic theory building so they would have a feel for the complexity of what these theorists tackled, and for their approach to problem solving and for the sheer creativity of the men and women who shaped the core of our theory. And she also accomplished her objective by listening well and with care to her students when they presented their clinical material, or asked questions, always alert to and interested in the compatibility of theory with practice.

Trudy loved psychoanalysis. She loved the theory and she loved the practice. She read the journals with the same attitude of excitement and anticipation some of us feel for a good novel. She loved to teach, to supervise, and to
write. In addition to her great love for her field she was married to a man who shared her interest and together they wrote a series of extremely valuable books, which were translated into many languages and used widely all over the world. I remember how exciting it was to have in hand the first of the Ego Psychology books, *Ego Psychology: Theory and Practice* (1974). Here was the written version of so much of what we had discussed over the years, written in that wonderfully clear language that captured the essence of what was most valuable to the clinician. To have studied with Trudy and read her books and articles cured many of us of ever accepting hazy knowledge. Ambiguity was one thing. That was a part of our work with patients, something to be respected. To not know where the material was going, to not assume, to be patient and curious, that is a sacred part of our clinical work. But hazy knowledge became not acceptable. Being hazy meant that one had not taken the study far enough. Trudy was always clear and succinct. She was a generous and committed teacher who really wanted her students to learn and patiently stayed with a complex idea until, we understood it. She set a high standard for teaching as well as for learning.

But I have gotten ahead of myself. I haven’t yet mentioned that some of us, upon graduating from the institute, continued studying with Trudy for a long time. She held what came to be called The Monday Morning Seminar and a group of about twenty of us attended this for many years. When I joined it had already been ongoing for some years and I attended for another dozen. The subject was psychoanalysis rather than psychoanalytic psychotherapy. Because Trudy was a serious thinker with an independent spirit her view of psychoanalysis as a treatment modality was not fixed. It evolved over the years and as long ago as the 70’s she came to regard the existence of a continuum reaching from psychoanalysis to psychoanalytic psychotherapy. This was in contrast to the more traditional position that placed a sharp divide between these two treatment techniques. The seminar became a forum for her innovative ideas and for our questions and comments. It was an immensely stimulating experience. I believe that the excitement generated by the dialogue had the reciprocal effect of sparking her thinking and ours.

As she grew old she observed with interest the continuing evolution of psychoanalytic theory. She felt that some of the new ideas were in fact new and fine, while others had been there all along but not given their current prominence. And when that was the case she lamented that “a part was being presented as the whole,” and she was saddened by the reductionism.

It is hard to end my remembrance of this extraordinary woman, a woman who helped and taught so many people. So let me close with this. Her marriage was a marriage in the deepest sense, her daughter a source of pleasure and pride, her career splendid and fulfilling. Hers was a life lived to the fullest, a marvelous life.

*Diana Siskind is a psychoanalyst and a psychoanalytic psychotherapist. She is the author of 3 books: The Child Patient And The Therapeutic Process, Working With Parents, and A Primer For Child Psychotherapists. She practices in New York City.*
I kept thinking that I could write more clearly about Sept 11 when it is all over. Perhaps I could sit in my armchair and reflect. But that, of course, is a fantasy. It is not over and will not be over. We will be facing the aftermath of this tragedy and its impact on our patients, our families, our communities and ourselves for a long time. The anthrax scare and the various airline incidents lead us to believe there is likely to be more. As psychoanalysts do we have something to contribute to an understanding what happened and continues to happen? As behavioral scientists do we have something to say? Did we think of these things on Sept 11?

As a psychologist psychoanalyst living and working just over the bridge from the WTC, I have been totally immersed in the events of Sept 11. Since I have been part of the New York State Psychological Association Disaster Relief Network for sometime, and was called to register at the Red Cross to work at a particular site shortly after the disaster occurred, then to be told, “No, the need is somewhere else.” The confusion was widespread and nobody quite knew where to go to be helpful. Many psychologists were frustrated with the Red Cross and became angry. I did run into many psychologists that I know in New York, and many Division members, as I did work in the disaster. It was always comforting to see a familiar face, a friend, and a colleague at the switching of shifts or to see a familiar name in the logbook from the shift before mine.

I ended up working in a number of settings: shelters for displaced people, the “Compassion Center,” which was set up for the families of individuals who were “lost,” and at a “Service Center” for people who were working at the WTC who need economic and other help as well as for people who were displaced from their homes because of the disaster. The breadth of these experiences begins to demonstrate the breadth of this disaster. The Compassion Center was the saddest. Set up in an Armory, families of victims, people who were last seen in the WTC and were referred to as “lost,” came to look through hospital lists to see if perhaps their loved ones could be found. Rarely was anyone located. The hospitals in NYC had been on alert for emergency care. Physicians waited, but there were few admissions. There weren’t many admissions because so many were “lost,” the euphemism for those that perished.

What did we do as psychologists? Not therapy, as we know it, but “emotional first-aid.” Some families were very contained and did not wish any emotional help. Others sat down and wept and wanted contact. A man from India asked me if I could speak to his young, pregnant wife about the loss of her brother. A worker asked me to speak to a young African-American man who was looking for a woman who had at the time of the attack fallen down on the ground in front of him, told him she was not going to make it and gave him her student ID card and her keys. He was weeping because he felt he hadn’t helped her enough. He was hoping to find that she had survived. In the meantime he was walking around with her keys and ID card. In the armory the walls were plastered with pictures of people who were lost. To me it seemed as if they were all 28 years old. The pictures were all of happy occasions: a wedding, a boating trip, and a father holding a child. So many of the people looking were the parents of the victims. But there were wives and husband and girlfriends and boyfriends. There were the representatives of various governments who were looking for their citizens who had been working there. It would be their job to inform the families of the deaths of their loved ones.

The headlines tell you of the large companies that lost thousands of people. Talking to immigrant parents of an only son who was lost, to the husband of a woman who perished and left three small children all under five, to the brother of a woman whose husband was lost and could not bear to come to this place, gives you yet another picture of this tragedy. Responding as a psychologist calls for a different response than we have been trained to make. First of all, we need to be sensitive to whether to respond at all. Some people wanted help and can ask for it. Others
would rather be left alone to find their own resources. Many, however, would like help and cannot reach out. To distinguish between the latter two types of people requires sensitivity that we are rarely asked to have. Were we doing anything that approached psychoanalysis? Clearly not. All of us who did this work were there as healers and as individuals who wanted to help. Helping no doubt made us feel strong in the face of helplessness.

I have worked with people with PTSD and in disasters before. This one is different in a number of ways. The magnitude is larger than anyone has experienced before; the systems set up to deal with it involve more agencies and governmental bodies, both city, state and federal. In places there was overlap of services and in places there were and are gaps. As psychologists working in it we were traumatized in a way that we do not find ourselves when we go into other kinds of disasters. At the same time that I was talking to the family of a victim, I stopped for a moment to think of a friend who lives in Battery Park City and I had not been able to reach. Transportation was disrupted; how to get home after the shift became an issue. For many of us in NYC, every part of our lives was affected. Every patient had a story and feelings that have to do with this disaster. Every student had a concern. By Friday after the disaster, I had calls to see people who had been affected: a woman, who had escaped, a relative of a passenger on one of the planes. In my position at Brooklyn College I was asked to be part of a group that developed the college’s response to the disaster, one that would serve students, faculty, and staff.

In my work within this tragedy, I was particularly struck with the acts of generosity and graciousness displayed by people. The newspapers showed pictures of potential blood donors lined up around the block, waiting to donate blood. But there were many other acts of kindness, both large and small. The day it happened, many of the finest restaurants in New York City sent food down to the rescue workers. One Red Cross worker that I spoke to told me that she felt a bit strange standing at ground zero and passing a tray of chocolate covered strawberries to rescue workers. They loved them. The gifts of food, clothing and other items requested for the rescue workers and families of victims was overwhelming. The Red Cross could not handle the number of volunteers that showed up. Thousands of people had to walk across the Brooklyn Bridge to get home that evening. Individuals in Brooklyn Heights got water and cups from local supermarkets and handed out water to people as they came off the bridge. Court officers from the Brooklyn courthouses were there to assist people who, unaccustomed to the strenuous walk, needed medical assistance. One of the most touching experiences that I had was when I left the Red Cross headquarters late one night I was stopped by a police officer who asked me if I wanted a free taxi ride home. I told him that I was heading for Brooklyn. He said that was fine. There was in front of the Red Cross headquarters a line of taxis standing there prepared to take people involved in this effort home. This was their volunteer service. I entered a cab driven by a Sikh driver. His English was broken, but he wanted to tell me his story and to hear mine. The Red Cross had debriefed me before that, but this was my real debriefing for the day.

I could go on with the stories that I heard, with the bravery and heroism that I saw, but I need to think about what I learned and where we go from here. I learned that psychology could have an enormous impact on everyday life. I saw in the various facets of my experiences how much psychology has to offer and how much psychoanalysis has to offer in the public arena in the face of disaster to assist the healing process. I learned that psychologists and psychoanalysts are a brave lot and a giving group. Nobody asked anyone exactly what they were doing, people worked together and grappled with the job that needed doing. I learned a lot about the graciousness of giving in a way that I only thought about before. I think we saw the worst human evil in this tragedy as well as the best that people can provide for each other.

There is much work to do in the wake of this event. The Board of Directors has formed a subcommittee on Psychology’s Response to Terrorism, of which I am a member. Terrorism is psychological war. It is the process of creating fear and anxiety in a population. Psychology and psychologists have the expertise to spearhead the effort to combat the affect on the population. Psychoanalysts with deep understanding of human motivation and understanding of psychology in everyday life have an important role to play. We need to understand and to help deliver ways of coping to a frightened population. We can make a significant difference and need to begin to do so.

Laura Barbanel, EdD, ABPP, is on the Board of Directors of the American Psychological Association. She is Professor and Program Head of the Graduate Program of School Psychology at Brooklyn College of the City University of New York and in private practice in Brooklyn Heights. She had been in the NYSPA DRN for some time and has been involved in the WTC disaster relief work. She is also a member of APA Board of Directors subcommittee on Psychology’s Response to Terrorism.
I look at the world and I notice it’s turning
While my guitar gently weeps
With every mistake we must surely be learning
Still my guitar gently weeps
George Harrison, 1968

I still weep for the losses we sustained on September 11th. So many people—too many to fathom. We who are New Yorkers have lost a part of our city. The Twin Towers seemed so solid, so permanent, so much a part of New York. The Pentagon… damaged and on fire. We lost our naivety and our sense of safety. Suddenly, we are so very vulnerable. And very, very sad.

How could this happen? No group is in a better position than those in the mental health field to understand the potential for destruction held by disturbed societies and disturbed psyches. We did not use what we know to inform our people and our government of the potential danger. From this point forward, we must be aware and we must use our understanding of mind and behavior to inform and to warn.

In *The Anatomy of Human Destructiveness* (1973), Fromm wrote of malignant aggression, which includes sadism (the passion for unrestricted power over another sentient being) and necrophilia (the passion to destroy life and the attraction to all that is dead, decaying, and purely mechanical). Fromm wrote this book to analyze the nature and the conditions of malignant aggression, for he knew malignant aggression was a danger to man’s very existence as a species. Indeed, fearing that Saddam Hussein, bin Laden (if he is still alive), and others of their ilk have nuclear devices or massive amounts of war-grade biological and chemical weapons, we can envision the death of millions…and maybe of life itself.

Fromm declared malignant aggression “evil,” and wanted us to know what evil looks like before it is too late. His analysis of destructiveness included an analysis of Adolf Hitler. He wanted us to know that there were many potential Hitlers. He wrote:

I believe that the majority of people do not have the intensely destructive character of a Hitler. But even if one would estimate that such persons formed 10% of our population, there are enough of them to be very dangerous if they attain influence and power. To be sure, not every destroyer would become a Hitler, because he would lack Hitler’s talents; he might only become an efficient member of the SS. But on the other hand, Hitler was no genius, and his talents were not unique. What was unique was the sociopolitical situation in which he could rise; there are probably hundreds of Hitlers among us who would come forth if their historical hour arrived (pp. 480-481).

The historical hour is here for many men in the Middle East. Malignant aggression in the form of sadism and necrophilia are described as “character-rooted passions” that develop as forms of relatedness. Fromm believed that we all have certain existential needs, such as the need to be related to others, to have an impact on others, to be devoted to something, and to achieve a sense of oneness and unity. He believed that we lack the instincts necessary to satisfy such needs and must, instead, develop automatic ways of reacting to these needs. The character-rooted passions are our own unique ways of satisfying these needs. Fromm wrote that if we grow up in a generally life-furthering environment (family and society), we would develop the biophilous passions of love, tenderness, justice, and the desire to grow things and to further life. If life-furthering solutions to our existential needs are frustrated, we are likely to develop the character-rooted passions of hate, greed, jealousy, envy, cruelty, narcissism, and destructiveness. Destructive relatedness might develop as the desire to control others (sadism) or the desire to tear things apart and bring living things to a stop (necrophilia).

In particular, Fromm saw the necrophilous character as one whose passion it is to transform that which is alive into something unalive, to destroy for the sake of destruction, to tear apart living structures. Such a person believes that the only way to solve a problem or conflict is by force and violence, not by sympathetic effort, construction, or example. There is a marked interest in sickness in all its forms. He said that the necrophilous person is attracted to all that is dead, decayed, putrid, and sickly, and to all that is mechanical. In addition, he wrote that they are attracted to bad odors and “look as if they are always smelling a bad odor,” as if mankind itself was putrid to them. He emphasized that this was a characteristic of Adolf Hitler. Interestingly, the most prevalent picture of Bin Laden shows an expression that looks as if he had just smelled something foul.

Fromm wrote that the character-rooted passions form the basis for man’s interest in life, his enthusiasm, and his excitement. They underlie dreams, religion, myth, drama, and all that makes life worth living. He believed that man seeks drama and excitement, and when he cannot get satisfaction on a higher level, he creates for himself the drama of destruction. He wrote that the passions are “man’s attempt to make sense out of life and to experience the
There are undoubtedly also political and economic reasons that contribute to the anger and destructiveness of so many young men. Certainly, there are political and business leaders there who oppress their own people. Fromm said that necrophiles want to destroy everything and everybody, often even themselves; “their enemy is life itself” (p. 387). They may describe themselves as great liberators and builders and saviors, but in truth, they are using the social, economic, and political situation to feed their own needs. Usually, they bring massive death and destruction to their named enemies and, ultimately, to their own people.

Understanding the personal and family dynamics of the terrorists and political leaders and studying the impact on the human psyche, heart, and soul of the social, political, and economic conditions of the area will provide some of the information the whole world needs to know in order to prevent future terrorism, war, and mass destruction.

However, if we do not also look honestly and without defensiveness at the Israeli-Palestinian conflict and at our own political stands in the Middle East, we will likely miss important factors in this violence. Very basically, though it sounds simplistic, we need to ask how each side makes the other feel. Are we as innocent as we would like to believe, or have our businesses and governments been exploitative and arrogant in our dealings with the people of these areas? Have we supported oppressive regimes for our own advantage? Do we have our own corporate and governmental leaders who manifest destructive character-rooted passions? Have our actions made it easy for terrorist leaders to point to us as the enemy?

Destructive and exploitive leaders in business and government damage the psyches of those subject to their power. They have the potential to thwart life, freedom, and growth. If our businesses and governments have contributed to the demoralization, poverty, and sense of impotence of the people, then we must make major changes in our corporate and governmental policies. There may be nothing wrong with seeking oil and doing other business in the Middle East, as long as we are respectful to the people of those nations.

We know the cycle of mistreatment and hate, the cycle in which one who is deeply hurt grows up to hurt others. We also know the cycle of love, responsibility, and caring; the cycle in which one who is loved, cared for, and respected grows up to love, care for, and respect others.

Those who study the field of mental health know how to describe dangerous persons, groups, and governments. We know how to describe the conditions needed for the development of the destructive character and of destructive societies. I hope our professions will use what they know to warn others when we see destructive people.

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The Psychoanalyst as Community Practitioner

Mark B. Borg, Jr., PhD

Although most psychoanalysts don’t think of themselves this way, so many of them responded to a community-level crisis—volunteering their services around the World Trade Center disaster—that it is clear that psychoanalysts do sometimes operate as community practitioners.

I believe that the theory and practice of crisis intervention could profit greatly by cross-pollination between the psychoanalytic point of view and the experience of community psychologists. To illustrate the benefits of such a consolidation, I want to consider—as a practicing community psychologist and psychoanalyst—the conflicting motivations that practitioners may experience and/or enact in the context of disaster intervention. I contend that the practice of creating and sustaining collaborative processes throughout a crisis intervention is an important intersection between community psychology and contemporary psychoanalytic theory and practice.

Role and Anxiety-Reduction

Immediately following the World Trade Center attack, abrupt changes took place in the architectural, social, and emotional atmosphere in New York—to such a degree that we were all challenged to reframe the ways that we understand problems, solutions, and the process of collaboration. At the least, the crisis and the tragedy has given us an opportunity to assess the motivations inherent in our day-to-day roles, and how we benefit (e.g., contain underlying anxieties) through role/identity maintenance.

One of hundreds of New York practitioners awaiting assignment and deployment at the Red Cross in the hours after the Twin Towers were attacked, I could feel the helplessness reverberating through the service-providing community that day. People were itching to get into action and became increasingly anxious as the waiting period dragged on. Small bands of practitioners planned surreptitious, makeshift interventions, some of which entailed fancied visions of getting to what would later be called “ground zero.” Arguments broke out between practitioners and Red Cross workers. There was competition among the practitioners over who would be called to intervene.

In the context of such overwhelming anxiety as we experienced in the disaster relief efforts on and subsequent to September 11, 2001, standard practitioner roles became make-shift, uncertain, and shifting. The Red Cross itself served as a substitute anti-anxiety system that practitioners could tap into to regain a sense of role and purpose. The anxiety related to actual disaster experience was being processed through an organizational structure which substitutes action for powerlessness and then exports people in crisis-defined roles (inhabited by practitioners); these then intervene in the more wide-scale insecurity that has been unleashed in the community.

The training of Red Cross “disaster mental health workers” is geared toward prevention of post-traumatic symptoms. The community psychologist Julian Rappaport (1981) poses a potential problem in prevention philosophies:

Prevention programs aimed at “high risk populations,” especially programs under the auspices of established social institutions, can easily become a new arena for colonization where people are forced to consume our services...thereby providing us with jobs (p. 152).

To have a “job” in this scenario is to have an ongoing and potentially empowering means of dealing with the acute stress created by the tragedy. Yet the same scenario implies a vision of the community wherein one group (help-givers) establishes a false dichotomy between themselves and the group of “victims.” (Countertransferential) anxiety-reducing motivations may be submerged beneath the “good intentions” that also motivate the response to disaster. Such splits may create and sustain blind spots around the ways that those in the help-giving community have themselves been impacted by the tragedy and result in the enactment of disavowed trauma or anxiety.

An empowerment approach, in contrast with the prevention approach discussed by Rappaport, redefines the practitioner’s role relationship with the target population. Our role becomes one of collaborator/facilitator rather than “expert.” As collaborators, we learn about the participants through their cultures and their struggles. Our skills, values, or plans are not imposed; rather, we become resources for the community. This role relationship suggests that what we do depends on the particular place and people with whom we are working, rather than on the predetermined technologies that are applied in all situations (Rappaport & Seidman, 2000).

Colonization and Empowerment

Rappaport (1981) states, “By empowerment I mean that our aim should be to enhance the possibilities for people to control their own lives” (p. 154). Rappaport’s definition takes on a new ambiguity, however, when traumatic events motivate us to enact help-giving roles in order to suppress a full awareness of the anxiety and powerlessness that threatens our own sense of security. Whatever the context, it behooves us to be wary of the problems implicit in the desire to “empower” others, as opposed to supporting them.
in their own self-defined approaches to working through trauma. Empowerment is internally-drive and sustained. When this is not the case, it is possible that “empowerment” has been corrupted into an implicit power tactic that may underlie the desire (or need) to change/help others. However seemingly necessary any change process may appear in the context of disaster, such desire/need is a common underlying motivation in colonizing practices—the processes whereby one culture imposes its values and assumptions on another (Ashcroft, Griffiths, & Tiffin, 2000).

Illich (1976) describes a form of cultural iatrogenesis in which the belief that experts should solve our problems for us creates a culture of alienation and wide-scale hopelessness about the ability to control one’s own life. One of the primary aims of terrorism is precisely the provocation of feelings of that kind. Colonizing practices, countertransferentially submerged beneath crisis intervention, can iatrogenically amplify insecurity and terror such as were brought, full-force, into the lives of New Yorkers on September 11, 2001.

Smith (1999), in his evaluation of a failed empowerment project in South Africa, suggested the following questions as a conceptual framework for preventing potentially empowering interventions from becoming unwitting forces of colonization: 1) To whom am I accountable for my work, and in what ways can they best benefit from the project? 2) How do I stand to benefit from this project myself? 3) How can the project best suit the local context? 4) How does my approach prevent me from seeing alternative perspectives? 5) How do my values influence why I choose to do this project? (p. 14).

This framework serves as a system of checks and balances that can help us delineate and reframe our own conflicting motivations without having to enact them in ways that transform potentially help-giving practices into security operations that “benefit” primarily ourselves. It can also help us recognize the possibility that it is precisely in the aftermath of disaster that we, as practitioners, may be especially vulnerable to this pull.

The Collaborative Process
Interpersonal psychoanalysis emphasizes that the practitioner’s ever-present, though not always conscious, role is one of participant-observer (Sullivan, 1953), rather than neutral, authoritative social scientist (Mitchell, 1997). Interpersonalists are also interested in the “real,” as well as the “distorted” or fantasy-based aspects of transference experiences (Fiscalini, 1994; Levenson, 1991); indeed, my colleagues and I have found the study of these manifestations of unconscious process in community work through exploration of its transference-countertransference dimensions has enabled a much more satisfactory understanding of our own past work (Borg, Garrod & Dalla, 2001).

However, as important as I believe the transference-countertransference dimensions of community work to be, I would like to address here a topic that is a primary focus both in contemporary community psychology and in contemporary psychoanalytic discourse—the collaborative process. The participant-observer stance can help practitioners address Smith’s questions, because it encourages us to maintain a conscious focus on our own motivations, reactions, investments, anxieties, etc., as they relate to the traumatic events and as they surface in our engagements with community members. In the context of this need for collaboration and awareness, I will now attempt to describe a collaborative community intervention process that was initiated at the time of the World Trade Center disaster.

Community Crisis Intervention
I belong to a multidisciplinary community crisis intervention team, whose members possess expertise ranging from community and organizational psychology to public law and psychoanalysis. In the week following September 11th, we contacted the New York State Psychological Association and volunteered our services. We have, since then, been meeting weekly to address what we would need from each other to be able to sustain a long-term approach to community intervention in this crisis. A primary focus of our meetings is how to facilitate this intervention without having to assuage our anxiety by demanding certain results from the community.

Two weeks after the tragedy the vice-president of a large public service organization called us. She explained that five of the organization’s thirty operational units had been in the immediate vicinity of the World Trade Center. Various unit managers had contacted her and were already working to create a forum where the impact of the disaster on their organizational “community” could be addressed.

We discussed possible forms of intervention with the VP, who suggested that the unit managers contact us and use our services when and as they thought it appropriate. Two weeks later we received our first call. Since then we have been working with the various units, looking for ways to collaborate with them in their efforts to re-connect with each other and with the larger organizational community.

The impact of the crisis decimated this organization, which did feel itself to be a community. But the absenteeism, terminations, and decreased organizational functioning that resulted from the attack were threatening the bonds individuals had worked hard to establish, and now had to rebuild and sustain. Interdependencies that had existed prior to the tragedy had to be developed again, by individuals who no longer felt like the same people they had been before, their lives so shaken by fear and loss.
Throughout the initial stages of the intervention, therefore, the employees were experiencing feelings of breakdown. Our team helped them to develop and implement community focus groups to further their goal of reestablishing connections with each other as well as with the larger organizational community. In these groups, members were able to tap into aspects of organization’s community identity that were historically supportive to the establishment, and in this case reestablishment, of their affiliative bonds to one another.

The employees found that in these groups they could confront the impact of the disaster most effectively by creating a sense of safety and support in their work environment. This realization allowed them to create a forum for developing and implementing self-defined and mutually-supportive solutions for dealing with the impact of the crisis through regaining their sense of connection to one another. Employees voiced the need for each other, and the sense that they could not get through this alone. The individual members’ awareness of being needed in each other’s process of recovery, is a key factor in their own, and members of the initial focus groups have subsequently volunteered to help foster such processes in other organizational units.

As these sentiments developed in the intervention, we recognized them as feelings that we ourselves had had as we were planning the intervention—fears that our connections had been traumatically disrupted, fears that we could not make it through alone. Our group continued to meet weekly, therefore, to ensure for each of us the reconnection work and support we would need—so that we would not have to look to the organization members for it. We also realized that in our own sense of collaboration with each other, as a team, we were able to become most aware of the ways in which we (and the organization) have been impacted by this disaster. In our weekly team meetings, we address the ongoing impact that the work is having on us. This consistently brings us back to the question of the potentially colonizing influence of our need/desire for the employees to “heal,” and diminishes our need to colonize to assuage our own anxiety. If the intervention is to be empowering to members of the organization, then we, as practitioners, need to help each other be aware of our own conflicting motivations: the desire both to do our job and to continue our own processes of working through the trauma. After all, each of us on the intervention team was also personally impacted by the disaster. By questioning our own motives on an ongoing basis, and supporting each other in our own healing process, we are reminded to sustain a critical review of the work. This supports continuing the process of creating, maintaining, sometimes losing, and then re-establishing a sense of collaboration among ourselves as well as with the organization employees.

Concluding Remarks

There are many problems associated with long-term intervention processes. Not the least of them is that such processes require that practitioners, especially if they have been impacted by the same or similar traumatic events, reconnect with their own disavowed experiences of trauma. This being so, I believe that practitioners may consciously confront the pull toward imposing help-giving roles while supporting others in their own self-defined approaches to recovery when collaboration is the framework for community crisis intervention. In maintaining such collaborative processes it is possible to sustain rebuilding efforts that are empowering to those helped as well as to those who help.

For a community practitioner dealing with crisis, being an observer is not enough. In order to experience the fullness of an interaction we must understand the significance of what we see, hear, feel, and touch. This requires active participation in the interactive process as the community develops its own strategies for dealing with trauma and crisis. The practice of actively seeking expansion of self-experience seems to be in synchrony with the goals of both community psychologists and psychoanalytic practitioners. If we as analysts and community practitioners keep in mind that our roles intersect as we try to meet the needs of our shared communities, we may be able to find ways of increasing our ability to work together with overwhelming crises.

References


Dr. Mark Borg is a psychologist and a candidate at The William Alanson White Institute. He is co-founder and Executive Director of the Interpersonal Empowerment Institute, which is a community revitalization organization. He lives and works in New York City.
I was in my office with a client Tuesday morning, September 11. With a loud knock on the door, it swung open and my husband was standing there shaking and telling me the World Trade Center has been hit and it was bad. I looked at him in disbelief, wondering why he burst into my office like that. I told him I’d be free in a few minutes. Perplexed (my client didn’t register the meaning of this intrusion any more than I did), I finished the meeting and went upstairs to see what had happened. The TV was blasting, the picture of the imploding towers was unbelievable and I stood there as if it were just another bad movie on TV.

I’ve been a psychologist for more than 25 years and pride myself on being in touch with my feelings and knowing how to deal with them. I walked out of the room and went to do some paperwork in my office. It wasn’t until much later that day that I was able to even begin to comprehend what had just happened.

I know all about the process of mourning loss. I know it from the books and I know it from my heart. First, the shock of disbelief, then the rage or sadness, then the sadness or rage, moving toward the experience of deep sorrow and pain of loss before resignation and acceptance. I struggled to make sense out of what is still incomprehensible. I know what happened but my feelings won’t go there. They wander around and away, as if in a different world, saying, “Let’s go out and play in the sunshine, it’s another fine day.” I pride myself on being honest and yet there is not a whit of honesty as I watch myself parade around in the sunshine. Now I’m starting to be critical of my avoidance and thinking that if I were so good at processing my feelings I’ve sure got a funny way of showing it. Now I know, there are none. I cry, relieved and frightened.

We all have been changed by the terrorist assault. I do not yet know the ways, but doubtless they are more than I can comprehend now I yearn to feel the clarity that was mine on September 10. Right now I’ll settle for feeling that I can remember who I am, what I stand for and try to live every hour according to the values and beliefs that are my heart. In helplessness, I wish to strike out at someone and roll back the reel of time, I wish to strike out and return the punch, I wish this infamous event had not happened. We are stuck with it. Can we find our selfhood, as individuals and as communities, to have it live on with sufficient meaning so that we do not take the vengeful path? Getting back to a normal routine feels trite and impossible. It is no such thing if we can bring our brokenness with us and let it teach us what it must.

Bat Dying
By Alastair Reid
November 22, 1963

As often as not on fair days, there is time
For words to flex their muscles, to strut
Like peacocks, discovering what to say in the act of saying.
The music of meaning emerging from
The sound of the words playing.
Every now and again, however, the glass breaks
The alarms shrill, the women hide their faces.
It is then that words jump to their feet and rush
Like white lipped stretcher bearers
Tight lipped, tense to the unspeakable scene.
They grab air, water, syllables, anything handy
There is blood.
No nonsense, no adjectives, no time.
All that words could have been, like tourniquets,
To keep those innocent lives from spattering away,
Instead of as now.
A dirge, a bell tombing, a stutterer, a sigh.
Silence.
There is nothing now for our words to do but remain
Unspoken, mute, like mourners.

Bat Dying speaks. I no longer haunt myself with having to find the words. Now I know, there are none. I cry, relieved and frightened.

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For words to flex their muscles, to strut
Like peacocks, discovering what to say in the act of saying.
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Silence.
There is nothing now for our words to do but remain
Unspoken, mute, like mourners.
RESPONSE TO MAGGIE BAKER I
LINDA L. GUERRA, PHD

In Dr. Baker’s account of her feelings and reactions on the unforgettable day of September 11th, we find an example of bravery and risk-taking. It takes courage to put into words feelings that one is having that may meet with disapproval, and/or may trigger uncomfortable emotions in others. This is especially true when writing about one’s response to this immeasurable and ongoing tragedy. We have all been deeply affected and traumatized, even those of us with specialized training and experience in dealing with loss, trauma and human emotions. I can personally resonate with a lot of what Dr. Baker describes. As much as I have wanted to emotionally comprehend what has happened, deal with it, and make meaning out of it, I have had an equally strong desire to avoid this grim, bleak emotional morass. Like Dr. Baker, I have also engaged in some self-criticism in relation to this desire to avoid, even while knowing that this desire is very human, very common, and even a necessary part of our mental processing of trauma. Furthermore, it takes time to work through the complex, multi-layered emotional reactions to trauma.

As a practicing psychologist, psychoanalyst, and survivor of my own personal psychoanalysis, I know that although feeling one’s feelings sounds simple, it can sometimes be brutally difficult. The terrorist attacks in our country constitute a situation that we Americans have never before experienced. The shocking and swift murder of thousands of ordinary people, and the almost instant destruction of buildings that were such symbols of American life, has left us all reeling. Our illusions of safety and control, our notions of fairness and evil, will never be what they were on the day before these horrific attacks. No amount of professional training or personal psychoanalysis can make us immune from experiencing the desire for revenge, the desire to escape, and/or feelings of panic, confusion and fear. Why would we even strive to avoid these feelings? The mark of a “well-analyzed” individual is not that she never experiences primitive, negative, or shameful feelings, but that she recognizes, tolerates and learns from them. As Dr. Baker points out at the end of her essay, if we can use these emotions to get to a place of increased understanding and empathy for others, and ourselves, if we can avoid impulsive action based on these feelings, then we are transcending the primitive, and doing the very best that human beings can do.

RESPONSE TO MAGGIE BAKER II
DENNIS DEBIAK, PHD

I resonated so profoundly with Dr. Baker’s eloquent description of her reaction to the terrorist attacks. Many times since these events, I too have felt unable to find the words to describe my experience. What resonated the most for me in Dr. Baker’s description was the self-criticism. I have felt this too. I’m not doing enough to support my clients, students, and friends and relatives that were affected (although not mortally) by the attacks. I think that these self-critical reactions are common to many of us as we live through the aftermath. I have found that many people have criticized each other for not having the “right” reaction. For example, some have criticized others for watching too much of the media coverage of the events, while others are accused of sticking their heads in the sand and not keeping up enough with the unfolding events.

I think that it is hard for us all to realize how traumatized we have been by these events. Our sense of security in the world has been shattered. We now worry about getting on airplanes more than we ever did and for much different reasons. Whenever I see the Philadelphia skyline, I imagine airplanes crashing into the buildings. We are scared and many of us feel the need to be “on alert.” Therefore, we have all experienced a major loss, whether or not we know anyone who was killed in the attacks.

Whenever our self-criticism or criticism of others wells up, I think we need to realize that our behavior is in part a reaction to trauma and that we need to give ourselves a break. Whether we need to immerse ourselves in news reports, avoid the news, have control over seemingly menial aspects of life, or “play in the sunshine,” we must realize that these are our ways of coping with a reality that is frightening and sad. Our ways of coping are sometimes different than those of others we encounter. We might be piqued by someone’s pacifism if we rationalize our trauma-induced need for control or revenge by saying it is our duty as the most powerful country in the world to declare a war on terrorism. Our coping methods often conflict and it is difficult for us to be compassionate and respectful of defensive styles that are opposite of ours.

Group psychotherapists talk about “universality,” or the distress-ameliorating capacity of realizing that others are experiencing similar feelings, thoughts, or other reactions. I think that our self-criticism might diminish if we talked to each other more about how this collective trauma has affected us. We would see that all of us alternate between irritability and denial and between grief and a desire for revenge. Talking would enable us to have more compassion for each other and for ourselves.
RESPONSE TO MAGGIE BAKER III

O

ne cannot always live on the edge of the next disaster: something protective in the human psyche begins to pull back, to return to everyday life, trying to save psychic energy for the next awful event. But, even as I try to focus on the normality of the everyday, I am always aware of some unseen danger lurking in the background. Life will never be the same again: our country is no longer a charmed island safe in the churning sea of world violence and catastrophe.

I was struck by the raw candor of Maggie’s report of her varied reactions to the catastrophe. True to her self psychology roots, she shows us that the therapist/psychoanalyst is not a person “beyond” emotion, but someone right in the midst of all the messy and glorious feelings that make us human. She does not try to hide or clean up the details of her emotional disequilibrium with a false “professional” distance. To me, this is at the heart of our work as therapists. As Harry Stack Sullivan reminded us, “We are all more human than otherwise”—this includes both therapists and their patients. There is no hiding from our full humanity, even behind the therapist’s chair or couch. Linda Guerra underscores this when she asks, “Why would we even strive to avoid these feelings?” Yet we know that there is something in us that still thinks being a therapist means not having certain feelings. This is a big mistake. To the contrary, we are challenged to have more and more of our feelings, to learn to bear them, and so help others bear and own the full range of their feelings.

At a time when great waves of feeling are sweeping over us as individuals, groups, and nations, it is crucial that we clinicians continue our work of exploring and getting acquainted with all the feelings we humans can be gripped by: both the joy and the terror, the love and the hate, the hope and the despair. They all live within each of our minds and hearts. Dennis Debiak gives us an important caveat: there are no “right” reactions to the ongoing horror we face. There are an infinite number of reactions, and each of us will swing among many responses, most out of our immediate conscious control. This requires compassion both for others and for us, reminding us that our defenses are necessary and that they come in a variety of styles. What we do strive for, however, is to become more conscious of the feelings driving us before we act on them in ways that may be hurtful to ourselves or others. This includes trying to catch our impulse toward quick and easy judgments—whether we blame others or ourselves.

Carl Jung said he believed the greatest danger in our world was not the splitting of the atom but the splitting of the human psyche. We know the defense of splitting from our own therapy and our clinical work. Yet it is always shocking to see how spontaneously we resort to splitting when faced with primitive emotions: we grab for the quick right and wrong, the black and white, the absolute good and the absolute evil yet we are all—every human one of us—a complex mix of both. Maybe Melanie Klein really got it right when she insisted that ambivalence is something we are always striving towards and not something we can take for granted. When the storms of disaster hit, our primitive splitting and projection swing into full and alarming force. Yet, it is also miraculously true that so many have had the impulse to reach out to strangers, to love, to feel gratitude for this fragile and precious world, and to help repair the torn fabric of our common life. Catastrophe exposes character and moral fiber in amazing ways.

As we move ahead with the necessary chores of life, as our nation and our allies struggle with the important distinction between possible “justified force” versus a “just war” (which I believe is an oxymoron), I hope we will not take our role as therapists and psychoanalysts for granted. We have something important to say about tolerating the full range of human feeling and impulse, struggling to withdraw our projections onto others and to accept our ambivalence and many-mindedness. All of this is not done just for self-awareness but so that we can take full responsibility for our actions and contribute to the goodness in the world in whatever way we can.

Maggie concludes her reflections by saying that we must let our brokenness teach us what it must. This reminds me of the common Anglo-Saxon root for both “wound” and “wonder”—wundt—means “to be opened up, penetrated.” September 11 has penetrated us, ripped us open, whether we like it or not. Such places of wounding can be both opportunities for infection and contagion or of deep cauterizing and opening up to compassion. The violence in the world has broken our hearts open in a new and alarming way. May we as human beings and therapists allow our woundedness to be the opportunity for the wonder of deepened compassion and human solidarity to grow. May we be moved to join all of sisters and brothers on this globe in our common human struggle toward cooperation and acceptance of diversity as a path to greater universality. May our opened-up hearts be filled with the unexpected riches that can come, in some unfathomable way, from such a horrendous loss.
It has been months now since great tragedy, suffering and death of loved ones struck us through terrorist attacks in our midst. In self-defense and retaliation, in war, we have captured, injured or killed many of the perpetrators and some of those who harbored and trained the terrorists. While ideally a pacifist and always a humanist, in reality I support self-defense, hopefully always with minimal injury and death. In the use of high-tech weapons, not nuclear nor chemical nor biological, and in excellently trained Special Forces troops, we hopefully have minimized casualties and death in war and made much more difficult the continuation of terrorist attacks. Unfortunately, we may have increased the suffering, death and victim experiences of innocents and many who had little choice but to harbor terrorists. We seem to have found ways of aiding them. Effective transportation, corruption and weather, however, are likely more serious problems than enough aid in reaching these innocent sufferers. Changing terrorists into reasonable citizens is another matter. The question is therefore asked: What is the special social character of terrorists? Hard upon this question is the next: Can the destructive motivations and actions of terrorists be altered? These are unanswered, perhaps even unanswerable, questions. We need, however, to try.

A mentor of mine in psychoanalytic training, Erich Fromm, himself a psychoanalyst, but also a social psychologist and a social-political activist, wrote a book about the authoritarian personality in Escape From Freedom (1941), about the politics of the Cold War in May Man Prevail (1961), and about his research on human destruction and killing in The Anatomy of Human Destructiveness (1970). He gave a much-needed, well-researched and thought-out picture of the authoritarian social character of someone like Hitler who was a mass murderer. He published Escape From Freedom just as we were going to war with the Nazis and the Japanese. By the later 1950s, he began focusing his creative attention in the U.S. to the Cold War, the real possibility of a world-devastating nuclear war, the emerging of the authoritarianism of Joe McCarthy, brutality on the college campus and in racial incidents. By 1970, he was publishing his researched views on destruction, necrophilia and death, and their tragic undermining of life, love and humanitarianism.

Thirty-two years after his 1970 book we continue in terror of annihilation by nuclear bombs. To this day the buttons are ever-present to start a nuclear war, as are the men to push them if necessity seems to command. Annihilation can still be done in the compulsive obeisance to one’s nation state. The Cold War is over, however, and it seems likely that America, Europe, Russia and China, the four most powerful nations, will slowly reach peaceful accords. Other, smaller wars of less powerful nation states, however, do pose world dangers since they have had and may continue to have use of chemical and biological warfare, if not nuclear.

We now have the added terror of human bombs, chemical, biological and possibly nuclear warfare done by terrorists. As great an immediate world danger in 2002, annihilation is pursued by bands of fanatic terrorists bathed in religious delusions and rigid compulsive actions of murder by suicide of the enemy, the non-believer, in order to attain eternal salvation. Few in numbers, they hide in nation states and in religious belief systems, and are very difficult to identify. On the positive side, we seem to be edging toward a world community of nation states whose leaders and peoples wish to find such predators and to save our world and its peoples from annihilation. It does not seem that religious leaders are as intent on finding such predators in their midst. They need to recognize the grave danger of religious terrorists, not only of their intent to annihilate the world, but also of their willingness to sacrifice the religion they espouse. Religious leaders need to expose these terrorists in their midst, just as do leaders in nation states. The religions of the world and the nation states, through their leaders and elementary free education, should not only teach humanity, love and compassion for one’s fellow man. These leaders and their religious school teachers and public school teachers must disown vocally and actively name those who misappropriate their teachings and offer false hopes in the name of violence, hate, murder and suicide.

Someone like Erich Fromm (1900-1980) needs to research and write about terrorists as a “social character type” who can commit mass murder and suicide in the name of a holy war, not a nation state. Fromm’s social character that he designated necrophilic, a complete obsession-delusion and compulsion with death, is a start here. Re-reading Anatomy of Human Destructiveness is pertinent. There is also a need to socially characterize the victims of terrorists and cult followers. The cult followers are compliant in their obedience to their gurus. Terrorists cannot easily become empowered unless they have both victims and cult followers. As loners, without cult followers, they rarely wreak damage in the culture, although they do kill and suicide. With obedient followers, however, they can become organized into highly disciplined groups, trained with up-to-date weaponry, high-tech information-communi-
cation technology, and skilled in the use of sophisticated bombing devices. Terrorist’s sophistication and capabilities are usually underestimated - a serious error that understanding the social character of terrorists might correct.

The terrorist leaders, not unlike leaders everywhere, are few in number. They undoubtedly are bright, if not brilliant, talented, have charisma, have remarkable organizational and communication skills, can delegate responsibility to a select few, often have marriage and family, and are willing to sacrifice much else in their living in order to maintain their leadership. Terrorist leaders include Hitler, Goering, Goebbels, Himmler, Eichmann, Stalin, Idi Amin, Saddam Hussein, bin Laden, Napoleon, to name a few. They are authoritarian, have no fear of death or of killing others, offer fantastic expectations for fealty and obedience, and are usually paranoid characters. What do I mean by paranoid characters? They imagine that those who are not obedient and loyal to them are enemies who are out to persecute and victimize them. In order to avoid persecution and victimization, they attack, declare war, kill, torture, and victimize. Usually, their fear and image of persecution is only ended when the persecutors they imagine are destroyed. They are continually in a survival experience of life and death; and often feel powerful and most effective when they have killed their imagined persecutor. Fromm came to call such people, usually men, not only authoritarian but necrophilic, an intense attraction to death. He held out little hope for changing such characters into humanistic and compassionate individuals. They need to be permanently isolated, imprisoned, robbed of power and leadership. Under such conditions, they often suicide or become so ill in body and/or mind that they die. Ninety-nine percent of us, as humans, have varying degrees of humanistic caring and concern. We find it very difficult to believe that such people cannot be changed. Therefore, we are always on the verge of forgiveness and freedom for them. They usually have utter contempt for the “weakling” humanists; and believe we will forgive and free them. Such characters, few in number, gravitate to the extremes of religion and/or nation states; and use the religion or nation state to further their megalomaniac destructive demands.

I have had only one clinical experience with such a necrophilous person when I was a young psychologist working in the Veterans Administration’s huge Mental Health Outpatient Clinic, a few years after my army experience in World War II. The experience was forty-seven years ago, my notes were kept at the clinic, but some memories are starkly etched in my mind. An ardent American member of the Nazi party, a veteran of WWll, was brought into the mental health clinic, against his will. A court judge had ordered him that he would be on trial and likely imprisoned if he did not seek treatment for his “mental condition.” The chief and assistant chief psychologist of the clinic called me to their office. They explained that our department had been ordered to treat this veteran. He had adamantly refused all medication and other forms of treatment (insulin sub-coma, group therapy, etc.), hospitalization, but grudgingly agreed to see a WASP psychologist. I was one of very few WASP psychologists there. They had selected me to treat him. When I saw him, he would only talk about the Nazi party, his reorganizing of it, their eventual victory, and his attempt to enlist me in it. When I insisted on talking about his mental condition, he would throw a tantrum, threatening harm to me and/or suicide. After many sessions conducted in this fashion, he refused further treatment by never appearing again at the Clinic. I was quite shaken in my complete inability to connect with him; his intense hatred and threat to destroy all who did not believe as he did. I also was most anxious that he might commit suicide and/or homicide. I never heard from him again, nor what happened to him. I think that variations on such behavior would be the norm, however, when terrorist leaders are forced to seek mental help.

I have only begun to state our world dilemma. Who will carry it further?

References


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rising to power.

We also know how to describe the conditions needed for the development of loving human beings and societies. I hope someday we will be able to effectively articulate how crucial it is that we create a world of loving, humane families, communities, and nations. In the meantime, we will, from time to time, weep for the loss of peace, the loss of safety, the loss of New York’s towers, and most deeply, for the loss of so many lives.

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Early Transference Interventions with Male Patients in Psychotherapy or ‘The dilemma of Early Transference Interpretations: Can’t live with them, can’t live without them’

Elisabeth Banon MD, Marcella Evan-Grenier, PhD, & Michael Bond, MD

In a previous study of psychotherapy with borderline female patients, we found early transference interpretations without the “buffer” of defense interpretations and/or supportive interventions to be “high risk” for the therapeutic alliance. We then turned to a sample of male patients with personality disorders to see how they would receive transference interpretations early in their treatment and to explore the role of other interpretive and non-interpretive interventions in maintaining the early therapeutic alliance.

Psychoanalytic theory proposes that interpretations are mutative and produce change through the acquisition of insight. Transference interpretations in particular are advocated as having the greatest potential to produce such change. However, empirical studies on the effectiveness of transference interpretations have offered mixed results. Although several studies have found a positive correlation with outcome for interpretations in general, earlier studies showing a positive relationship between transference interpretations and outcome have been followed by more recent research yielding minimal evidence for such a relationship.

Studies that correlate interventions with treatment outcome have been criticized by several authors. More specifically, Hill notes that “the correlational method is not sensitive to issues such as quality and timing of the intervention ... To rectify these methodological problems, many researchers have begun to study the immediate effects of therapist interventions.” From a psychoanalytic viewpoint on timing and quality of transference interpretations, Freud cautioned that the transference should not be interpreted early on, unless it becomes a resistance and threatens the viability of the treatment. He differentiated between negative “hostile” transference, which provided resistance, and positive transference, which he further subdivided into erotic and affectionate. He termed the latter subtype of positive transference the “unobjectionable positive regard for the analyst.” He proposed that this was the “vehicle of success” for the treatment and thus needed no interpretation. Similarly, Meissner, referring to more disturbed patients, advised that early transference interpretations could be experienced as critical attacks. Buie and Adler recommended using transference interpretations in the latter half of therapy after having created a soothing and holding
environment with the use of support in the earlier stages.

Studies that examine the therapeutic dialogue have added to our understanding of the impact of transference interpretations. These studies have focused on patient responses to interventions as predictors of outcome. Transference interpretations that are followed by affective disclosure rather than increased defensiveness have been consistently associated with positive outcome. However, this relationship also holds for interpretations that do not address the transference. Furthermore, transference interpretations were twice as likely to elicit a defensive response when compared to other interpretations.

We studied interactive patient-therapist sequences focusing on early transference interventions and asked: 1) How do male patients receive transference interpretations early in psychotherapy as compared to female patients? Does the negative or positive “valence” of early transference interpretations (i.e., whether they address an ambivalent or hostile attitude versus a warm or idealizing patient-therapist relationship) influence their impact on the alliance? and 2) How do therapists manage the alliance following early interpretive work?

**Method**

Subjects were the only 7 males obtained from a larger sample of 45 patients in a naturalistic long-term dynamic psychotherapy project at the Sir Mortimer B. Davis-Jewish General Hospital and McGill University in Montreal, Canada. Selection criteria include the presence of one or more personality disorder diagnoses on Axis II and/or the presence of a current mood and/or anxiety disorder diagnosis on Axis I. Subjects must be at least 18 years old, cannot have a diagnosis of organicity or psychosis, and must not be acutely suicidal or abusing substances in ways that would interfere with treatment.

Treatment was weekly dynamic psychotherapy with experienced clinicians with dynamic or psychoanalytic training. All sessions were audiotaped.

Axis I to V diagnoses were obtained via semi-structured diagnostic interview and confirmed by the Structured Clinical Interview for DSM-III-R (SCID II). Sessions 3, 4, and 5 were transcribed verbatim for each subject and rated for therapist interventions using the Psychodynamic Interventions Rating Scale (PIRS) which has satisfactory reliability and construct validity. Self-report therapeutic alliance scores were obtained using the California Psychotherapy Alliance Scale (CALPAS).

The manualized PIRS scale consists of two categories, interpretive and non-interpretive interventions. Interpretations consist of transference (TI) and defense interventions (DI), each of which are further scored for depth of interpretation on a level of 1 to 5. Non-interpretive interventions consist of acknowledgments (A), clarifications (Cl), questions (Q), therapist associations (Ass), reflections (R), work-enhancing strategies (WES), support strategies (SS), and contractual arrangements (CA).

To rate the immediate effects of interventions on the alliance, the three authors first examined session transcripts independently for “turning points” defined as notable changes in the patient’s degree of emotional elaboration or level of defensiveness. Turning points tended to occur around movements toward or away from a more interpretive stance.

From segments with turning points, the three authors rated the moment-to-moment change in alliance associated with interpretations by assessing immediate patient responses. If these included elaboration of material preceding the intervention, or conveyed a sense of collaboration and emotional connectedness or attunement between patient and therapist, the alliance was deemed to have been enhanced or at least maintained by the intervention. If however, the response included increased defensiveness or resistance, the alliance was deemed deteriorated or in danger of being so unless reparative techniques of support ensued. It may be argued that the alliance is not accurately assessed by solely examining written transcripts for what is said by therapist and patient because the complex non-verbal interaction will be missed. This is a potential limitation in our methodology and remains beyond the scope of this paper.

**Clinical Material**

**Impact of Early Transference Interpretations on the Alliance:**

**Negative Transference Interpretation Alone:** Mr. A has a mixed narcissistic and dependent personality disorder. He presents while in remission from polysubstance abuse with 15 months of sobriety and intake Global Assessment of Functioning (GAF) of 57 (moderate impairment in global functioning). Early self-report alliance score is relatively high (total CALPAS score = 5.75, sample mean = 5.50 + 0.76). The following excerpt illustrates the risk of a TI early in the fifth session addressing a negative transference.

Hearing the patient commiserating about all the sources of pressure in his life, the therapist inquires about negative feelings towards the therapist:

**TI-1**  **TH.:** So you remember too that last Tuesday I had asked you to think about coming twice a week...

**PT.:** Yeah, it’s cool.

**TI-1**  **TH.:** Do you think that was also another added sense of pressure?
PT.: No, no, ’cause I mean my assumption right away up front is that I’m not going to be waking up at six o’clock in the morning to make this appointment. And that’s fine and if it becomes a pressure situation I’ll just let you know and we’ll just—we’ll change it immediately, you know. But that didn’t add to it at all.

Q TH.: You usually stay up late?

PT.: I mean, I don’t give myself a time to go to sleep...

Here, defensive denial and a move towards more superficial content follow an early interpretation of potentially negative transference involving the patient’s feeling pressured for more closeness by the therapist. To preserve the alliance, the therapist moves out of the transference with a non-threatening question. Later in the session, the therapist turns to a defense interpretation (DI) addressing the same conflict over closeness and fear of rejection. This interpretation is followed by positive emotional elaboration and seems to be integrated by the patient without posing a threat to the early alliance:

DI-3 TH.: ...But that there’s probably some fantasy operating in there that has a bad outcome. That you are imagining that this is not something about this is not going to turn out well and so you protect yourself, right off the bat, by not pursuing it...

PT.: Interesting. I do think about this girl though. It’s her face, you know. She’s very pretty. Very pretty girl... I mean, is it abnormal to think if like a girl she could be your girlfriend right away? You know, I don’t know if that is normal or not... Maybe (laughs) you know, there’s a song, “she ain’t pretty, she just looks that way”....

DI-2 TH.: See, there already is the bitter fantasy that she may look pretty, but she is not going to be a nice person.

PT.: I might just—I think I’m just plain afraid ... this is a pattern I established after I failed the grade, how I shut myself in and never admitted to someone that I liked them or never knew how to say: “Hey,” you know, “what are you doing?” ... but what do you do... you go out for a coffee or something like that?

Follow-up data for Mr. A reveals that he has remained in therapy for 2.5 years until he moved to another city. At termination, he reported being pleased with his progress and had attended 125 sessions yielding a session density of 50 sessions per year.

Negative Transference Interpretation followed by Defense Interpretation: Mr. C has mixed narcissistic and obsessive personality disorder and presents with a major depressive episode and co-morbid substance abuse. His intake GAF is 69 and his early self-report alliance is good (CALPAS=5.75). In session 4, a low-level transference interpretation (TI) is offered in response to the patient’s request at the very beginning of the session that the therapist be more active:

PT.: At this stage I do need more dialogue and more, ugh, not just sitting—not just you sitting there and taking notes, but also talking to me. I don’t know if that’s a problem. I don’t know if that’s possible, but because of this very one-sided thing that I have had with you right now, I feel quite uncomfortable with you...

TI-1 TH.: ...what does this mean, this discomfort at the ball being in your court? What is this discomfort at speaking on your own behalf, from yourself, as opposed to my being much more active and directive, which then defines the situation from me, the other person.

PT.: Uh-huh.

DI-1 TH.: And further still last week I connected that to your experience that other people take certain positions in your life which tend to define you. The example that sticks out in my mind was the issue of your wife moving with your kids to H. and your experience of that, that she should do what ever she wants because you wanted her to feel free of the marriage and so on.

Here the therapist interprets the patient’s emerging ambivalence towards him and towards the frame with a level-2 TI and rapidly follows with a defense interpretation. The patient responds with elaboration:

PT.: Certainly I recognize from exactly that—and I did talk at length about that last week—that I felt often that my life has always been in the control of others and it’s one of my—one of the reasons why I’m sort of strongly reacting against my present family and marital situation is maybe because I just can’t stand that anymore...and I certainly am reacting against that, maybe in order to take control over my life...So in that same vein, the idea that maybe I’m not yet comfortable with even controlling this discussion... I may have the same tendency to give somebody else control.

This negative TI rapidly followed by a mix of DI and support is well tolerated. The patient is able to
make connections to important relationships in his life and appears in touch with the affect that accompanies these early insights. This patient remained in therapy for 7 months and received 28 sessions (session density=48).

**Missed Negative Transference Interpretation:** Mr. D has mixed narcissistic, obsessive-compulsive and passive-aggressive personality disorder. He presents with a major depressive episode, and co-morbid dysthymia, alcohol abuse, obsessive compulsive disorder—both obsessions and compulsions—and generalized anxiety disorder. His intake GAF score is 57 and his early self-report alliance score is high (CALPAS=5.75). In session 8, he repeatedly refers to his ambivalence towards the therapist. This is not picked up and no interpretations addressing the negative transference are given. Increasingly superficial discourse follows and the alliance deteriorates within the session:

The patient, talking about his boss but likely referring unconsciously to the therapist, warns him of his fear of staying the course and getting close:

PT.: ...I have tried a lot of things, but I have never stuck with anything... Most of the time, he (the boss) just listens and other times he tries to provide solutions, but the solutions are too (laughs) too simple and not realistic, you know. Don’t take into consideration the reality of the situation....But I feel that he is not providing me the support that he should as a boss....If I were in his shoes, ...I would do something. I would try something else until—try and try until we succeed...

Q TH.: I’m wondering if there was more that you wanted to say about your “fight” with your wife this morning...if it is worth looking at the details step by step.

After briefly conceding to the therapist’s request to explore the relationship with his wife, the patient seems to withdraw from exploring his internal world and moves to the more emotionally distant topic of medication:

Pt: Well (sighs) I was disappointed that, ugh, that she didn’t apologize to me, I guess...Just expressed my disappointment and I saw she wasn’t too happy with my disappointment and she was disappointed that I was disappointed...Sometimes I wonder if the Prozac is going to—the effect is going to maintain itself, you know. I had a couple of days this week I didn’t feel I was in control, at work, of my emotions at work, you know...Am I getting immune to it? Are the effects dying down...I was coming home more stressed.

**Discussion**

Ever since Luborsky’s paper, “Everybody has won and all must have prizes,” there has been a debate about the relevance of specific interventions and specific styles of psychotherapy. Despite conflicting messages in the field of psychodynamic psychotherapy regarding the use of early transference interpretations, some consensus that they are “high risk” and possibly “high gain” interventions exists. There are inevitably times when patients present transference issues early in therapy. They may involve “therapy-interfering behaviors” that both Linehan and Kernberg would agree require some confrontation.

Thus, the therapist may not have a choice but to address issues that are impinging on the patient-therapist relationship. While remembering that Piper et. al. found an inverse relationship between the proportion of transference interpretations and both therapeutic alliance and favorable therapy outcome for patients with a high quality of object relations, the therapist must also heed Linehan and Kernberg’s recommendations. Then the question becomes how best to deal with early transference. This series of case studies offers some guidance.

Early in their therapy, most male patients in our sample were expressing ambivalence towards the therapist, especially defensive aspects of closeness to and dependency on the therapeutic relationship. Our findings indicate that transference interpretations alone, even at level 2 on the PIRS, stimulate anxiety and threaten the moment-to-moment alliance, as seen by patients’ increased defensive-ness. These do not have to be interpretations of an explicitly negative transference in order to be threatening. This was illustrated by Mr. A’s denial that he may feel pressured by the therapist’s invitation to increase session frequency. Therapists usually followed up by trying to attenuate the anxiety with questions, explanations and support strategies, or with defense interpretations.
Failure to offer transference interpretations in the face of negative transference also appears problematic for the alliance. It is as if the therapist is avoiding acknowledging an issue within the dyad and the patient starts distancing, as seen with Mr. D, whose discourse manifested themes of abandonment, isolation and withdrawal when the therapist did not draw potential parallels between the patient’s intense ambivalence towards his ineffectual and unsupportive boss and how in therapy he may also be feeling alone and unhelped by the therapist and by the frame.

In our sample, early transference interpretations, when immediately followed by defense interpretations, preserve the alliance. Here the effect is to outline the patient’s ambivalent feelings towards the therapist and then to point out that this pattern seems to exist outside the therapeutic dyad as well, in the patient’s relationships with loved ones. Mr. C manifested a negative transference: his wish to be the passive recipient of the therapist’s insight and work on the one hand, and his anger about feeling controlled by the therapist on the other. The therapist remarked on this conflict within the therapeutic relationship and then broadened it with a defense interpretation, which addressed this same relationship pattern, but with the patient’s wife. This sequence of interventions diffused the anxiety associated with the early transference interpretation, preserved the alliance and allowed for elaboration and deepening of the conflictual material brought by the patient. Bales’ equilibration model suggests that the therapeutic environment must promote disclosure and allow for the reduction of anxiety, with patient and therapist participating in the equilibration process together. Perhaps, directing the discussion away from the transference early on helps the “equilibration” and enhances the alliance and reduces the tension in the therapeutic relationship.

All seven subjects in our sample had a high early alliance as measured by the CALPAS. Still, the alliance deteriorated following both transference interpretations alone and missed transference interpretations. It was preserved by the sequence of early transference interpretation followed by defense interpretation. Regarding valence of transference interpretations, few if any therapists interpreted a truly positive patient-therapist relationship in these early transcripts. However, any mention of this relationship early on, even in a neutral way, elicited resistance in the patient and negatively impacted the moment-to-moment alliance.

The main limitations in this study include our small sample size and the variability in patients’ pathology and diagnoses. It may be difficult to generalize our findings to a particular patient profile or diagnosis but the findings probably reflect patients that come for psychotherapy: a heterogeneous mix of mostly Cluster B and C personality-disordered patients with multiple Axis I disorders, most often mood and/or anxiety disorders. We did not formally assess accuracy of interpretations. One could argue that inaccurate interpretations, or those with poor timing, would likely have a negative impact on the alliance, precluding any useful conclusion about interpretations.

In summary, we conclude that like female patients, male patients with personality disorders are highly sensitive to early transference interpretations and that both positively and negatively valenced transference interpretations seem disruptive. However, when a patient manifests early ambivalence towards the therapist or the frame, in a fashion that may threaten the viability of the treatment, this negative transference needs to be interpreted. In this instance it seems that both transference interpretations alone or avoiding transference interpretations altogether will likely threaten the alliance. Here, accurate transference followed by defense interpretations within a context of support seems best suited towards maintaining the alliance. The context of support is crucial for both male and female patients so that interpretations enhance the alliance rather than disrupt it. We acknowledge that these findings will need replication in a larger sample covering a variety of diagnostic categories.

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Gender Effects in Psychotherapy

Gender is perhaps the most salient patient characteristic for clinicians to consider (either consciously or unconsciously) when they first see a patient. The potentially important role of gender in psychotherapy is highlighted by a growing literature indicating that males and females differ on a wide variety of variables. As well, it has been documented that women utilize psychotherapy more than men (Kessler, Brown, & Bromm, 1981) and typically present with different issues. Women often present with issues associated with problems in close relationships. These relationships tend to stay emotionally important even after separation or repeated disappointments. Men more often present with issues in connection with loss or impending loss of autonomy, often in their jobs. It is probably in this context that women tend to express symptoms and suffering more clearly and are more inclined to use and accept help, while men, trying to preserve autonomy, tend to suppress or deny suffering or the development of disease. Reflecting social roles, these gender stereotypes lead to differences in the use of diagnostic categories and to biases of the extent of morbidity among men and women for some disorders. Despite these demonstrated differences, the effect of gender on the quality of the psychotherapy experience remains poorly understood.

The emergence of gender as an important topic in the psychotherapy literature is connected with contemporary social issues. Much attention was devoted to gender during the decade of the 1970s and the early part of the 1980s when women’s rights and feminist advocacy issues were strongly voiced. More recently, gender in psychotherapy has received less attention, resulting in a decrease in clinical and empirical publications. Much of the focus on gender, particularly in earlier years, was directed at examining whether gender of the patient or gender of the therapist had an important impact on the outcome of therapy. Others argued that one must consider the match between patient gender and therapist gender in order to understand how gender affects therapy. Few investigators, however, have examined the interaction between gender and other important variables, e.g., type of therapy.

This last point concerning the lack of research examining the interaction between gender and other conceptually relevant variables served as the impetus for a study conducted by my colleagues and me at the University of Alberta. Our study investigated whether males and females each responded similarly to different forms of psychotherapy. In this article, I will present the theoretical rationale for why we examined this issue and the main findings from our study. First, however, I would like to give you some idea of what previous research on gender effects in psychotherapy has produced, by presenting a brief review of the literature. I am sure that after reading this article you will share a similar conclusion to mine; that despite a few promising findings, research has provided us with little practical information that we can confidently apply to our clinical practices. Perhaps after reading this review and musing over the highlights and shortcomings of the research conducted to date, some of you will generate new ideas that may guide future investigations of gender effects in psychotherapy.

Effect of Patient Gender

A commonly held assumption among clinicians is that female patients are more likely to benefit from psychotherapy. It has been argued that females are more sensitive to interpersonal issues and are more affectively responsive, leading clinicians to expect that therapy would be a more productive experience for them compared to males (Kirshner, Genack, & Hauser, 1978). Heatherington, Stets, and Mazzarella (1986) add that there may be a correspondence between therapists’ ideas about which patient behaviors make for good therapy and female patients’ greater tendency to show these behaviors. Indeed, this may account for why women are more likely to be referred to psychotherapy.

Patient gender has been investigated in a large number of studies. Some of these have examined whether patient gender has an effect on premature termination of psychotherapy. Findings from many of these studies have indicated no significant differences between males and females (Frany, 1992). Some studies, however, found that males were significantly more likely to continue psychotherapy (Brown & Kosterlitz, 1964). On the whole, it does not appear that patient gender has an important impact on continuation of therapy.

Most studies of patient gender effects in psychotherapy have examined the association between gender and treatment outcome. Several older studies reported minimal relationship between patient gender and outcome (Knapp, Levin, McCarter, Wermer, & Zetzel, 1960), while a few reported that women had significantly better outcome than men (Kirshner, Genack, & Hauser, 1978). More recent studies have provided consistent evidence of a lack of association between patient gender and outcome (Thase et al., 1994; Zlotnick, Shea, Pilkonis, Elkin, & Ryan, 1996). Overall, the findings indicate that patient gender has little effect on therapy outcome.
Effect of Therapist Gender

Despite the early belief that the gender of the therapist is irrelevant to the therapeutic process, a number of authors have written about the perceived superiority of female therapists (Cantor, 1990; Lerner, 1984; Mogul, 1982). Female therapists have been viewed as more patient, sensitive, nurturant, intuitive, and culturally better prepared for their roles as helpers and healers. Jones and Zoppel (1982) reported that patients (both male and female) who were seen by female therapists perceived their therapists “as more accepting, attentive, and comprehensible, and in general reported forming more effective therapeutic alliances, which in turn tended to promote more successful outcome” (p. 271). Mogul (1982) has noted that some authors suggest that an effective therapist, in addition to being authoritative, objective, and independent (which she considers masculine traits), must also be sensitive, nurturant, and patient (which she considers feminine traits). These authors contend that, culturally, it is easier and more supported for women to acquire the more masculine qualities than it is for men to acquire those viewed as feminine.

Research on this topic has largely been confined to naturalistic studies in which the relationship between therapist gender and outcome has been studied post hoc. In a study that is marked by its contrast to the naturalistic methods used by most investigations of therapist gender, Jones, Krupnick, and Kerig (1987) compared post-treatment outcome and satisfaction levels of 60 women who were assigned to either a male or a female therapist. This quasi-experimental study included the use of a manualized brief treatment, equivalently trained and experienced therapists, monitoring of therapist procedures, and random assignment of patients. The results indicated that greater symptomatic improvement, both at post-therapy and follow-up, occurred among those patients who were seen by female therapists. Unfortunately, the absence of male patients from the sample brings into question whether the results reflect a general superiority of female therapists for all patients or just female patients. However, the finding of superior outcome for female therapists replicates earlier findings of this research group (Jones & Zoppel, 1982) and others (Kirshner et al., 1978). More recent studies, however, have found that therapist gender has a minimal relationship with treatment outcome (Zlotnick, Elkin, & Shea, 1998). This is consistent with a review of therapist gender effects in psychotherapy that concluded that therapist gender is a weak and inconsistent predictor of treatment outcome (Mogul, 1982). Different results of the various studies may be attributed to differences in the patient samples, in the therapeutic approach, or in the assessment of outcome. Although the findings concerning therapist gender effects in psychotherapy are inconsistent, there is some indication that female therapists may have better outcome than male therapists in brief therapy.

Interaction Between Patient Gender and Therapist Gender

Because of the inconsistent findings concerning the specific effects of patient or therapist gender, some people have argued that there may be interaction effects between the gender of the patient and that of the therapist, and that focusing solely on one party may not provide meaningful answers. The idea of an optimal fit between patient gender and therapist gender has received considerable attention. A common notion in popular literature (magazines, newspapers) and clinical literature is that female patients do better in therapy with female therapists because female therapists are more able to understand the stresses and pressures experienced by their female patients, and are less likely to disempower them (Kaplan, 1985; Kirshner, 1978). Support for these claims came from early studies that found that same-gender therapy dyads (i.e., male patients-male therapists, female patients-female therapists) tended to have better outcomes than mixed-gender dyads (Jones & Zoppel, 1982; Kirshner et al., 1978). Later studies, however, failed to provide support for an optimal fit between patient gender
and therapist gender (Flaskerud & Lui, 1991; Zlotnick et al., 1998). Overall, limited research on this topic precludes forming any conclusions about gender matching between patient and therapist, yet the trend in recent studies suggests that matching has little impact on treatment outcome.

**Interaction Between Patient Gender and Form of Therapy**

Relatively absent from the psychotherapy literature on gender is the issue of whether male patients and female patients respond similarly to different forms of psychotherapy. No author has described which form of therapy may be most suitable for men or women. However, a number of writers have argued that male and female patients may prefer or benefit more from different aspects of psychotherapy. For example, Kaplan (1986) and Stiver (1986) have argued that female patients prefer to be listened to and understood in a way that precludes the kind of distancing that may occur in more traditional interpretive models of therapy. These authors posited that women prefer to participate in a relationship that is characterized by empathy, affiliation, and affective expressiveness on the parts of both participants. These are qualities that tend to be more characteristic of the patient-therapist relationship in supportive forms of therapy.

Others (Jordan, Kaplan, & Surrey, 1983; Lemkau & Landau, 1986) have argued that female patients benefit more from an approach that considers external pressures, e.g., societal pressures for women to be both homemakers and income earners, which permits an understanding of many women’s sense of inadequacy in the face of these pressures. Such consideration counters the tendency to place responsibility for their problems on themselves. Diminished self-blame can, in turn, free women for more effective problem solving (Nolen-Hoeksema, 1987). This suggests that a supportive form of therapy may be more beneficial to female patients because it focuses on external circumstances, encourages problem solving, and makes use of praise and gratification.

Relevant to male patients, Hare-Mustin and Marecek (1986) and Kaplan (1987) note that a man’s sense of self is more characterized by independence, distinction, and separation from others. Thus, men may prefer a form of treatment that provides them with a relationship that allows them to maintain some emotional distance and sense of independence. Such a relationship tends to be more characteristic of interpretive (expressive) forms of therapy.

Certain aspects of therapy may be more beneficial to male patients. Stiver (1986) has suggested that the very factors involved in rearing men for independence may lead to an underdevelopment of affective awareness and expressiveness. Men typically use coping strategies that involve suppression or denial of their emotions. Thus, interventions that enable them to examine their emotions may be more beneficial in facilitating change (Allen & Gordon, 1990). Interpretive therapy, with its focus on uncomfortable emotions and intrapsychic conflicts, is more likely to provide males with new methods for dealing with their problems and new experiences of expressing and examining their emotions. Although interesting, this set of ideas concerning what male and female patients may differentially prefer or benefit from in psychotherapy is not based on strong empirical research, but rather on the clinical experience of the various authors. Thus, they must be regarded as speculative.

In a recently completed study, my research group attempted to examine the interaction between patient gender and form of therapy (Ogrodniczuk, Piper, Joyce, & McCallum, 2001). We examined the effect of patient gender on outcome in two forms (interpretive, supportive) of short-term, individual psychotherapy. The two forms of therapy differed considerably on aspects that the literature suggests may be differentially preferred by and beneficial to men and women. Supportive therapy involved education, advice, praise, and an emphasis on strengths and talents. The supportive therapist provided direction and guidance, focused on external circumstances related to the patient’s difficulties, encouraged adaptive functioning, and facilitated problem solving. Anxiety and regression in the sessions were minimized. In contrast, interpretive therapy involved ongoing pressure on the patient to talk, exploration of uncomfortable emotions, and interpretation of internal conflicts. The therapist abstained from providing direct praise and gratification, and was moderately active and transference-focused. The patient was responsible for beginning each session and deciding what followed.

Eighty-eight female and fifty-six male patients were randomly assigned to 20 weekly sessions of either interpretive or supportive therapy. The therapies were manualized and therapists’ adherence to the manuals’ guidelines were monitored. Outcome was repeatedly assessed (pre-therapy, post-therapy, 12-month follow-up) in the areas of depression, anxiety, and general symptomatic distress. Both forms of therapy were equally effective. However, a significant interaction effect between patient gender and form of therapy was found for measures of depression and general symptomatic distress at post-therapy. Male patients had better outcome in interpretive therapy than in supportive therapy. Female patients had better outcome in supportive therapy than in interpretive therapy. A greater proportion of males made clinically significant and reliable change in depressive symptoms in interpretive therapy (63%) than in supportive therapy (29%). A greater proportion of females made clinically significant and reliable change in supportive therapy (61%) than in interpretive...
therapy (36%). The interaction effect was not significant at 12-months follow-up, likely because most patients tended to maintain their post-therapy levels of outcome during the follow-up period. The findings suggest that patient gender may be differentially influential with different forms of short-term therapy.

A description of the patterns of change for men and women in this study may help clarify the results at post-therapy and at follow-up. During the treatment period, men in both forms of therapy improved, however, those in interpretive therapy made significantly larger gains. During the follow-up period, men who received supportive therapy continued to make modest improvements, eventually reaching nearly the same outcome levels achieved by male patients in interpretive therapy at post-treatment. Male patients who received interpretive therapy did not continue to improve during the follow-up period (i.e., they maintained their post-therapy gains). For women, patients in both forms of therapy made improvements, although those who received supportive therapy made substantially larger gains. During follow-up, patients from each form of therapy maintained their post-therapy outcome levels. Thus, female patients who received supportive therapy continued to maintain a more favorable level of outcome.

Discussion
The findings concerning gender effects in psychotherapy so far have been largely disappointing. With regard to gender of the patient, most studies have found that its effect on the outcome of therapy is minimal. The consistency of this finding, coupled with the lack of a convincing rationale of why male or female patients should benefit more from therapy, suggests that patient gender, when considered alone, provides little prognostic value to the clinician.

With regard to gender of the therapist, the findings are more inconsistent. Earlier studies provided evidence for the superiority of female therapists, while more recent studies suggest that therapist gender has little impact on the outcome of therapy. Thus, the literature has yet to provide any clear evidence for the relevance of therapist gender in psychotherapy. Further research is required to establish more consistent results to either refute or support the claim of female therapist superiority. Until then, the current findings have little practical value.

Gender occurs within a context of other salient features in treatment. Thus, clinicians and researchers have recommended that the effects of gender be considered in a variety of interactions rather than as a central determinant of therapeutic outcome. One of the most obvious interactions to consider was that of patient gender and therapist gender. Investigations in this area were driven by arguments from feminists that male therapists were not well equipped to provide adequate therapy to female patients. Although some support came from early studies of this issue, later investigations provided evidence to suggest that matching patients and therapists based on gender was of little use for improving benefit from treatment. Again, the practical value from the current findings is limited and should not influence clinicians’ treatment decisions.

The interaction of patient gender with other important variables has not received much attention. One promising stream of research on gender effects in therapy concerns the examination of the interaction between patient gender and form of therapy. Although no author has indicated which form of therapy may be most suitable for males or females, the literature on gender differences described earlier in this article have implications for treatment.

As reviewed above, some authors have suggested that female patients may prefer a more collaborative and personal relationship with the therapist and benefit more from problem solving and interventions that underscore the influence of external circumstances for current difficulties. These are characteristics that are consistent with a supportive form of therapy. For male patients, it has been suggested that a more neutral relationship between the patient and therapist may be preferred and that males may benefit more from interventions that encourage introspection and examination of uncomfortable emotions. These are qualities that are more consistent with an interpretive form of therapy.

In summary, providing patient-therapist relationships that are consistent with female and male patients’
preferences can be expected to facilitate initial trust and willingness to work, which may be of particular importance in short-term therapies. Patients may then work on difficult topics and engage in new coping strategies that otherwise would have been avoided. For female patients, this may involve a greater focus on external problem solving to counter a ruminative response style that amplifies vulnerability to depression (Nolen-Hoeksema, 1987). For male patients, this may involve introspective examination to facilitate greater affective awareness. The result of such work would likely be greater benefit from treatment. These hypotheses are admittedly speculative and have only been tested in one study (Ogrodniczuk et al., 2001). However, despite their speculative nature, the ideas provide plausible implications for practice. Further research is needed to substantiate or refute these claims.

Differences in outcome at post-therapy and at follow up in my study may indicate different patterns of change in men and in women who receive interpretive or supportive psychotherapy. Different patterns of change may be influenced by the separation from the therapist at post-treatment, which may have different meaning for the genders due to the greater dependence on interpersonal relationships in the women. For therapists outside a research setting, who often do not follow up their patients, these changes may go unnoticed. Relying on outcome at post-treatment only, may lead to undue gender bias in prognostic evaluations and in indications for treatments.

Methodological limitations of past research on gender effects in therapy may have contributed to the preponderance of non-significant findings. They include use of small sample sizes, use of only female patients, lack of valid and reliable measures of outcome, post-hoc collection of outcome data, and failure to consider the form of therapy (when more than one form is provided). An alternative explanation for the lack of significant findings is that gender has little predictive value when considered alone.

However, limitations are also associated with my study that found a significant interaction between patient gender and form of therapy. The study did not utilize process measures that could elucidate how the therapy process evolved differently for men and women. Such measures would have proven useful in attempting to identify which patient and therapist behaviors were responsible for the different outcomes. The differences in outcome for men and women in the two forms of therapy may have been influenced by patients’ preferences for a particular type of therapy. Unfortunately, such pre-therapy preferences were not assessed. Finally, generalization is limited by the fact that the majority of the patients and therapists were Caucasian. Anthropological research has suggested that gender roles may differ as a function of ethnic background.

As should be evident from this review, investigations with an exclusive focus on the effects of gender on the outcome of psychotherapy will do little to advance our knowledge of important variables to consider in treatment. Research that addresses the limitations of previous studies that were listed above will help forward our understanding of gender effects. In addition, gender research outside the realm of psychotherapy may provide promising directions for future research. For example, men and women have been found to use different coping styles (Nolen-Hoeksema et al., 1999), which have implications for how male and female patients participate in therapy. Researchers must consider conceptually relevant variables that may interact with gender to affect treatment outcome, rather than examining post-hoc gender effects. Research that is theoretically-based and supported by prior research is more likely to produce significant findings that may have important implications for clinicians.

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If you take a moment to think about your current patients, or glance at case vignettes in recent psychoanalytic journals, you are sure to be struck by the number of patients whose presenting problems concern the relationship with their significant other. Researchers generally indicate that 60-70% of all patients who seek psychotherapy do so because of problems in a marriage or other intimate tie. I am therefore grateful for the opportunity to present the second Special Section on couples, couple therapy and psychoanalysis. The first Special Section gave a broad overview of how both psychoanalytic and family systems theories contribute to a rich array of approaches for treating troubled couple relationships. This second set of articles raises broader questions about the implications for psychoanalysis of understanding the degree to which our patients’ subjective selves, their regulation of emotional states and their interpersonal behaviors are shaped by, and reinforced within, their intimate relationships. It is important for all psychoanalytic clinicians, whether or not they treat couples, to consider how psychoanalytic treatment is affected by what is happening in our patients’ relationships outside therapy and how those relationships are affected by the patients’ increased self-preoccupation, and the intense involvement with the therapist, that characterizes most analytic treatments.

These papers look at important parallels between the early infant/caregiver system and the adult couple system, explore the impact of the analytic relationship on the marital relationship, and question the assumption that problematic marital dynamics will be replicated in the patient-therapist interaction. In so doing, they indicate ways that understanding our patients in their naturally occurring systems can complement and enrich the understandings that emerge within in the therapeutic system. Family systems theorists have always argued, what relational psychoanalysts have more recently come to believe, that people cannot be fully understood in isolation from the relationships that shape and maintain their sense of identity and security. Yet it is a conundrum that the insights and technical innovations in relational, interpersonal, and intersubjective psychoanalysis have remained focused on the patient-therapist relationship, and have not been applied to understanding the couple relationship. How can we understand the failure to carry these ideas beyond the consulting room door? We cannot hope to answer large questions in these brief articles, only raise awareness that they deserve serious consideration.

Dr. Shimmerlik’s article is a refreshing example of taking theories and observations from infant research, that have been used to illuminate the psychotherapy relationship, and applying them to patterns of affect regulation and communication in adult couples. Given our understanding that interpersonal behaviors, and the experiences of self and other in relationships are co-created and context-sensitive, it is logical, and fascinating, to explore the salient relationships directly.

Stechler’s article on the patient’s spouse addresses issues of how individual therapy and analysis impacts on others not in the room. It raises important questions about what it means to know nothing about the “other,” who plays so central a role in the patient’s life, and in the therapeutic work, beyond the patient’s subjective experience. He observes that when therapists confuse their alliance with their patients with allegiance to one side of a patient’s ambivalent feelings about their partner, the result may be harmful to the couple relationship.

The third paper carries these issues one step further in recognizing that relational learning within one interpersonal context does not necessarily transfer to a very different one. It addresses the therapeutic limitations that may occur when therapists do not how patients are experienced by intimate others, do not know the partner and do not have access to aspects of patients’ transferences that are enacted with their partners. It proposes that under many circumstances, patients’ relationships will benefit from concurrent individual and couple therapies, particularly when therapists coordinate the treatments so that each benefits from the other.

I hope that the articles in both Special Sections spark an interest in analytic practitioners to learn more about couples and become more familiar with open-systems models that can deal with the mutual impact of multiple interpersonal systems. I also hope that we, as a profession, begin to think more deeply about how seemingly value-neutral clinical decisions, such as where we draw the boundaries around whom we treat, or what kinds of information we privilege. These decisions have impact on the lives of other people outside our offices.
Implicit Communication Processes In Couples

Susan M. Shimmerlik, PhD

At this point in the evolution of our field, developments in psychoanalysis and family therapy, as well as findings from neuroscience and research in infant development are pointing to convergences in our understanding of the human experience. This paper addresses one point of convergence related to affective communication, and specifically to the distinction between implicit and explicit modes of experience.

One of the significant contributions of the family systems approach was the understanding of behavior in its interpersonal context, specifically understanding the organization of relationship patterns and the circular, recursive processes that maintain these. Initially, these were radical ideas, reflecting a profound departure from psychoanalytic thinking. However, there is now a substantial body of literature emerging from infant research conceptualizing and documenting development as a recursive process between neurobiological, relational and intrapsychic processes. In these models, the infant/caregiver relationship is conceptualized as a system (Beebe, et. al. 1992; Sander, 2000; Tronick, 1989) in which internal experience is seen as emerging from and inextricably tied to relational experience. These models emphasize the centrality of mutual state regulation in the early caregiver/infant relationship (Schore, 1994; Tronick, 1989). These regulatory interactions are seen as bi-directional, i.e. the influence of both partners is mutual, although not necessarily symmetrical, and is characterized by the micro-exchange of information through perceptual systems and affective displays (Tronick, 1989; Stern et. al., 1998) which lead to identifiable patterns of interaction (Beebe, 1992). These communications are carried out between caregiver and infant through synchrony and matching of behaviors in non-verbal realms; tone of voice, vocal rhythms, bodily movements, gestures and particularly facial expressions, especially through the eyes. Through these communications, which can occur in under 1/2 second (Beebe et. al., 1997), the caregiver helps to regulate the infant’s states of arousal, paving the way for the gradual development of the infant’s capacity for self-regulation.

Crucial to understanding this process is the role of memory. It is now fairly well established that different kinds of memory take place in different parts of the brain, and that there are at least two memory systems that must be distinguished, the explicit and the implicit memory systems (Schacter, 1996). Explicit memory, or declarative memory, is the memory of conscious awareness of factual knowledge and autobiographical events and includes narrative memory. Implicit memory, or procedural memory, on the other hand, is an earlier form of memory that does not require conscious processing and has to do with patterns of action responses, such as riding a bike. It is memory that involves the direct encoding of experience into somatic, perceptual, emotional and behavioral representations, remains outside of our awareness, and is thought not to involve an internal sense of recalling (Siegel, 1999). What is critical for the present discussion is that it is now believed that beginning in early infancy, relational and affective information is communicated, processed and stored through the implicit or procedural system, what Lyons-Ruth (1999) and Stern et. al. (1998) refer to as implicit relational knowledge. Amini et. al. (1996) suggest that during the vital exchange of signals between infant and adult, underlying patterns and regularities in the attachment relationship are detected, extracted, encoded and stored. Thus, the growing infant acquires implicit relational knowledge regarding what relationships are like and how they are conducted in ways that were never conscious.

There is now a rapidly growing body of psychoanalytic literature attempting to apply these ideas to the transference/countertransference relationship in psychoanalytic work with adults (e.g. Beebe and Lachman, 1998; Clyman, 1991; Schore, 2000; Stechler, 2000; Siegel 1999; Stern, et. al. 1998). Critical here is the idea that throughout life, we continue to process, store and communicate relational, affective information out of our awareness through the implicit or procedural system. Stern et. al. (1998) talk about the “stable, implicit knowings between analyst and analysand, their mutual sensings and apprehendings of one another” that they refer to as the “shared, implicit relationship,” (p. 917) knowings that have implications for therapeutic change through their transformation in the therapeutic relationship.

However, I believe it is clinically useful and theoretically enriching to consider this new developing framework in understanding the complex communicational processes in natural systems and to therapeutic interventions with couples and families. Let me give a clinical example. I am sitting with a couple, Amy and Jeff, both lawyers in their early 30’s. He presents as distant and disconnected, with an extremely limited capacity for self-reflection. He is often unfocused in the sessions, waits for her to raise issues but then can be easily roused to anger if he feels she has misrepresented something. She is highly emotional and extremely reactive and has a hard time containing her reactions to him. Their relationship...
has been characterized by struggles and heated escalations at each decision point and now they are struggling over the decision to have a second child. Early in our work, I ask Jeff something about his family; there is a moment of silence, Jeff seems bewildered, perhaps a little confused, seemingly a bit closer to some internal experience. Then, within seconds, Amy begins to sob. He turns to her, as if riveted, expressing confusion about what is happening to her, and the moment of opening to him is lost.

Within this emerging framework, we can now consider that what I witnessed was a highly patterned, mutually constructed, interactive affective sequence, carried out through the implicit memory system, in which she is highly attuned to his pain and he in some ways counts on her to divert him, enabling him not to experience his pain and allowing her to experience her own pain via him. He complains of her intense reactivity but feels safer having her express feelings to which he has limited access and which make him feel out of control. On the other hand, although she complains about his distance and unresponsiveness, she becomes extremely anxious when he exposes his vulnerability in any way. Sensing him in pain triggers for her experiences of responding to and taking care of her depressed, disabled mother and younger brother after her father walked out, leaving her no opportunity to express her own needs. Over time, Amy and Jeff have become exquisitely attuned to what they themselves and the other can tolerate. When he feels anxious or vulnerable he knows what he can do to trigger her anxiety, goading her into action/reactivity, mobilizing his anger and helping him to disown his vulnerability. These processes are not static, but always in flux. Bateson (1971, p. 241) talked about the infinite dance of shifting coalitions to capture the often small fluctuations that underlie the stability of a relational organization. Beebe et. al. (2000) talk about moment-to-moment variation is fundamental to communication: it provides an essential means of sensing the partner (page 101).

This formulation of a mutually constructed, recursive process represents a central feature of a family systems approach. However, the understanding of the processing, storage and communication of information in the procedural or implicit mode now gives us a way to understand the possible pathways through which these complex patterned interactions develop, become organized and are maintained. We can now consider how implicit messages are being sent and registered out of the awareness of the couple and the therapist. Thus Jeff is perhaps only dimly aware of the pain that is registering with him before Amy has taken it on and is in tears. She and I now experience a gestalt of all the implicit information: his shift of posture, the shift in his facial expression, his increased silence that represent a barely if at all symbolized experience for him. For her, this registers almost instantly. While she experiences it as about him, clearly it is also her pain that she is accessing, pain that she was never given permission to express as a child. What is critical here is that we are talking about a form of knowing that has not been symbolized. Lyons-Ruth (1999) uses the term enactive representations to refer to the idea that the organization of memory and meaning in the implicit or enactive domain only becomes manifest in the doing. (p. 578) I would argue that this “doing” is a major pathway through which relationship patterns become organized and are maintained and can serve to keep aspects of experience out of awareness. And this “doing” in its natural form is what couple and family therapists have a unique opportunity to observe and intervene in.

This has many clinical implications. I can only mention two briefly. I find it useful to talk to patients about the idea that much of what we communicate to and register from others occurs out of our awareness. As interactions occur in the room, we can punctuate them, disrupt them and ask the question “what just happened,” with the shared understanding that a process is taking place which may appear elusive but may be very real, even though what actually happens in any one of these moments may never be known. So, for example, within this frame, we were able to focus on helping Amy to contain her reactivity to Jeff, which was extremely difficult as she felt silenced, feeling her needs were being put second as they had been in her family. However, gradually she began to understand that her reactivity was just one point in a complex, mutually constructed interaction between them and served as a strange sort of protection for both of them, keeping them in their perpetual fight and blocking not only his access to himself but her access to other parts of herself. With this understanding she began to work hard in the sessions to contain her reactivity and to monitor her own subjective experience as well as what she was responding to in him, giving him, in turn, more space to sit with and process his experience.

A second important implication of this is related to the disjuncture between implicit and explicit levels of experience. That is, what one is communicating implicitly is often at odds with one’s conscious experience of oneself.
but may be accurately registered in or out of awareness by the partner. Furthermore, a distinction needs to be made between the accurate registering of an implicit communication and the complex, subjective meanings of that communication, conscious or not, that can easily be lost, obscured, or misinterpreted within the intersubjective field. This creates particular dilemmas in intimate relationships. I believe that one source of deep struggles in relationships is the failure of one partner to validate the implicit affective and relational messages that they are communicating. I believe that we need to make room to acknowledge and validate explicit communications that are received out of the sender’s awareness while at the same time helping the couple to be respectful of each other’s boundaries and maintaining the stand that ultimately each individual has to be the final authority over their own experience. In these situations, I encourage patients to try to pay attention to all the non-verbal communications, such as facial expressions, body posture, and tone of voice. For example, at one point when Jeff denied Amy’s “accusation” that he was angry, I joined with her in wondering what she was noticing that made her feel he was angry. When she responded that it was his voice, I suggested that there might have been something in his tone of voice, perhaps an edge, but that it could have many meanings. I was then able to ask Jeff if he was aware of an edge in his voice, and if so, what he thought that might be. I have found that this kind of interchange can help defuse volatile situations by validating the perceiv-er’s experience of picking something up but respecting the boundaries of the sender’s subjective experience and opening up a more exploratory interchange.

Why is it important for clinicians who do not see couples and families to consider this framework in natural systems, not just in the analytic relationship? Because these implicit interchanges occur out of awareness, because they are stored in procedural rather than explicit memory, and because they quickly become patterned within relationship, they create powerful, embedding interpersonal contexts in which split off aspects of experience are kept out of awareness. Can we assume these split off aspects of the self will show themselves as countertransference phenomena within the analyst? I believe the answer is yes, sometimes, but not always. And to the extent that aspects of these experiences do come into the analytic space, there is a risk that patterns in the natural systems will collude against that work developing. It has been my experience that disrupting these cycles in couples and families can at times help gain access to aspects of experience that individual analytic work has failed to access but which in turn can deepen analytic work.

I believe this emerging body of research and clinical theory has a great deal to contribute to our understand-
ing of interventions with families and couples. In turn, I believe that studying these processes in couples and families has the potential to contribute to this body of knowledge. I look forward to what I believe will be a rich and rewarding exchange.

References


The Patient’s Spouse

Gerald Stechler, PhD

The Spouse Comes Alive

Why am I always so surprised when I meet the spouse or partner of a patient I’ve been seeing? By the time the meeting occurs, I have already formed an image of the spouse based on my reading of the patient’s feelings and descriptions of that person who is so important and central in the patient’s life. As I listen to the patient, I am aware of the subjectivity of his or her view, and I also try to be aware of my own subjectivity in receiving that view. I never think the data can be taken at face value. Nevertheless, no matter how many times this scenario has been repeated, I never fail to be surprised, and even shocked at the experience of the face to face encounter with somebody I thought I knew, albeit incompletely.

It is not a question of whether my prior image is right or wrong. For a mental construct of that level of complexity, the question of right or wrong is simplistic and irrelevant. Furthermore, the idea of objectivity implied by the notions of right and wrong is also way off the mark. No, strange as it may seem, what is so remarkable is the essential quality of aliveness that resides in the spouse. I may know him/her fairly well as an object of perception, but what I am not prepared for is discovering the spouse’s own independent source of vitality. This person is not just in some gravitational orbit around the patient, but is the center of his/her own universe. It is both refreshing and alarming to shift from this dyad with an imagined third, to an actual living, breathing triad—refreshing because of the added vitality in the room, alarming because it makes me aware that the construct I have built of my patient’s marriage, in the absence of a direct encounter, lacks three-dimensionality. When the patient, spouse, and I all meet together, a whole new level of organization comes into being. We all are confronted with multiple perspectives. For example, as I am seeing the alive spouse, the patient sees me seeing the alive spouse. The spouse now has a view of self as an active player in the scene. These multiple perspectives raise our level of consciousness, forcing each of us to construct more complex, and more true-to-life, models of self and other, and of the marriage. (We have all had the experience of telling a personal story and then having another person retell the same story from their surprisingly different perspective.)

The construction of the patient’s marriage in the mind of the therapist is not a trivial matter, because often the marriage is seen by the patient as the most salient feature and cause of his/her suffering. Every patient tries to recruit us into aligning with his/her model of the dynamics of the suffering. In our own efforts to be empathic and form a therapeutic alliance, we pursue that alignment, leading us to the edge of a very slippery and dangerous precipice. We must not confuse the concept of alliance with allegiance. The key difference between the two concepts is that alliances do not imply exclusivity. I may have as many alliances as are mutually agreeable to me and to the other. Allegiance, on the other hand, does imply exclusivity. I pledge allegiance to one flag, one God, one person. As in the marriage vow, “I cleave unto one mate, and forsake all others.”

Allegiances also fly in the face of our psychoanalytic knowledge of the dynamics of affects. Affects, such as love and hate, come in polar pairs that result in ambivalent states, conscious or unconscious. The analyst must not pledge allegiance to any particular state of desire that the patient expresses because that state is just a segment of the total picture. We try to maintain a hovering position above the love-hate ambivalences, allying with both sides, and empathizing with the conflict per se. However, the picture is often murky. Projections may be very difficult to sort out, and the case that is made for the spouse’s hurtful inclinations may be most convincing. The therapist and patient can easily honeymoon on their mutual idealization, just as the couple did on the original honeymoon, but with the absent spouse now cast as the scapegoat.

This may sound like an unfair portrayal of our colleagues and us at work. But sensing my own vulnerability to the patient’s attempts to seduce me into allegiance, added to what I hear from supervisees and from patients’ reports from their previous therapies, I know that a triad can easily devolve into a mutually admiring dyad and an extruded third. This is much more likely when the third does not exist as a living, breathing being to the therapist. Where is our point of reference?

Should there be an additional point of reference? In discussions of this topic with groups of colleagues, I have heard the full spectrum of opinions. Some say that they always see the spouse of any long-term patient. Some say that they never do that, nor can they even imagine doing that, since it would interfere with their primary task of seeing the patient solely through the patient’s eyes, with no independent point of reference. Some say one of these techniques violates the fundamental ethics of psychoanalysis. Some say the other position raises fundamental ethical concerns. The issue of whether an analysis must be carried out within a hermetically sealed chamber remains unsettled. In former days that chamber was constructed to contain just one psyche. Now we recognize the impossibility of that abstraction, and the psyche of the analyst must be included.
conceptually and practically. But why stop there? Does it seem odd that the approach called relational psychoanalysis has only one particular relationship in mind, that between patient and analyst? Where is the concern for and consideration of all the other relationships that define the human condition? When those relationships are taken up as part of individual treatment, everything is seen from a single vantage point—looking at the world through the narrow end of the funnel. Must the patient’s perspective not only be privileged, but also freed from all context?

With or without the presence of the spouse, the more salient factors may be the mindset of the therapist and the nature of the training and supervision that prevails in the field. How schooled are we in seeing our patient as the unique center of attention, while at the same time viewing that person as just one of many players in a family or social system? This contradiction may be the key to our dilemma. We ourselves need to be capable of simultaneously holding several mutually exclusive and contradictory mindsets regarding our patient. He/she must be at the center of a universe, enmeshed in a dyad with us, and at the same time part of a system of reciprocally interacting beings with no one at the center. Our views of causality, or of psychic determinism must be equally complex. Causality is always bidirectional and circular, never unidirectional. Is this systemic perspective compatible with psychoanalysis? Is psychoanalysis possible without this systemic perspective?

The Dialectic Tension

It is clear by now that there are more questions than answers with respect to the issue of how broadly we define the field for the purposes of psychoanalytic treatment. The scope of psychoanalytic inquiry, as distinguished from psychoanalytic treatment, has always been very wide. But this has not been true for how the treatment is conducted. Throughout all of the changes and development in psychoanalytic thinking and theory, the therapy chamber has remained fairly sacrosanct and unchanged with respect to its perimeter. While the internal dynamics of the treatment have shifted from a one-person to a two-person psychology, the boundary around those two people has remained essentially impermeable. Certainly there are good reasons for this. Hurt and injured people need a haven of safety and confidentiality if they are to have a chance at healing and growth. Aspects of family life, current or historical, are likely to be deeply involved in the pathogenesis of the disorder. The exclusivity of the relationship with the therapist/analyst is fundamental to the treatment. Perhaps for the first time in their lives the patients have someone who is just for them; hence the shared illusion of the allegiance. However, it is important to recognize that this position is just one pole of a valid dialectic.

The other pole states with equal validity that the current family dynamics are critical in the maintenance of the pathology, and that for a solution to be enduring, changes in the whole system are required. This other perspective also takes into account the fact that there may be much more at stake than the well-being of the individual patient. In the case of a family with dependent children, does the analyst/therapist have any ethical responsibility for their well-being? Or, to put it another way, can we conceive of a resolution in which our patient’s well-being is advanced at the expense of another. It seems to me that the only way to avert this primitivistic zero-sum game is first of all to broaden our conceptual framework. Even if we are not ready to open our office, we need to open our minds so that the spouse and children receive as full a mental representation within us as is humanly possible. Collaboration with other therapists should not be an issue, although I have often encountered colleagues who, I believe, collude with their patients to close off all communication. We need to ask ourselves what is there about our selection of profession and mode of training that raises the value of analytic sequestering to such a high level? As with most good ideas, when they are carried to an extreme, they can become quite perverse.

To meet with a spouse for sporadic consultation is not a radical proposal. It does involve a redefinition of the boundary conditions. These conditions, as well as all other aspects of the treatment, are open to analytic examination. The patient and therapist can look at the meanings connected with either inviting or not inviting the spouse. If we feel that both patient and spouse would benefit from a live exchange, why let the remnants of a more rigid tradition inhibit us from raising the question of this potential boundary change?

Ethics

The ethical standards that have evolved around analytic practice devote a great deal of attention to concerns about boundaries and boundary violations. In general the hazards are always couched in terms of the danger of loosening the boundary, involvement in dual relationships, extra-analytic activities, etc. It goes without saying that there are good and sufficient reasons for these concerns and admonitions. But how do we address the ethical problems that can emerge in treatment as a result of defining the boundaries of responsibility too narrowly?

The model of public health may be apt in this regard. When a physician finds a patient with a communicable disease, the obligation is not only to that patient, but to the community at large. In mental health we have a parallel with the Tarasoff decision. These are extreme examples, for sure, but they do raise the question about the appropriate definition of the field of responsibility under varying circumstances.
The very idea of public health redefines who is the patient. It is no longer restricted to a single ill individual. If a community is at risk, depending on the circumstances, the whole community must be treated as the patient. I emphasize these points to illustrate that the concepts of systemic approaches to illness and health are nothing new in the history of medicine. That there is often a strong antipathy to these concepts is well demonstrated in Ibsen’s *An Enemy of the People*, in which a doctor discovers that the reason the visitors to the resort town in which he lives are getting sick is that the spa is contaminated. He feels he has done a great service. The townspeople feel otherwise, and condemn him as an “enemy of the people” for threatening their livelihood. Based on these arguments, we see that ethics, which always exist at the cusp of dialectic processes, are as legitimately concerned with too narrow a boundary as with one that is too loose. To the best of my knowledge, the ethics of psychoanalysis have never been examined from this perspective.

We must remember that it can go both ways. We may be shortchanging our patient if we know too little about the milieu in which he/she is living, just as we may be putting those around the patient at unnecessary risk if their presence is excluded from the treatment. The treatment itself enters into the life of the family, and its impact on them cannot be ignored. Intentionally or not, the analyst becomes an active player in the family dynamics, and thereby introduces questions of ethical responsibility. We have come to understand that rigid compartmentalization within an individual is itself defined as an aspect of pathology. Does the same logic apply to the establishment of rigid walls between the analytic dyad and the people whose lives are affected by the dynamics of that dyad?

In systems as complex as these, there is no single way of cutting the pie that adequately covers all circumstances. Above all, we must rely on our capacity simultaneously to hold multiple frames of reference. If we can accomplish those cognitive and affective gymnastics, we will see that holding the individual patient at the center of our attention, and at the same time holding the spouse and family at the center of our attention, is a matter of dialectics, and not an impossibility. Good ethics, good practice, and good theory suggest that we do nothing less than this.

I hope that these thoughts raise a lot of issues and questions, and welcome the opportunity to discuss them with the reader. I may be reached by e-mail at stechler@bu.edu.

**Concurrent Couple And Individual Therapy**

As analytically-oriented therapists, we often must decide what treatment to recommend to a patient whose marital conflict or frustrating love relationship is a major reason for seeking therapy. There is little in the psychoanalytic literature that considers whether or when the most effective approach for relational difficulties is an analytic individual therapy, or a more direct intervention in the troubled relationship itself, or both. No cogent theory explains how changes within the analytic dyad over the course of therapy affect patients’ closest outside relationships. Nor does psychoanalytic writing address the differential impacts of couple vs individual therapy on the common relational problems brought by patients. Freud set the stage for psychoanalysts’ neglect of real relationships outside the consulting room, except insofar as he feared that strong attachments to others presented problems and confounding factors for analysis. Outside relationships could drain energies from the transference; but worse, the intimate others “frequently show less interest in recovery than in keeping things the way they are. . .” (*Freud, 1917, p. 459*). The various schools of “relational psychoanalysis,” in studying the intersubjective and interactional elements of the therapy relationship, emphasize that patients are always adapting to particular interpersonal contexts, yet they too remain closed to input about the actual interpersonal contexts of patients lives. Dynamic systems theory, like family systems theory before it, has the potential to provide a framework for understanding interactions within multi-person systems, and between multiple nested systems of relationships. But the insights from family systems theory about the patterning and mutual regulation of behavior and emotions in close relationships, have never been incorporated into psychoanalysis, in part, I believe, because they present a significant challenge to the traditional dyadic treatment frame. The current interest in dynamic systems theory, which has been useful in examining interactional components of the analytic and mother-child systems, offers the tantalizing possibility of taking psychoanalytic exploration out into the realm of the multiple, interacting, interpersonal contexts that make up our patients lives.

In the absence of a unified theory in psychoanalysis, that links occurrences in the individual treatment relationship to those in our patients’ outside relationships, there is still much to be learned by comparing clinical work with couples and with individuals, guided by concepts from relational psychoanalysis and family systems theory. Working with relational problems from both perspectives, I have developed some ideas about why concurrent couple and individual therapy is uniquely suited to patients whose relationship problems are central and about the mutual impact
of the therapies, both positive and negative. Combining individual and couple therapies creates a multi-layered relational matrix which can powerfully reveal relational patterns, associated emotions and mental processes that may not otherwise be accessible. Each therapeutic modality can illuminate certain aspects of interpersonal experience that the other does not. The interaction of the two different processes can create a therapeutic synergy with more widespread and enduring impact than either an analytic individual therapy or a couple therapy alone could do. Combining the therapies may also prevent deterioration of the couple relationship, which research finds a more frequent outcome when individual therapy alone is the treatment, even when, as the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPPPP) finds, the therapy leads to substantial improvement in other areas of a patient’s functioning (Sandell, et. al., 2000).

While many analytic therapists do refer their patients for concurrent couple therapy, they may not fully appreciate its potential to deeply affect central relational schema in their patients. Referrals to couple therapy from psychoanalytic therapists are commonly related to therapy impasses, just those predicted by Freud. When a patient’s focus on the partner, and on their relationship, precludes a deepening of the therapy relationship, referrals often come in the form of “Can you help them contain the acting out in the marriage so we can get back to the work of therapy?” When the outside relationship appears to be destructive to the patient, and antithetical to the aims of therapy, a referral for couple therapy may come with a covert, or sometimes overt, hope that couple therapist will help the patient “get out of this pathological relationship.”

My broader view of indications for concurrent couple therapy starts from the clinical observation that key aspects of a patient’s relational difficulties, that are being enacted day-to-day in the couple relationship, may be expressed quite differently or be less central in the therapy relationship. Psychoanalytic theories that recognize that interactions are intersubjectively co-constructed make us aware that inevitably different aspects of patients’ selves and relational schema are activated in the patient-therapist dyad and in the intimate couple. We also know that attachment behaviors and the mutual regulation of affect are not characteristics of one person but are qualities of relationships and therefore can look different in different contexts. Even aspects of mental processes like “reflective functioning” can be more or less accessible to a patient in different interpersonal contexts (Fonagy and Target, 1996). Therefore, the inferences that therapists make about patients’ outside relationships are certain to be inaccurate, to an unknown degree.

The individual therapist also cannot control or know how change in the therapy relationship changes a patient’s ways of being with others. Patients themselves may be unable to utilize the insights and new relational experiences from individual therapy when they are in the emotionally-charged and self-reinforcing interactions with partners who have not been part of the change process. An unfortunate outcome is that very significant changes in individual therapy may remain local and have little impact on problems within the intimate tie that brought the patient into therapy.

With concurrent couple and individual therapies, patients have the advantages of two quite different learning environments and the opportunity to bring together different aspects of themselves, their views of their partners and relational modes that may otherwise remain compartmentalized. The privacy, safety and undivided attention provided by a therapist devoted exclusively to their care and understanding allows patients great freedom to experiment with new ways of relating and to focus inwardly on their deepest wishes and fears. There is less shame of exposure, more control over the timing and presentation of painful material and the capacity, conscious or unconscious, to omit material that conflicts with particular views of self and other.

The couple therapy setting feels less safe and less controlled, as patients are confronted with their partners’ competing needs, conflicting views of reality and volatile emotions. But it offers the therapist a view of the construction of their relational difficulties. The therapist’s role is quite different, decentering the therapeutic relationship in favor of observing, eliciting and directly altering the couple’s interaction patterns and experiences of each other. There is immediate and direct access to the couple’s ways of regulating distance, managing affects, and enacting transference role relationships. Transpersonal defenses, like projective identification, come alive. For example, a woman patient who disavows her own abandonment fears, can be seen to provoke intense separation anxiety in her husband by staying out late after she has haunted him with the potential dangers. Cut off from her own fearfulness, she disparages his anxiety, and constricts her perceptions to notice only those behaviors that “prove” that he is too anxious to reliably care for her. These defensive interactions, so confusing as to who is feeling what, or doing what to whom, can be deconstructed in vivo, and the various components explored. When partners are blocked from using conflict with each other to manage their own unacceptable feelings, they can begin to re-integrate disowned parts of themselves. This step is necessary for them to look at their partners as truly separate people, whose perspectives and experiences are distinct.

In disrupting the use of joint defensive operations, couple therapy can also make aspects of individual func-
tioning more accessible in individual therapy. But it also furthers the couple’s development of joint skills that will be important to their continued growth after therapy. For example, the focus on their behavioral and communication patterns helps the couple develop a “joint observing ego”, which will be a bulwark against future regression to old patterns when frustrated and disappointed with each other. Couples also develop joint ways to repair inevitable ruptures and get back on track. New kinds of interactions are often actively constructed with the therapist, and repeatedly practiced and discussed. When new relational experiences are reinforced, and consciously ratified, the couple as a unit can better withstand the gravitational pull of earlier relational modes. In essence, they become their own couple therapist, integrating the therapist’s functions into their ways of being a couple.

A final advantage of combined therapies is that couple therapy addresses relational issues that are unique to the adult intimate tie, a symmetrical relationship, characterized by mutual caretaking and requiring mutual empathy. The individual therapy relationship, which so gratifyingly offers unilateral care and interest, falls short of preparing patients to take the partner’s perspective and fully recognize the other as a center of its own subjectivity (Benjamin, 1996). Many patients, and non-patients alike, reach adulthood and commit themselves to intimate relationships without having fully developed the relational skills necessary to understand and meet another’s needs and negotiate intimacy with an equal. Individual psychotherapy is not the ideal setting for that kind of learning and, without the balance of work with the couple, risks reinforcing a more narcissistic orientation towards others.

Because of these complex demands of the adult intimate relationship, patients are sometimes viewed by therapists as needing a preparatory period in individual therapy before dealing with couple problems. But the relationship that they wish to preserve does not always survive the experience of individual therapy, unless the couple relationship receives help at the same time. Similarly, in couples characterized by pervasive projective defenses and entrenched conflictual interactions, therapists sometimes conclude that the partners are incapable of using individual therapy until the couple’s interlocking defenses and mutual projections are disentangled. Again, it is my experience that concurrent therapies are often preferable. They can function as holding environments for each other, for example, the individual therapy helping patients to bear and put in perspective painful feelings that emerge when the couple defenses are disrupted. Treating both couple and partners is also a statement that individual partners’ psychological growth is not incompatible with care of their most intimate relationship

Since there is little psychoanalytic discourse about concurrent therapies, therapists find few guidelines regarding relationships among therapists or coordination of their patients’ care. Some therapists believe in collaboration, while others may view efforts at communication between therapists as a form of countertransferential acting out. Such differences need not be problematic when patients are able to integrate the work themselves and the therapists basically trust each other’s good judgement.

But patients are often unable by themselves to integrate the work in the different settings, and recognizing divergent views among their therapists can become troubling. Couple and individual therapy provide very different perspectives on and experiences with patients’ relational issues. They have different therapeutic tasks, different therapeutic actions and access to different psychological data, which is the strength of combining the modalities. As a result, the therapists will almost certainly have substantially different pictures of the two partners and their relationship, intensified by the patients’ defensive splitting of elements of conflictual feelings. It is helpful for therapists to anticipate that they will at times be drawn into experiencing and enacting the patients’ conflicts as conflicts between the therapists. This should be a red flag signalling a need to listen to the therapists’ differing views as reflections of the patients’ conflicts and ambivalences that need to be brought together in both settings (Maltas, 1998). At such times communication between therapists may be essential to prevent fragmentation of the treatment or breakdown of the couple relationship.

References


This is the final volume in Pollock and Greenspan’s classic series, *The Course of Life*. The series was revised and expanded to seven volumes from the original three-volume set published in 1980 and 1981 for the National Institute of Mental Health by the United States Government Printing Office. The original three volumes were subtitled *Infancy and Early Childhood; Latency, Adolescence and Youth; and Adulthood and the Aging Process*. The 79 chapters were the work of 93 contributors, many of them such superstars in psychoanalytic circles as Anna Freud, Erik Erikson, John Bowlby, Peter Blos, Daniel Offer, Margaret Mahler, Marion Tolpin and Heinz Kohut.

Almost all of those original contributions have been republished in the current series, most with only minimal changes. The series is now published by International Universities Press. The newer volumes add 24 new chapters, and 63 new contributors had a hand in producing the revisions and new material. The focus of the revised volumes is both more broad and deep: infancy, early childhood and adolescence each now have their own separate volumes, while middle and late childhood are surveyed in another. Volumes on *Early Adulthood, Late Adulthood*, and *Completing the Journey* conclude the series.

The last volume in the series, *Completing the Journey*, the focus of this review, is the least expensive at $55.00, but clearly the best bargain if we are to measure value by original and current content. Eight of its 12 chapters are entirely new contributions authored by 15 analytic reviewers not previously included in the 1980s volumes. Published in 1998, it is five years more current than any of the revised series’ prior volumes.

As with most edited volumes with multiple authors, this one is uneven. A particular disappointment “Old Age,” by Ewald W. Busse. Perhaps I found it disappointing because in the 1981 edition this was one of my favorite chapters. It was packed with the kind of exceptionally well-chosen demographic data on the U.S. aging population that brings joy to any academic’s heart, offering fine detail on the physical health status of the elderly: mental illness prevalence rates among the old (with particular focus on depressive illness, suicide, phobias and hypochondriasis in that subset of the population); and demographics on employment, SES, marriage, sexual behavior, and widowhood in late life. It is a tremendous service for any author to compile and present in cogent form such a fine summary of the status of any particular segment of the population. Alas, in Busse’s minimally revised 1998 chapter, only three updated sources of data from the intervening years are incorporated, and thus the chapter seems out-of-date. Still, his summary discussions of psychological, social and psychoanalytic theories bearing on old age offer an appropriate welcome, background, and introduction to the subsequent chapters in the volume.
In contrast, the chapter on “Reminiscence and Nostalgia: the Pleasure and Pain of Remembering” by Pietro Castelnuovo-Tedesco still seems fresh as it makes its thoughtful distinction between nostalgia and reminiscence. In this short and tight contribution, Castelnuovo-Tedesco argues that “[r]eminiscence and nostalgia are separate entities and can be distinguished, especially when psychoanalytic concepts are applied (p.104).” He notes that reminiscences are sharp, vivid, often triggered by visual impressions or other sensory stimuli, and are ego-syntonic, gratifying psychological phenomena. And he believes they are central to “the development, maintenance, and evolution of identity (p.107)” in old age.

Castelnuovo-Tedesco sees nostalgia as different. Noting that nostalgia originally meant homesickness, he suggests it reflects a need to idealize the past, and he draws our attention to the vaguely dysphoric tone that characterizes nostalgia. He believes that people for whom nostalgia is a major affect in old age typically are “past-oriented; their longing for the past matches their dislike of the present and their dread of the future (p.110).” They are those old folks that Erikson indicated masked their despair with the face of disdain. Castelnuovo-Tedesco suggests that there is more integration of the past in a reminiscence, more introjection and identification with the lost objects, which permits those who are reminiscing to hold on to a safe inner anchor while allowing them forward movement, psychologically, even to the end of life. The person who is dominated by nostalgia, however, has not fundamentally given up the original loved object, and so has not been freed to move forward in the aging process.

I found these observations on reminiscence and nostalgia very helpful in understanding the affective tone of free associations in patients I work with as they talk about the past, and I listen with a more informed ear now to the quality and the frequency with which some patients tell and retell the tales of their childhoods.

Two of the new contributions in Completing the Journey are focused on minority populations. Joe Yamamoto, Arturo Silva, and Christine Chang report on “Transitions in Asian-American Elderly,” while F. M. Baker discusses “The African American Elder.” These authors are quick to acknowledge that single chapters cannot do justice to the immense complexities involved in trying to capture distinctions in the aging process in minority populations; even whole books on these topics have difficulty with the task. That said, Yamamoto, Silva, and Chang do the better job of helping the reader to appreciate the importance of a detailed understanding the path any single aged person has traveled through life within the context of that person’s culture, and its history and ecology. Given the immensity of the task laid upon the authors of these chapters, we can understand why it was that psychoanalytic contributions to the understanding of personality development as it relates to the aged in particular minority populations are not given much space. Nevertheless, especially for those interested in analytic work with minority populations, these are valuable new contributions.

Other new chapters on attachment behavior in dementia, depression in elderly women, grandfatherhood, and the shifts in analytic theory regarding the aged are useful contributions as well. Erik Erikson’s brilliant paper in Volume I of the 1980 edition, “Elements of a Psychoanalytic Theory of Psychosocial Development,” which covered in superbly condensed form his life-span theory, is not present in Volume VII of the new and revised edition because it was focused on the entire course of life, not merely on its final stages. But Helen Kivinik, his co-author of Vital Involvement in Old Age (1986), presents his theory and their views on the aging process, showing how an individual’s progress through the life cycle, and his or her management of the psychosocial tensions (no longer called “crises”) at each stage, culminate in an identity resolution that is as unique as that individual’s fingerprint. She concludes, “The very essence of balancing integrity and despair has to do with facing the certainty of sudden interruption—and becoming involved, nonetheless” (p.134).

A central controversy in psychoanalytic circles has revolved around the questions of whether or not there is genuine structural growth in adulthood. Freud’s dour view of analysis with patients past the age of 50 is mentioned by several different authors, and cited as one of the impediments to the advance of psychoanalytic understanding of the older adult: “The psychoanalytic study of aging was held back by [Freud’s] dictum that the mental processes of older persons are too rigid for treatment by classical psychoanalysis (Kahana & Morgan, 1998, p. 161).” But again and again in this volume psychoanalytically informed researchers, reviewers and authors challenge that gloomy viewpoint, arguing with considerable force that “Evidence of significant change in psychic structure in adulthood is now very well confirmed by numerous multidisciplinary findings” (Calvin Colarusso, 1998, p.289); or, as Robert Emde has written, “…it may be, in fact, that the psychology of adult development is as important for clinical psychoanalysis as is the psychology of early development” (quoted by Calvin Colarusso, 1998, p. 290). While this may not be news to those of us over the age of 60 who have benefited from a lifetime habit of careful self-scrutiny or from re-analyses at advanced ages, it nevertheless seems important that so many of these distinguished authors now freely challenge Freud’s assertion.

The closing chapter, Calvin Colarusso’s Continued on page 47
A s one of Dr. Lovinger’s devoted former students, I was quite pleased to be the beneficiary of a collection of her many teachings about child psychotherapy compiled into one small, interesting and practical volume. How many times I thought to myself, while attending to her instruction in supervision or in class, “I wish everyone who sees children in therapy could hear this.” I got my wish. Now everyone can know what I learned from Sophie Lovinger. Of course, the wisdom one has access to as a reader is not equal to that of a supervisee but Dr. Lovinger has done a marvelous job of providing an inkling of what it was like to sit in her office and process sessions with a child.

One is drawn in by her perspicacity in capturing the charms of childhood while regarding this most remarkable of populations in a sincere and mindful manner. As well, her volume is an easy read; free of the tortuous, abstracted, and alienated treatment of the subject that characterizes so many similar works. She writes about children and psychotherapy like an Olympic diver dives, with an easy grace both captivating and effortless, insinuating that anyone could do it if they only had the courage and motivation to try.

Lovinger’s book is reminiscent of the writings of Selma Fraiberg, the distinguished Michigan social worker-psychoanalyst, in one essential aspect. It consists in the prodigious capacity for slipping inside the skin of the child and to know (remember) what it is (was) like in the child’s world. Dr. Lovinger is the quintessential child psychoanalyst in the only way it makes sense to be one: firmly ensconced in the developmental perspective and perennially concerned for looking at life from the child’s point of view. In this regard, there is always a respect for the cognitive skills, the developmental summons, the family circumstances and the conditions upon which the therapeutic contract and frame is founded—all areas which are frequently dismissed by the untrained and/or indifferent would-be professional.

We begin at the beginning, naturally enough. A parent calls the therapist. The therapist thinks about the child, the parents, the family, the sessions for parents and child in this child-centered (but not child-only) endeavor. An assessment is initiated. The therapy situation is created. The adventure as experienced by the pre-school child, the latency aged child, the adolescent is embarked upon. The objective? To help the child establish or re-establish himself/herself into his/her appropriate developmental level sans the internal conflict, symptomatology and isolation with which he/she entered the therapeutic relationship. Another objective that Dr. Lovinger keeps in mind is the finding and re-establishing of the “lost empathic bond” between parent and child which is assisted by conjoining on the parents the job of being “co-therapist(s) at home with their child.”

Ever the analytically-informed and inclined therapist, Dr. Lovinger discusses resistances, transferences, counter-transferences, dreams, interpretive stances, termination issues...always within the context of the principal child therapy modality—play—and always with an eye toward the developmental vicissitudes. But this work is no pedagogic declamation. Dr. Lovinger provides much down-to-earth guidance about such ordinary matters as establishing a child therapy (play) room, stocking it with suitable toys, utilizing psychological tests for evaluation and understanding refusals, rage reactions and enactments. In this respect, her work is much like a manual of operations and would be
an excellent resource for the beginning clinician.

Dr. Lovinger strengthens her “how to” approach with caveat and commentary. One pertinent dictum is the notion that interpretations should be specific and concrete. “What is addressed or attended to by the therapist could be looked at as an interpretation even though it is not technically considered one” (p. 98). The process is similar to all analytic therapy but the attitude toward interpretation in the case of children is distinctive: “interpretations should not provide children with information they would not have been expected to gain given their developmental status” (p. 101). In consideration of the frequently found unevenness in development; the lags and premature advancements created by hyperstimulation (often sexual), this counsel seems apropos. To do otherwise, to adultomorphize (or, for that matter, infantilize) would appear to sabotage the goal of integration in personality elaboration. While such a caveat may seem trite to those of us who dedicate many of our waking hours (and often sleeping hours) to the cause of understanding others and ourselves through psychoanalytic thought, it is by no means a self-evident proposition. In the average managed-care clinic, more preoccupied with financial than with clinical solvency, there seems a real need to restate the obvious for clinicians who will see children from exigency rather than expertise.

As I read, I was occasionally absent and preoccupied by memories...of my own childhood, my child patients, my training years and “Sophie-isms.” “During this practicum, you are not to ask questions in therapy. It will be difficult.” Difficult it was—but easier to be with my patients than it ever had been before. And it struck a chord of awareness and conviction. Of course! How could it be otherwise? The only way to help was to reflect the substance of the individual, not to always grasp for more in an unsatisfied manner and, indeed, as a starving child who always wants to know why but never really hears the answer despite many offerings. Such was the opening of a particular “door of perception” courtesy of Dr. Sophie Lovinger. As she tells it in her book: “Confrontations are experienced by the child as a violation of his integrity. A direct question is experienced as a confrontation and an expectation to give of an already impoverished store of childhood experiences” (no less true, I’ve found, of adults in most of the states of mind with which they typically enter therapy).

Furthermore, insights about past occurrences, behaviors, and relationships are beyond the ability and contrary to the developmental pushes of children across the childhood and early adolescent years. Children have greater interest and investment in the here-and-now aspects of their lives. Putting the past in perspective, understanding past relationships, and the ability to reflect upon oneself are functions usually beyond the abilities of children” (p. 100).

Dr. Sophie Lovinger has been a member of the Michigan Psychoanalytic Council since its inception. She has served in many capacities, most recently as the Vice President for Education and Training. She and Dr. Robert Lovinger have been staunch believers in the value of an analytic education at the graduate school level. Having moved to South Carolina, their influence on our searching, curious lives will be sorely missed. However, their legacy of psychoanalytically-informed practice survives through their indulgent mentoring of many students and supervisees in Michigan. It is a happy day that has seen a portion of this bequest endowed by “Dr. Lovey” in this recent work.

Diane Gartland is a clinical psychologist in Farmington Hills, MI. This review was previously published in the newsletter of the Michigan local chapter.
Practicing What You Preach: The Lessons of Relational Supervision and Consultation

The Supervisory Relationship: A Contemporary Psychodynamic Approach is a very important book. It enriches an all-too-small literature on supervision and consultation. It invites supervisors and clinical consultants to examine their theoretical positions on the supervisory process and consider their technique. Ultimately, the authors encourage the readers to challenge their underlying assumptions about the task and process of supervision and consultation. The book is rich with clear arguments and compelling examples of supervisory dyads in the midst of a complex relational process of both observation and participation.

Supervision provides many of us with some of our most important relationships in the course of our professional development. Yet, despite what we know about human relationships and what we understand about the influence of supervision on the therapeutic relationship and the self of the therapist, we have let this relationship remain invisible. These powerful relationships often shape more than one’s therapeutic relationships, but one’s professional identity and sometimes, the direction of one’s career. This is a sobering responsibility; it underscores the necessity that we apply the same level of thoughtfulness and care to understand the supervisory process as we do for the therapeutic process.

As a profession, however, we pay little attention to issues of technique, theory, and methods of supervision. How many of us have had a course in clinical supervision? How many of us have received supervision on our supervisory work? How many of us are familiar with the literature on supervision? How many of us have examined not only the influence of clinical supervision on the therapeutic dyad (or couple, or family system, or group dynamic), but on the professional identity and development of the supervisee (therapist)?

I ask these questions, not to rebuke, but to highlight the valuable resource with which Mary Gail Frawley-O’Dea and Joan Sarnat have provided us. The Supervisory Relationship is organized around the basic premise that we can and should apply relational principles to our supervisory relationships. Specifically, Frawley-O’Dea and Sarnat urge supervisors to focus on the nuances of the supervisory relationship itself and to address these relational patterns explicitly. They note that the dynamics of the supervisory relationship provide fertile ground for examining the conscious and unconscious dynamics of the therapeutic relationship, of the therapist’s (supervisee) learning process and identity formation, and of the parallel (to the therapeutic process) process enacted within the second dyad of the supervisory relationship. Further, they suggest that this approach provides the most respectful and useful environment for the developmental process of the supervisee.

Attention to the relational dynamics of the supervisory dyad is an obvious extension of the attention to the evolution of the therapeutic relationship.

In their overview chapter on supervision, Frawley-O’Dea and Sarnat, offer a simple but elucidating framework.
for categorizing approaches to supervision. They identify three dimensions for evaluation: 1) The nature of the supervisor’s authority in relationship to the supervisee; 2) the supervisor’s focus, i.e., the relevant data for supervisory processing; and 3) the supervisor’s primary mode of participation. These three dimensions and their various combinations summarize the major theoretical perspectives in supervision. I also found these dimensions provide a template for any supervisor to assess either his or her own practice of supervision or a particular supervisory relationship.

To introduce their proposed method of supervision, Frawley-O’Dea and Sarnat review three primary models of supervision (five, with subsets) using these three dimensions. They discuss five models, reviewing their strengths and weaknesses: Patient-centered (Classical) model; Therapist-centered (which includes three subsets: Learning Problem or Ego Psychological; Empathic or Self-Psychological; and Anxiety-focused or Object Relational); and finally their own model, Supervisory-Matrix centered (Relational) Model. This approach allows the reader to locate him or herself (and his or her experience) in relation to the subsequent material in the volume. This organization directs the reader’s attention to specific aspects of the interaction between supervisory task and the relationship between supervisor and supervisee. In doing so, it keeps the analysis crisp and focused rather than over-generalized and vague.

A strongly persuasive and helpful aspect of this book is its use of detailed examples. I have rarely seen books on supervision that capture the conversations that are part of the work. Because of the multiple tasks and levels of analysis inherent in the endeavor, there are countless choice points in every supervisory session. It is invaluable to see the specific comments and responses, and to consider their subsequent analysis by the authors. Here as they have elsewhere (Sarnat, 1992; Davies & Frawley, 1994), the authors show their talent at capturing the real drama of clinical and supervisory work.

The examples show enormous respect for the complex person of the therapist. Without pathologizing, Frawley-O’Dea and Sarnat address the impact on psychotherapies of the therapist’s anxiety and fears, personal history, current life events, and transference to the supervisor. They address the essential issues of therapist dissociation and regression without censure. They offer examples of direct and compassionate invitations for the therapist to understand the interaction of their personal experience with their clinical work. Again, these topics are underrepresented in our professional literature and yet part of every therapist’s professional experience. I was glad to see the piece addressing the impact of a patient suicide on the therapist, another topic on which we are too often silent.

An inestimable benefit of both the model and the detailed examples they offer is the humility and non-defensiveness of the supervisors. I think that these qualities are essential for successful relational work. It is not, however, possible to teach a therapist to be open and non-defensive without modeling it relationally. Traditional supervisory relationships built on the assumption that the supervisor is the authority with the “correct” answer, tend to convey the message that a therapist is either correct or a bad therapist. This belief can lead not only to the presentation of a false self in supervision, but also to the development of a rigid and defensive stance when a patient or client challenges the therapist. As a consultant, I have seen many therapies founder on this very issue; when a therapist reacts out of shame, she or he withdraws from connection, often hiding behind a protective cloak of authority (Saakvitne, 1998). When clinical supervision intensifies shame, it can result in the therapist needing to maintain rigid defenses to protect his or her self-esteem. The relational model illustrated in The Supervisory Relationship offers an alternative. When the supervisor can model non-defensiveness and mutuality in constructing the supervisory relationship, the therapist is given permission to be fallible and develop skills to examine and renegotiate a therapeutic relationship.

My primary disappointment with The Supervisory Relationship is its restricted scope of influence; by defining the focus of the book so narrowly, the authors severely limited the audience for which it is written. I think the ideas in this book are valuable to all clinical supervisors and all students and professionals receiving clinical consultation and supervision. One limit stems from their assumption that supervision is a relationship between a senior clinician and a student or psychoanalytic candidate. In fact, supervision and consultation relationships not only should, but do take place over the course of a professional lifetime and attention to the relational dynamics in each of these relationships is just as valuable and complex as it is in an explicitly hierarchical model.

A second limit is their exclusive focus on psychoanalytic practice. I had hoped the use of psychodynamic in the title implied a broader audience, but the repeated referral to institutes and candidates suggested the book was written for a select few, the psychoanalytically devoted. I believe there a many clinicians who practice psychoanalytically informed or psychodynamic psychotherapy and who seek and/or practice clinical supervision for whom the topic of the book could offer invaluable ideas and insights. Third, the authors define the term relational solely within the realm of contemporary psychoanalysis, without so much as a nod to the feminist contributions to the concept of relational psychology (i.e., The Stone Center). This chauvinism (if you will) is unfortunate, since the perspectives
can only enrich one another. Psychoanalytic theory does not develop in a vacuum and we need to acknowledge the cross fertilization of many influences on our ideas and values.

The core of this book is rich and could easily be elaborated to explore various implications or corollaries to the theory. What are the implications when the supervisor and supervisee are from different mental health disciplines? How does the dynamic work when the supervisor has personal life experiences that are similar to those of the client? Or when the supervisor has overlaps in life experiences with the therapist (supervisee)? How would this theory work in a peer supervision model, or a group supervision model? How does this model facilitate or inhibit attention to the self of the therapist, including addressing issues of vicarious traumatization, vulnerability, and impairment? In short, the book was excellent and left me hungry for more elaboration.

I spend a third of my professional work life as a clinical consultant and supervisor. I am delighted to have this thoughtful and thought provoking book to help me grapple with the plethora of choice points in the complex, multi-level relational process of a clinical supervision. Elsewhere, I have written about the power of relational teaching in mental health, that is, using a teaching style that models the use of an empowering, respectful therapeutic stance (Saakvitne, 2002). I can think of no venue better suited to relational teaching than clinical supervision.

REFERENCES


Karen W. Saakvitne is the clinical director of the Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy in South Windsor CT and Northampton, MA. She has co-authored three books on the treatment of trauma and the self of the therapist, and a fourth book on relational teaching. She is a nationally known consultant and teacher.

Review of Pollock - Continued from page 42

“Development and Treatment in Late Adulthood,” from which the quotes above are taken, is a special treat. Not only does Colarusso present the data supporting the notion that structural change can occur throughout the life cycle, he presents a thoughtful and well-constructed conceptualization of development in adulthood, including specification of developmental tasks of late adulthood. He offers guidelines for conducting a life review and an adult diagnostic evaluation, and he proposes that Anna Freud’s concept of “developmental lines” be extended through the complete life cycle. He cites the literature on the analysis of older patients, and raises treatment issues including transference and countertransference; he concludes with some review of special techniques for working with the elderly. As is true for most edited volumes, I found that reading this book was a bit of a bumpy ride, perhaps a little like life itself. But Colarusso brings the ride to a smooth and satisfying end, as we might all hope will be true for our own lives.

In 1981, if you had bought the paperback edition of the three-volume *Course of Life* published by the U.S. Government Superintendent of Documents, it would have cost you a total of $31.50. The newly revised and expanded set costs $492.50 if you buy each of the seven books individually. While the cost is now more than 15 times greater, the content has only increased by 23 percent.

The good news is that one-third of all the new chapters in that seven volume series are contained in this final one. *Concluding the Journey*, the least expensive of the series, it is far and away the best value.

References


Mary Pharis is a Division 39 member, a past president of the Austin Society for Psychoanalytic Psychology, and retired from the University of Texas at Austin where she was the Willoughby Centennial Fellow in Child Welfare.
Two themes arise immediately in the preface to this book, themes that guided Steve Mitchell’s writings since his initial solo book in 1988. The first theme is that of wrestling. He writes that Freud “wrested” (p. ix) psychopathology from neurology. This is not simply a reference to Freud but also to Mitchell himself. In his books, Mitchell had been wrestling various ideas and perspectives on human psychology from the margins of psychoanalysis and bringing them into the center, a new location that, he believed, better reflected their actual importance in the analytic process. The second theme, which dominates Relationality, is the work of Hans Loewald. Mitchell had become intrigued with Loewald’s work and had even discussed Loewald’s life and work with Loewald’s widow. He saw in Loewald a brilliant earlier interpreter of the combined intrapsychic and interpersonal human experience to which Mitchell contributed throughout his writings. Opening Relationality with, in turn, a brilliant elaboration of Loewald’s work, Mitchell furthers, in each chapter, an agenda he shared with Loewald. This agenda was to show the constant intertwining of the intrapsychic and the interpersonal in development, unconscious mental activity, and clinical work. In pursuit of fulfilling this agenda, Mitchell’s book also includes illuminating chapters that draw out the theoretical and clinical implications of the writings of Fairbairn and Bowlby, to create what, tragically, turned out to be the last version of the relationally grounded theory of psychoanalysis he had been evolving in a series of books from 1988 through 1997.

In 1988, in his first solo book, Relational Concepts in Psychoanalysis, he began to show the conviction that many clinical situations and problems could not be understood nor resolved unless certain ideas about development, mind, and therapeutic action were brought from the margins of psychoanalytic discourse onto center stage. Steve found these ideas wherever they existed in each psychoanalytic theory and integrated them with a courage and brilliance that made what he called relational psychoanalysis a generative base of thinking and arguing for an entire generation of clinicians.

In 1993, in a book titled Hope and Dread in Psychoanalysis, he put forward the argument that psychoanalysis is a process involving, most fundamentally, the progressive and regressive excitements and anxieties of both analyst and patient. These states of mind mesh and clash constantly in the clinical situation, as the members of the two-person analytic team balance fantasies of analysis being a place where the limits of human relating can be dissolved and fantasies of analysis showing itself to be a despairing illusion. As Mitchell continued to develop the notion that what he called relational psychoanalysis was a composite, a kind of family with a cast of theoretical characters that belonged together but didn’t necessarily get along harmoniously in every way, he added that, across all these theories, the waxing and waning of tension and reconciliation, hope and dread, between patient and analyst is the medium of change in clinical work.

In that 1993 book, Steve foreshadowed what was to remain a central interest of his for the rest of his life—the nature of analytic knowledge and authority. His thinking on this subject reached a peak in his 1997 book, Influence and Autonomy in Psychoanalysis. Among the questions that matter now to psychoanalysts none outweighs the one Mitchell took up in 1997: how, paradoxically, whatever shred of autonomy each of us has in creating ourselves as human beings might be enhanced by a treatment in which we expect to be influenced by the authority and knowledge of another person. He demonstrated a breathtak-
ing capacity to open up the theoretical labyrinth that had been constructed in the psychoanalytic literature to address this and related questions and to illuminate the clinical situations in which they trouble us as both clinicians and patients.

In the book under review here, Mitchell joined his own theorizing skill with that of Fairbairn, Bowlby, and Loewald to synthesize an integrated approach to organizing psychoanalytic experience. He starts with Loewald’s notion of a primal and viscous sensational/affective flow of experiences. Our minds organize these experiences according to “different principles, varying organizational structures” (p. 58), that Mitchell called modes: the mode of nonreflective behavior, the mode of affective permeability, the mode of self-other configurations, and the mode of intersubjectivity. “These organizational schemes emerge sequentially over the course of development, but they also operate simultaneously in adult experience on a continuum from consciousness to unconsciousness” (p. 58).

Mitchell’s modes are sort of a combination of stages and positions. They emerge sequentially, but they remain lifelong ways of organizing experience, especially affective experience. So, it seems worthwhile and to the point of the book being reviewed to consider in some detail Mitchell’s theorizing about affective experience. With regard to this topic, Steve and I had conversations over the years in which it became clear we held the same views on some issues and different views on others. The substance of the key agreements and disagreements can be found on page 61, where an aspect of Steve’s writing style is also illustrated:

Early in life, and on the deepest unconscious levels throughout life, affects are evoked interpersonally through dense resonances between people, without regard for who, specifically, is feeling what. Questions like, Who started it? and Who did what to whom? are often useful to ask at other levels of organization. But these questions tend to be meaningless when intense affective connections are involved, as in strong sexual attraction, terror, murderous rage, or joyous exhilaration.

I agree that during an unfolding interpersonal event (not to mention over the course of an evolving relationship such as an analysis) if we were to stop and wonder how it had come to be that the participants were talking in a particular way and feeling just the way they found themselves feeling, then we would have a hard time answering Steve’s questions. On the other hand, the issue of who is feeling what seems different to me, and it is specifically here that Steve and I each thought that the other became tricky in their thinking. I have kept insisting that feeling states are biological/psychological phenomena generated and felt by individuals, where Steve, as in the quoted passage, held to a relational matrix of feeling states that made even the question of who is feeling what an unproductive and misleading one to pose.

The trickiness (to me) of Mitchell’s writing style here is his stringing those three quoted sentences together as if they all made the same point. They don’t. They make two different points. One is about origins of feeling states, where I agree with Steve that telling the history of feeling state X would inevitably become telling a history of people and minds in interaction. The other is about the experience of feelings, where I argue that participants feel what each of them feels and it matters a great deal who is feeling what at any given moment. By contrast, Steve tended to emphasize affective contagion (which I agree is a common and well-researched phenomenon) and moments in which “Intense affects…tend to generate corresponding affects in others” (p. 61). In his effort to draw affect into his relational framework, he de-emphasizes moments when, for example, an excited infant’s excitement is not part of a state of shared excitement co-created with mother, but leads to anxiety in the mother. His clinical examples and various aspects of his theorizing certainly allow for this, but when he was directly using intense affective experience as a key building block in his theory, he tended to emphasize people co-creating affective states or making affective states possible in each other, rather than moments of affective disjunction when one person interrupts the flow of another’s affective experience and a relational breakdown occurs, a breakdown that highlights, often in a painful way, for one or both participants, their separateness as affect-generating agents. There is, in fact, a fascinating clinical vignette (pp. 66-69) in a subsection of Chapter 3, titled “Feelings in the Air,” in which Steve and his patient start out analyzing the patient’s confusion about where the feelings of love reside (in the air, as the patient starts out fantasizing, or in himself or in his lover). After exploring various understandings in which one or each person separately feels or doesn’t feel love and projects or takes in love from the other, Steve reports:

The more we explored the situation, the less useful was the effort to choose between the view that the love “in the air” was hers, which he was afraid of, or his, which he evacuated outside the boundaries of his experience of himself. We were speaking about an affective experience that could exist only if it operated in both of them [p, 68., Mitchell’s italics].

Here Steve makes clear his clinical commitment to his theory of affects as largely, if not entirely, intrinsically shared, along the full trajectory of their origin and vicissitudes. Yet, for me, this leaves unanswered questions about other permutations of loving feelings in a scene involving two people such as the unrequited love of one person for another who does not feel
love for them.

So, I end up retaining my disagreements with Steve with regard to certain aspects of his theorizing about affects, in which efforts he seems to me to try to recruit affect into his overall relational theory, even at times when affect doesn’t exclusively belong to that theory. I think the stronger parts of the book involve his doing what Loewald did—creating visions of development and clinical work that consistently evoke new reflections on my own clinical experiences, but also involve something Steve did constantly and Loewald did rarely—the creative and insightful reporting and conceptualizing of the thorny and complex clinical situations we all face and which Steve used to illustrate his equally unique and creative renderings of familiar theories (such as the Fairbairnian, Loewaldian, and attachment theories he weaves together into what turned out to be his final relational theory). Take, for example, the case of a woman, presented in Chapter 3, who was painfully and confusedly conflicted about the role she wanted sexual excitement to play in a man’s attraction to her. Steve tells her: “I think people, including men, sometimes like you very much for reasons over which you have absolutely no control” (p. 73). Viewed from one angle, he is teaching her, if not preaching to her, a piece of wisdom in which he believes. Viewed from another angle, however, we can see an ingenious interpretation of a specific anxiety. She worries constantly about the uncontrollability of other people’s affects when they experience her or interact with her. Defensively fantasizing the existence of a strategy that would allow her to control other people’s affects, she is tortured by such a strategy eluding her. In the months following Steve’s interpretation she becomes less tortured, less depressed, and better able to tolerate and enjoy men.

This interpretation doesn’t fit neatly into any particular major theory and that seems to me to be typical of the vignettes in the book. They appear in the context of an effort to illustrate a theory or a theoretical point but they mainly demonstrate Mitchell’s clinical style of creating with patients a continuous and timeless story, from their childhood up to a current life dilemma or into their relationship with Steve, about some basic human conflictual struggle. The life story ingredient of this clinical style is sometimes missed in accounts of Steve’s work because of his argument against a developmental tilt in psychoanalytic theorizing (1988). While one would not expect to find Steve talking about or talking to a patient about a baby part of the patient, he did often sum up cases in ways such as this: “A very crucial dimension of Robert’s analysis was learning about his tendency to draw others into repetitive enactments of his early relationships with his mother” (Hope and Dread, p. 118).

What distinguishes Mitchell’s use of developmental theories was his assessment that even experiencing oneself as an infant is not the result of going “deeper” into oneself, nor are the needs one might become aware of, inside such a psychic state, infantile needs. Such experiences of oneself as an infant and the needs that emerge into consciousness (or into the transference-countertransference experience) along with them were not for Steve collapsible into their earliest manifestations. These experiences and needs, rather, were considered by Steve to be “expressions, at different developmental levels and through different cognitive and symbolic modalities” (Relational Concepts in Psychoanalysis, p. 158) of fundamental relational needs that persist throughout life. So, while it has been a mistake to assume he didn’t think developmentally, it is true that he didn’t find useful those notions that lead some analysts to think, write, and interpret baby-ness with regard to experiences and needs.

Taking Steve’s own developmental point of view into account, it is not surprising that he ended up assembling the cast of Loewald, Fairbairn, and Bowlby as the lead characters in this book. Steve may have figured he needed a team to contend theoretically with the ego psychologists and Kleinians from whom he mostly typically differentiated his relational approach (see especially Chapter 4 of Influence and Autonomy in Psychoanalysis for the clearest and least contentious differentiating by Mitchell of his position from that of these two major schools of psychoanalytic theory); but, whatever his motivation, his choice of these three figures clearly reveals an attempt to create a solid developmental
base for relational theorizing. He values Loewald for his conveying of the idea that each of us begins life as part of a primal affective density and a unified parent-child team out of which the “I” (or multiple selves), that each of us will experience ourselves as being, gradually emerges. He values Bowlby and attachment theorists not only for their capturing of the sufferings and conflicts that result from insecure and chaotic parental management of the parent-infant team but also for their capturing the interactive early development of the lifelong important capacity to hold in mind a coherent and organized life story within which to live (and thereby the developmental grounding by these Bowlbian attachment theorists of recent psychoanalytic theorizing about the inherent hermeneutics, constructivism, and narrativity of mind). Finally, there is Fairbairn. Steve didn’t simply recount Fairbairn’s theorizing in *Relationality*. He forced Fairbairn into a dialogue, as one might see in a movie where a character conjures up a holographic image of a dead father and constructs a dialogue with that character. Steve did this to some degree with every theorist he considered, taking some statement written by that theorist and then insisting that, if one meant what that theorist appeared to mean by that statement, then one (including the theorist himself or herself) would also have to believe, not believe, be led to claim, or agree or disagree with x, y, or z proposition of Steve’s. He did it especially with Fairbairn, whom Steve desperately wanted to show to have been, in spirit and basic beliefs, a committed foundational member of the relational way of envisioning development and mind and of playing the game of psychoanalysis. Steve ultimately values Fairbairn for his assessment of early life as not mainly a terrifying attempt to find in the world or construct in the mind objects with whom (or with which) to play out one’s libidinal excitement, aggressiveness, or death instinct derivatives, but, rather, mainly, at its inception, an attempt to join the human team. The infant arrives equipped with motor, sensory, affective, and cognitive capacities that are inherently for playing the game of life with other human beings. As contact is made and broken with these other humans, the infant is excited, aggressive, angry, and anxious. I would add that for Fairbairn, moments when the infant was libidinally excited were crucial (by contrast, Klein and her early colleagues such as Isaacs emphasized the anxious, enraged infant). In those excited moments the infant needed the other human (contact with whom had evoked the upsurge in excitement) to receive the excitement and get excited, in turn, about the infant’s excitement. It’s the infant’s basic welcome onto the human team.

Steve combined his readings of Loewald, Bowlby, and Fairbairn with his own four relational modes theory to create *Relationality*. The attempted combination is choppy and forced in places. There might have needed to be another book in which Steve flew solo without Loewald, Fairbairn, and Bowlby and just wrote and thought within his four mode theory. What does stand on its own, in this book, as in Steve’s earlier writings is a unique clinical style that combines Sullivan’s detailed inquiry (Mitchell asks probing and evocative questions in many of his vignettes), Loewald’s emphases on the interpenetration of fantasy and reality and the need for clinical flexibility, attachment theory’s finding of the trajectory from secure attachment in childhood to coherent making of meaning in adult life, and Fairbairn’s attentiveness to what the patient needs from the analyst (not need as an infantile residue or a phantasy/defense against primitive anxieties, but need as exemplified in a baseball double play, where the fielder who catches the ground ball needs another player to cross second base at just the right moment and make the what would otherwise be an isolated event into the double play) to emerge from his or her previously isolated and closed intrapsychic system.

As the last message from a brilliant and creative analyst to his colleagues, this book is an essential reading for all of us.

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Cherishment: A Psychology of the Heart
By Elisabeth Young-Bruehl and Faith Bethelard
New York: The Free Press, 2000, 240 Pages, $24.00
Nancy McWilliams, PhD

Cherishment is a daunting book to review; it does not fit the usual psychoanalytic mold. It somehow manages to be both a scholarly publication and a trade book, a significant addition to psychoanalytic developmental theory and a personal diary, a travelogue and a love story. With the notion of cherishment, Elisabeth Young-Bruehl and Faith Bethelard are introducing a new word to both the psychoanalytic lexicon and the English language, both of which have lacked a concept for what they describe and explore. Yet unlike many writers who enjoy coining words and phrases, they write simply and fluidly. Cherishment has none of the plodding, obfuscating jargon found in so many psychoanalytic contributions. Although the authors make an argument that deserves to be taken seriously, they develop it in the context of a shared narrative of discovery and in a tone of wonderment that may disconcert psychoanalytic scholars who are not accustomed to having their intellectual provisions served up with so much Winnicottian playfulness.

In a deceptively slim and unpretentious volume, Young-Bruehl and Bethelard appear to have an ambitious agenda. First, they are making an argument about the importance of giving adequate weight in psychoanalytic metapsychology to the presumably universal expectation of young children to be loved. In fact, they posit that without an understanding of that state of mind, psychoanalytic theory is conspicuously incomplete. Second, they are trying reach an audience that includes educated but psychoanalytically unsophisticated readers, whom they acquaint—by explicit instruction, example, and analogy—with the general terrain of contemporary psychoanalytic thinking. These lessons in psychoanalysis address not only the nuances of its theories but also the subtleties of its clinical practice and the power of its therapeutic effects. Third, they are relating their ideas to a motley assortment of intellectual traditions and art forms, including, among others, Greek philosophy and literature, Western modern art and poetry, ancient Chinese spiritual traditions, and Japanese child-rearing practices. Finally, they are documenting the relational contexts in which their own appreciation of the phenomenon they call cherishment has germinated, matured, and flourished. Their sources of inspiration include their individual reading, courses in their analytic training, their respective personal experiences as both patient and therapist, and most significantly, their experience of each other during the process of discovery. I will address each of these aspects of the book.

First, let me comment on their argument for the existence of a basic human need for affectionate connection, with its associated wish to feel prized by the caregiver. “Cherishment” is a neologism intended to be roughly synonymous with the concept of amae, as described by the Japanese psychoanalyst Takeo Doi. The territory spanned by amae seems to include another affective stance for which English lacks a single term; namely, agape, the ancient Greek word for a deeply tender, affectionate love that lacks romantic or erotic overtones. A two-person concept rooted in an infantile era before the two persons were entirely distinct psychologically, “cherishment” seems to encompass both the expectation to be cherished and the complementary disposition to do the cherishing. When Freud talked about this area of human psychology, he referred to the “anaclitic” instincts. Although the expectation to be cherished shares some conceptual space with Bowlby’s language of attach-
ment and fits rather snugly with contemporary relational theorizing, cherishment as described by the authors has many attributes of a drive. Indeed, Young-Bruehl (2001) has argued elsewhere that we need to give renewed consideration to Freud’s original concept of a two-track motivational system in which primary affectational strivings coexist with the more urgent libidinal drives.

I agree with Young-Bruehl and Bethelard that we need to learn more about the primal need to be loved, a concept that Freud originally endowed with instinctual status. In addition to sources of information about such a need that one finds both in studies on attachment and in the now-vast research literature on infancy and infant-parent interaction, I would like to see the psychoanalytic community pay more attention to contemporary empirical studies by biologists, neurologists, psychophysicists and comparative psychologists. For example, there is now a vast literature about thermoregulation in mammals and other animals. The need to be warmed by the mother’s body after childbirth is arguably even more primary than the need to suck; death comes quickly if one is not protected from the cold. Because it is more critical to newborn survival, nurses in neonatal hospital units are given much more exacting training in dealing with heat loss and “cold stress” in babies than in teaching their mothers how to nurse comfortably.

The continuing dependency of human beings on our earliest caregivers to create an optimal thermal environment is so ubiquitous a fact of infancy that, like water to the fish, it may not ever have struck us as interesting. Yet a cursory look at ordinary language—warm people, cold people, warming up an audience, casting a cold eye, basking in the warmth of a smile, offering cold comfort, warming to one’s subject, giving the cold shoulder—suggests there is something very basic about thermoregulation, something vital, sensual, intimate, tender, dyadic, and more clearly connected to the affectional system than to sexuality or aggression. With some notable exceptions (e.g., Slavin & Kriegman, 1992; Schore, 1994), it has been a long time since cutting-edge analysts have tried to integrate psychoanalytic clinical observations with the discoveries of our scientific contemporaries in fields other than clinical and developmental psychology. And it may be particularly important currently that we do so; it is arguable that Freud’s success in getting the larger world to respect the psychoanalytic paradigm had something to do with his penchant for relating his own discoveries to those of his predecessors and contemporaries in physics, biology, and neurology.

As for the third issue, the integrations that Young-Bruehl and Bethelard have made with an improbable array of other disciplines, the book is a true original, full of quirky but rewarding excursions into all kinds of human meaning-making. The exhilaration that characterizes the authors’ discovery of their respective personal unconscious
lives reminds me of the atmosphere I felt when I was teaching in Moscow and St. Petersburg shortly after perestroika had removed the Soviet taboo on psychoanalytic studies. Therapists in Russia were the most mature, erudite group of professionals I had ever addressed, the cream of a crop that had been ruthlessly weeded at every stage of the demanding Russian educational process, who consequently were much more widely educated in the arts, literature, history, and science than I can ever hope to be. At the same time, because they were just discovering psychoanalysis, they had all the giddiness of young graduate students reading Freud for the first time: They teased one another about their “complexes,” jumped with glee on one another’s Freudian slips, and couldn’t wait to get their patients on the couch and talk to them about Oedipus. Not that Young-Bruehl and Bethelard are doing that, exactly, but they breathe a similar kind of youthful enthusiasm into descriptions of their explorations, while simultaneously embedding their ideas in a body of erudition that is dazzling in its sweep.

Finally, I want to say a few things about the relational context of Cherishment. Although Young-Bruehl has done most of the actual writing, the book’s status as a genuinely coauthored work is evident throughout. One of the ways in which I am not sure it succeeds concerns the authors’ effort to convey to readers the quality of their intellectual and emotional synergy as they were discovering cherishment in one context after another. When I began analytic training in the early 1970s, my experience was greatly enriched by my close friendship with a colleague who was exploring this revelatory new psychoanalytic world with me. Sometimes, after reading an article or attending a class or case presentation, we would even have similar dreams. The sense I had of falling in love with psychoanalysis was not separable from the sense of immersion in a loving relationship. Around the same time, I was witnessing the nascent collaboration of George Atwood and Robert Stolorow, who had joined the Social and Personality Psychology faculty at Rutgers within a year of each other while I was studying there. Because their mutual passion for psychoanalytic engagement was both infectious and impenetrable, it engendered an emotionally complicated atmosphere among their colleagues and students. Our enjoyment of and admiration for their synergistic connection co-existed with painful individual feelings of exclusion from something precious.

Such intense intellectual-emotional-spiritual teamwork seems to me realistically enviable and rather rare; it may be closely related to both creativity and productivity. One thinks of Freud and Fliess, Tocqueville and Beaumont, Melville and Hawthorne, Marx and Engels, John Stuart Mill and Harriet Taylor, Simone de Beauvoir and Jean-Paul Sartre, Sidney and Beatrice Webb. Anyone who has experienced the phenomenon that Young-Bruehl and Bethelard are trying to represent understands how the process of learning together is an inextricable part of what is learned. But I am not sure how well the experience lends itself to the written word. And their readers’ transferences to their collaboration may be as conflicted as the emotions generated by Stolorow and Atwood in 1974. There is a kind of falling in love that comes through in their co-authorship that can evoke either a sense of pleasurable co-discovery (as in “Everybody loves a lover”) or an irritated defense against the pain of marginality (as in the disparaging “Love is blind”). Or both. Such reactions may complicate both the popular and scholarly response to their contribution.

Young-Bruehl and Bethelard have subtitled this work “A Psychology of the Heart.” In both form and content they have delivered on the promise. Notwithstanding the inevitable emotional and intellectual complexities it poses by being so personally intimate and at the same time so learned, I encourage my colleagues to read it. And if you want to absorb Cherishment in the spirit in which it was written, curl up with it by a fire and let yourself be warmed.

References

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Division 39 Authors
Two recently published books authored by Division 39 members were not included in the January book list:


Forgiveness, if we are to believe journalist and psychoanalytic psychologist Robert Karen, is not just for Buddhists and Christians; it is for all of us. In this wonderful book, Karen has negotiated the space between pop psychology and psychoanalytic study. The divide is usually great, but this work bridges it and does so in an understated, but elegant manner. Karen seems to shy away from showy dramatic displays of simple cookbook narratives and suggestions on how to forgive. Moreover, he connects his material to sophisticated psychoanalytic concepts that allow for depth of study without the need for an oxygen tank.

There are no prescriptions in this book and plenty of attention to the complexity of human events. If Aristotle had Karen’s book available when he was writing about moral ethics in the fourth century B.C.E., then he would probably have added forgiveness to his list of virtues.

According to Karen, forgiveness is a facet of the workings of love; it is about “allowing someone back into your heart.” It is not a simple choice because often too many layers of psychology stand in the way. But the same layers that entrap us may hold the potential to liberate us. It is these layers of psychology, in their glorious and degrading dynamism, which the author explores. The topic has not received much attention in psychoanalysis except for implications that can be found in the work of Melanie Klein.

Karen begins his examination of the “forgiving self” with an introduction to the psychology of forgiving and not forgiving. He then divides the book into three parts: loss, resentment and connection. Throughout the text, we are treated to many detailed clinical illustrations of individual, group and couples therapy, literary and cinematic examples, personal disclosures, and commentaries on historical events. Karen does not address acts of evil. His is a more modest aim. The hurts and conflicts to be found in this book “are of a subtler nature and almost all emerge in the context of standing relationships. They arise out of rage, envy, hatred, selfishness, idealization, false hope, misunderstanding, and all the other frailties to which human psychology is prone” (p. 8).

The first part of the book is titled “The Landscape of Loss” and contains five chapters dealing with saints and monsters, the flight from mourning, how we hold out for the heaven of infantile bliss, the failure of protest and repair, and inner drama where, according to Karen, we often get stuck and generate emotional scar tissue. Throughout this section, the author betrays his particular admiration for attachment theories. This is no accident because Karen is also the author of highly praised 1998 trade book Becoming Attached (Oxford University Press).

The second part of the book is titled “The Landscape of Resentment.” Here Karen first explores the way we blame others in order to get further away from ourselves:
heart. In his choked-up, husky voice, he declares that all he wants of his country is the same thing those broken-down, forsaken POWs want: “For it to love us as much as we love it!” (Now give me my blankie and my bow and arrow, I’m leaving here forever!). (p. 151)

The final part of The Forgiving Self is “The Landscape of Connection” and may be my favorite because of the modest hope it offers for us to re-experience love in the face of hurt and loss. Here Karen includes seven chapters about the redeployment of love, the renewal of protest, forgiving our parents, negative passions, letting go and more. He further defines forgiveness, not just as an aspect of the workings of love, but also as staying connected, of reconnecting, of repairing broken pieces of a relationship. For this to happen it means relating to others from an inner place of secure attachment:

I don’t need to revert to an infantile binary state and excommunicate your badness from my life. In this inner configuration, sadness and hurt, anger and hatred, can all exist. One does not feel persecuted and bitterly alone. Enough caring remains to act as a brake against self-loathing, as well as against nursing or misusing one’s anger. (p. 160)

In reading this superb book I often found myself impressed with the masterful writing style and the intricate understanding of complex psychoanalytic concepts. Karen knows how to write and he knows his psychoanalysis. My admiration for him grew as I came to the end of his book. In discussing the two sets of parents that we often deal with—the parent we grew up with, whom we struggle with internally, and the living parent of today—Karen writes about a series of encounters with his difficult and dying father. I found myself quite moved by his story and experienced a shift in my own attitude towards my own father.

Early on in The Forgiving Self Karen states that change in one’s stance towards and practice of forgiveness often requires a therapist and the experience of a relationship that can access repressed and disowned parts of ourselves and offer a fresh perspective on what is possible for us in the realm of love and loss. In this light, his purpose in writing a book on forgiveness is to inspire. He has achieved his purpose.

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Perhaps the all-time greatest Greek tragedy is the failure of the early philosophers to question common wisdom about emotion. They could have recognized thought and feeling as equally important mental processes. Philosophy and psychology would not have been compassed to intellec-tuitive views. Proponents of intellect- based principles in each field are scornful, scathing, denunciatory, of such equality. Others, with certitude, declare that they understand emotion and its place, but they continue with an intellec-tuitive view, derivative of ancient common wisdom. That is a wrong path. It is based on errors in observation, errors in fact, and errors in logic.

Why, I keep wondering, have psychological theories not abandoned the fatuities in philosophy and fully embraced “thought” and “feeling” as equally important mental pro cesses? The benefits of shifting to that view of fundamental theory make it important. Theory becomes more lucid. Psycholo-gists, using such a dual mind theory, have brought permanent cures instead of treatment to classic neuroses and other emotion muting and storm disorders; they bring clearer understanding to pattern disorders. Because patients always want cures, a total shift to these ideas about emotion dynamics seems inevitable. But dual mind theory, because it involves fundamental theory, also pervades every aspect of life experience. The related concepts bring logical de-scriptions that add to a natural psychology of health and illness.

For decades, we have known and accepted the existence of a bicameral brain with localization of function, even with apparent exceptions to the purity of right and left brain functions. Why do the various mind theories not parallel neuroscience by shifting from the illogical, ancient premise of a unitary mind to that of a two-part mind? That time-hallowed unitary mind theory, declared thought is a dominant, first event—and only after a thought event occurs does emotion arise as a second event. Emotions are thus position ed as adjunctive, lesser valued, intellectively supervised elements. That description does not serve us well.

The premise of a dual mind is more tenable. In that view, sensory data are routed concomitantly for separate cognitive and affective kinds of evaluations. It does not matter for psychology whether that route is ultimately right and left brain functions. Why do the various mind theories not parallel neuroscience by shifting from the illogical, ancient premise of a unitary mind to that of a two-part mind? That time-hallowed unitary mind theory, declared thought is a dominant, first event—and only after a thought event occurs does emotion arise as a second event. Emotions are thus positioned as adjunctive, lesser valued, intellectively supervised elements. That description does not serve us well.

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it is. The logic of building a science of mind by carefully observing matters outside of mind seems puerile.

While behaviorists’ careful observations, measurements, and statistical analyses may qualify their field as science, does that make it a mind-science? Nevertheless, its many proponents claim behavioral science is the essential psychological science. Repeated, audacious claim of superior scientific practice has been the basis of indoctrination that “Behaviorism is Psychology.” That indoctrination has been so effective that it convinced many that psychology is a subpart of behavioral science. That claim, when viewed in terms of structure of theory, is no more persuasive than a claim that behaviorism is a sub-part of psychology.

Treatment successes for behavioral approaches are claimed for only a limited list of symptom disorders. No serious claim of effectiveness in treating pattern disorders has been made. The publicized successes with panic and phobia have been touted far beyond their actuality. For those patients who have consulted me after such treatments, any apparent benefits of behavioral treatment were cures of episodes rather than cures of disorder. No general data tells whether my experience is general. While curing psychological illness episodes is not terrible for a non-mind science, it is not good enough for psychology, not good enough for patients, and not as good as is otherwise available. Proponents of behavioral approaches repeatedly claim the mysterious nature of disorders makes permanent cures unattainable. But, the crux of the matter is the insufficiency of behavioral theory to explain the nature of those disorders. Those disorders are not arcane mysteries when viewed through a dual mind theory.

Cognitive psychologists just as stalwartly stand fast with a unitary, half-mind theory. In keeping with William James’ famous mistake in observation and logic about emotion process, that view declares thought always precedes emotion. The corollary declares emotion is secondary and subordinate—simply a less important element—with uncertainty as to whether it is even mental. The claim: Correcting faulty logic and faulty perception cures psychological disorders. That erroneous simplification of mental process (also clearly at odds with current understanding of neural process) makes the cognitive field theory defective and its applications ultimately too limited for the tasks to which it is applied. Just as has occurred with behaviorists, the claimed cures of disorders have been cures of episodes. Even so, cures of episodes are not terrible for a half-mind theory. But patients deserve permanent cures of storm and muting disorders that are regularly available elsewhere.

Biopsychiatry is of special interest to the field of psychology because its public relations media onslaught reaches nearly everyone in the Western world many times each day. The message, in its many forms, is that understanding psychological issues is done most advantageously by reducing discourse to that of electro-chemical brain process. The public relations campaign is based on solid evidence of near miraculous effects of chemicals on the two brain disorders, schizophrenia and endogenous depression—which drugs control, but do not cure.

Extrapolations to other disorders involve glossing over differences between brain disorders and psychological disorders, and differences between suppression and cures of disorders. Regardless of the gloss, that campaign convinces millions of people to take a pill to make them “feel less.” The pharmaceutical campaign has been so successful that most prescriptions are given by internists and family practitioners. Those specialists rarely are cognizant of meaningful distinctions between endogenous and reactive depression, between fear and phobia, nor are they likely to discern that neither grief nor sadness, not mourning nor unhappiness makes depression. The list of further important distinctions is long. Far too often prescriptions are given to make people oblivious of their discomfort with healthy emotion responses to unfortunate life situations. However, those discomforting responses appear because their emotion systems are working well. Reducing awareness of emotion makes it difficult for people to guide their lives, or do the harder work (and use courage) in facing their inner world. But facing the world within is the one path shown to enable living better with oneself or permanently curing one’s psychological disorder.

Reductionist activity is always a mistake. Brain physiology can describe bodily responses to life experiences, but cannot deal with mental content and its processes. It is irrational to expect that drug treatment of psychological disorders brings new understanding and integration, or that it resolves consequences of current or past life experience. No application of chemicals alters the integration of childhood or later experiences. But that is the subtle, false implication in the sales of drugs for psychological problems. Understanding how to use one’s own emotions in curing storm and muting disorders, and resolving one’s conflicts in pattern disorders bring results that patients want. Achieving those results requires the emotion awareness that is suppressed by drugs.

Psychoanalysis is the one school of psychology with a whole mind theory. It remains the one school of psychology with credible explanations of character pattern disorders along with a credible system of modification of those disorders. In contrast to what psychoanalysis accomplishes for pattern disorders, successes in treatment of emotion-storm and muting disorders have been as limited and slow as with any other treatment system.

Recognition that there are very different categories of disorders with different causes and processes is not yet generally accepted in psychoanalysis. Comprehension of that distinction enables us to work with each type of disorder with its own treatment requirements.
Cure Or Amelioration?

For effective treatment through understanding character pattern disorders, psychoanalysis has no viable competition. To a worldwide public that now lumps together counseling, guidance, coaching, primal scream, eye movement, tapping, gestalt, biopsychiatry, psychotherapy, dynamic therapy, and psychoanalysis, we should not be surprised that few people are sophisticated enough to distinguish among kinds of troubles or among kinds of remedies.

If a disorder is not well described by a theory, cures are chancy. Schools of thought that are built from half-mind theories (as in cognitive psychology) or outside-of-but-near-to-mind theories (as in behavioral science and biopsychiatry) or from partial theories (as in the various pop psychologies) have their ultimate extinction built-in by their insufficiency to explain well or work effectively with the content of the field. How could a science of mind be meaningful enough to endure unless both foundation and structure of theory fit with valid whole mind processes?

Schools Of Thought And Treatment

When we compare treatment approaches for storm disorders such as panic or phobia, we find Cognitive, Behavioral, and Psychoanalytic schools each focusing on aspects of triggers of episodes rather than on processes of illness. For each school that is a weakness.

Cognitive therapists ignore the complex mental state that is the disorder process and work intellectually on the individual’s illogical thought about the trigger situation. They persuasively counsel patients to correct thought and reasoning. Patients who are in trouble with themselves because they do not use their emotions well, are taken further away from emotion. Even if they are persuaded about a specific episode, it can leave them unprepared for variations on the theme. Behavioral therapists, ignoring the disorder processes, approach the trouble as if external “trigger” is “cause.” They attempt to wear down the (conduct) response in a series of painful confrontations with that feared trigger condition. Because behavioral theory does not discriminate between specific emotion and complex process, practitioners lump together the simple emotion, “fear,” and the more complex emotion-storm, “panic,” as if those are the same. Psychoanalysis makes a nearer miss, concerning itself with internal response to triggers in terms of the individual’s historic conflict experience. That gradually modulates the internal response, in a long process, trigger by trigger. Biopsychiatry is unique in ignoring the triggers as well as the psychological illness processes, to treat the physiological symptom manifestations resulting from the illness processes. It is like treating pimples while ignoring the chickenpox.

Psychoanalysis appears to be the one current mainstream school with enough breadth as a school of thought to have the potential to survive in the long run. But survival cannot be assured without a serious, continuing activity to note and improve weak-points in its science and its field theory. Defensive declaration that psychoanalysis is “all true” damages the field.

On A Future For Psychoanalysis

While psychoanalysis may benefit from public relations and political activities, meaningful, long term benefit can come only from solidity of scientific advances. In every scientific field, repeated examination of activities and their relation to fundamental ideas is necessary for progress. But that endeavor has been weak among psychoanalysts. Because disputes occur about what is fundamental, that becomes a prime place for active observation, thought, logic, and discussion.

A Beginning In Sorting Out Some Fundamentals Of Theory

Over several decades, I have been testing, demonstrating, and writing about various aspects of affect. That work is valued by many people—both public and professionals. Recognizing emotions as fundamental, always useful elements of personality that are equal in importance to cognition, led me to suggest some dynamics of emotion. I suggested that each emotion is always useful, never an illness nor danger, but dynamics of emotion can create illness. Understanding that requires definitions of the special functions of each carefully distinguished emotion and its dynamics. I have suggested categories among pure emotions and various para-emotions. My discoveries of potentiation, emotion storms, and muting brought ideas for new diagnostic categories and treatment paradigms to fit types of illness. This has made cures instead of treatment available to many.

This work has awakened interest on the nature of thought and feeling in many people. My one-year-old personal website receives several thousand hits each week from people worldwide. Those people consistently seek more knowledge of the nature of health and illness. Some, wanting cures instead of treatment, have willingly traveled long distances to work with knowledgeable therapists.

For those interested, books and articles, appropriate for individual or classroom use are available. The book Uses Of Emotion, is published in United States and England and is available through any bookseller. Other writings and books are available in journals or on the web-site: www.drkennethisaacs.com. Grateful acknowledgment is made to Matthew Enos, PhD and Joan Gross, PhD for helpful contributions.
Psychoanalytic psychotherapy with children has been called “applied” by Roy Schafer (1983). This is because some therapeutic aims and procedures ideally suited to young people seem to compromise accepted psychoanalytic practice. Many children find it difficult to sit still and think, much less recline unnaturally for the full fifty-minute hour. Notwithstanding E. J. Anthony’s (1982) friendly suggestions to a child to sit (not lay) on the couch in order to talk things over, children need to move about and express their troubles actively. While they often say whatever comes to mind, this is not quite the same as the adult who studiously struggles to adhere to the fundamental rule and who consciously attempts to define who he is. As Schafer notes, “…the young child simply does not have the means of fully defining what we later regard as its own life experiences” (p. 129).

Moreover, the child’s adaptation to reality is not as developed as in the adult. Stressing the vital autonomy of young children in their quest to know the world, R. W. White (1963) reminds clinicians that “it is the child who strengthens his ego, actively exploring and testing a world in which, by happy design, a child’s initiative and intentions are often enough efficacious” (p. 94).

Psychoanalytic psychotherapy with autistic children is especially “applied.” A therapist must often attend to subtle nonverbal cues since it is difficult to determine how much language a mute or barely speaking young autist comprehends. Even fluent autists are said to use language for their own, usually private, purposes rather than for communication. And the ceaselessly remote attitude of autistic children differs sharply from the temporary difficulty of other recalcitrant patients. Yet, young autists’ need to explore and test the world actively, however dangerous this mission may seem, is not foreign to the autistic mentality. In many such children these “efficacious” initiatives and intentions pave the way for greater social contact.

The psychotherapist can employ common therapeutic guidelines productively in working with this hard-to-reach but fascinating group of young people. I intend to show that two therapeutic aspects central to psychotherapeutic work, empathy and introspection, are a proper focus in work with autistic youth. The autistic experience infuses the two aspects in an interesting and often liberating way. It also infuses the ways in which they use language. Their erratic, sometimes quaint way with words poses a challenge for psychotherapists.

At the root of the autistic disturbance is the child’s exaggerated, often phobic, reactions to stimulation by other people. The ordinary infant, from the outset, connects to her parents by various means. Language follows nonverbal yet social developments as the baby realizes what her mother is all about and intuits how to respond (Stern, 1985). But the autistic infant initiates few social contacts with her caretakers; even if she and her family enjoy some early, minimal association, it all too often ebbs and wanes with later developments (Maurice, 1993). The infant who once cuddled and let herself be hugged discovers efficient ways to ward off the social world, thus protecting herself from its overwhelming impact. So it is often at this point, from about one year to eighteen months, that the autistic toddler sometimes stops speaking or uses language only to further her personal, solitary needs.

Yet empathic conversation is the very modality by which a psychotherapist can reach such a child. What’s more, by way of more developed, social two-way talk the young autist begins to attach to her therapist. Several conversations between seven-year old “Stacy” and me about natural phenomena and about feelings serve to illustrate these points.

Stacy was a student at the University of Chicago’s Orthogenic School during my tenure there. She displayed many behaviors typical of autism when she was admitted at the age of five. She referred both to herself and to me as “you,” she was relentless in her demand that situations remain exactly the same or be precisely predictable, and she confused people with things (when singing nursery rhymes, she told me she was a record player as she marched rhythmically in a circle). She was phobic and angry about the perceived dangers of the world and the functioning of her body. Because she was so often overstimulated by the sights and sounds around her, she lacked out at everything and everyone near her in an attempt to destroy offending objects or to push people away. She gazed eerily at me with a blank look that told nothing of her thoughts and feelings until her little body went into motion. Then she seemed to turn the world upside down in her rage. How to speak with such a child? Indeed, why try?

Nevertheless Stacy was an uncommonly intelligent little girl and, by age seven, had begun to use pronouns normally and to ask questions about the workings of the natural world. In his book on autism Bruno Bettelheim (1967) describes the trenchant need to activate the autistic child’s interest in the world and in those who people it. Young autists “came to life only when we [staffers] were able to create the conditions, or otherwise be the catalysts, that induced them to take action on their own behalf” (p.
When it wasn’t raining Stacy played at personifying the thunder, calling it “Rumble Bumble.” Imagining the thunder to be a person seemed to give her the control she had always tried to exert over the weather. She would tell “Rumble Bumble” what to do, then enact “Rumble Bumble’s” compliance. (She later learned in class how to predict the weather.) She even mischievously dubbed the noises her hungry stomach made “Rumble Bumble.” She attributed an equivalence between an event rumbling outside with one rumbling inside her.

Erikson (1950) describes something similar in his portrait of “Jean,” a case of “early ego failure.” He does not use the term “autistic” to describe Jean but rather calls her “schizophrenic.” Yet many of her behaviors as a young child recall those of Stacy at the same age. About such children Erikson writes: “They have a defective screening system; their sensory contacts fail to master the overpowering impressions as well as the disturbing impulses which intrude into their consciousness” (p. 172-3).

Although autistic children may experience early ego failure I do not believe it is primarily due to disturbing impulses. All children have disturbing impulses. Ego failure is more likely the result of young autists having withdrawn from a social world because of its overstimulating effects. Once reconnected to the social world they may be bewildered by new and surprising affect, thoughts, and impulses but this, I believe, is a later, propitious development. Having earlier lost all or most human contact, they have created a private, often satisfying haven, an inner environment that, however, hardly encourages ego development. After all, the ego, as Erikson has famously shown, is considerably social.

In the empathic moment it is important to consider the language these children display. It reveals whether a child is bothered by stimuli from the outside (thunder) or from within (stomach noises). Moreover, their words reveal whether ego development is stalled or progressing. When Stacy referred to both the thunder and to her stomach growlings as “Rumble Bumble,” she likened one thing to another. She did not slacken but advanced rather normally as she, much like some of Jean Piaget’s (1962) subjects, inventively and humorously compared two threatening, but interesting sounds, behaving as if they were real people. The child symbolist usually expects an appreciative response from a human audience. Impressed by Stacy’s versatile imagination, I was often amused by her theatrical antics. Perhaps Erikson’s patient Jean, too, played to an

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Conversations About Natural Phenomena

Stacy had always been terrified of thunderstorms. Particularly the noise and sudden lightening flashes panicked her. So she tried desperately to make the rain stop by all sorts of magical maneuvers. One of these was her attempt to stop the rain by going outside: to her, going in when it rained suggested going out to stop the rain, thereby stopping the thunder and lightening. I found myself clarifying and rephrasing her questions and statements to make sure I had understood her accurately. “Maybe you think it will stop raining if we go outside,” I said warily one day, “since we come inside when it rains.” I was wary because whenever I guessed incorrectly what was bothering her she reacted as though my statement was an outrageous affront and tossed her toys ferociously across the room. But this time she assented, excitedly, “Yes!” “Well, no wonder you wanted to go outside, then.”
audience when she told a toy dog to go to sleep and to stay under the covers. A child’s use of metaphor marks linguistic sophistication. It represents a move away from egocentrism toward socialization (Piaget, 1981).

When Stacy was persuaded that going outside would not stop the rain and when predicting the rain reduced her anxieties about the thunder, she began to ask even more questions. Once it was, “Where does the sun go?” “It’s the earth that moves, not the sun,” I replied, hoping she would think out the problem for herself. “But does it go down?” “It looks like it does.” “It always shines, do you mean?”

So urgent was Stacy’s need for plain sense that she picked up from our conversations a linguistic habit I had developed to make sure we understood each other. She frequently rephrased my statements with “do you mean?” tacked on at the end. This, I believe, did not represent echolalic repetition. By following my lead in asking me, as I’d asked her, “do you mean” at the end of many statements, she was flagging her need to get our communications straight. In this benchmark interpersonal endeavor, rather than merely repeating me, she was fighting her way out of autism, out of her lonely, solipsistic existence.

It is by way of empathic conversation, then, that intelligent, speaking autists may attach or reattach to significant others. This is why it is so important to get a genuine conversation going—admittedly, no easy task—to instill and encourage the idea of social discourse.

Physical closeness is often not a viable therapeutic technique with these children. It is much too stimulating to their sensitive tactility. A softly spoken, gentle conversation affronts them less and appears to be more easily controlled by them. To actualize discourse the therapist must, though, guide and channel the young autist’s often haphazard linguistic efflorescences so as to render them intelligible, then to create in such a child a clearer idea of the social purposes of language.

Writing of her sensory sensitivities, childhood autist Donna Williams (1992) expresses it thus: “In order to receive pleasure from physical touch, it ought always to have been initiated by me and I ought, at the very least, to have been given a choice.” She writes about very small autistic children that they “would have to be challenged to learn that they can choose” (p. 214). Learning that they can choose is easier for them in conversation than it is when they are overcome by the stimulation of physical closeness. When the therapist keeps a proper distance, the young autist, reassured by this simple gesture, feels freer to choose the words with which she wishes to communicate.

A Conversation About Feelings
Yet the more Stacy conversed with me, the more she became afraid of intimacy. She realized that our conversations about natural phenomena lessened her anguish and led her to feel more affectionate toward me. But relating to things had always been safer than relating to people. When she sensed that I truly liked her, she would smash toys or other objects to bits as a warning to me not to act too loving toward her. “I’m trying to break your feelings,” she once told me, as if this explained everything.

In an important way what she said did explain everything. Her sentence said it all: she was only trying to break my feelings. She had learned not to concretize that which is better symbolized. Since she could not actually see feelings being broken the way she could observe a toy being destroyed, she concluded that things and people must have different properties. She then invented an expressive metaphor, one that served her well, to signal how she felt, a manner of speaking with me about the intensity of feeling toward me. She had taken immature—“preconceptual”—thinking once more into the realm of metaphor. I thought she meant to say something like, “I wish I could break your feelings because they make me feel too close to you; but I know I can’t rid myself of feeling the way I rid myself of toys.” Despite her progress in communicating, Stacy still felt overwhelmed, intimidated actually, by intimacy.

The clarification of meaning that occurred between Stacy and me (and in my work with others like her) helped prepare her for introspection, another common aspect of psychoanalytic psychotherapy. The link between a statement’s meaning and introspection arose from the fact that as Stacy tried to determine what she intended to say, she became more attuned to the internal workings of her mind. In listening to me ask, “do you mean...,” and in asking me the same question, she sought to understand what she and I intended to say to one another. In effect, she framed an intersubjectivity between us. She introspected upon the liberating effects of what Daniel Stern (1985) calls “interpersonal realities” (p. 255).

She applied the same questioning process to her internal “dialogues.” She talked to herself about what she believed to be true and real. Once she differentiated things from people thus: “Things don’t heal; people do. We don’t fix people; we fix things. Things heal? No, they don’t.” Then she returned to social dialogue in an attempt to determine the real. She called out jokes from the safety of her dormitory bed. Referring to a TV advertisement, she said, laughing, “The Jell-O with hands has feet walking” She had concluded that what was funny was not “real.” In these and many other instances Stacy became sensitized to her own mind, its beliefs, its theories. Most important, her “theory” of humor was consensual: others’ laughter “proved” that what she said was only a joke.

She also began to muse on the true and the real
in regard to her growing sense of self. Referring to her obstreperous behavior, she confided that she had always thought of herself as a hopelessly incorrigible little brat. “I came to the [Orthogenic] School very, very bad,” she moaned dourly one day. As she began to tell her personal story to me, a trusted and by now, significant other, Stacy became even more attuned to aspects of herself. Now it was safe, even heartening, to recognize that I liked her. If this were true, then how could she be utterly and hopelessly “bad”? I attempted to differentiate her “bad” self from her “bad” feelings when I said, “You are not bad, Stacy, because you have bad feelings sometimes.” “Do you like me?” came her rapid reply. “Do you like me even when I act up and throw chairs?” I told her that, deep down, I always cared about her even though, sometimes, her impetuous behavior upset me.

Still, conversing with others was, for Stacy, not without its hardships. She realized that our close relationship, now intense and ambivalent as she approached her tenth year, often made her uneasy. The potential for discomfort in the therapist’s presence obtains for many children in psychotherapy. But autistic children, unlike their peers, have fewer experiences socializing, conversing, being with other people. When they reluctantly leave their solitude, they often act shocked by the stimulation emanating from what Temple Grandin (1986), a childhood autist, calls the “people world.” A relationship’s intensity offends their oversensitive sensoria and bombards them with more thoughts and feelings than they can comfortably manage. They feel intimidated by the heavy presence of the other.

Thus, the timing of important talk, that is, interpretative statements, is of the essence in work with these children. The same can be said for the timing of silence. One must be especially careful not to say too much and allow the young autist time to process what has gone on between her and her therapist. Autistic children routinely recoil from the intensity of intimacy, ignoring, for the moment, its rewards and, above all, to companionship while coming to terms with a less foreboding, more comforting world.

Empathy and introspection are luxuries when frightened, solitary children are at risk...A relationship flourishes when young autists resonate to its tangible rewards and, above all, to companionship while coming to terms with a less foreboding, more comforting world.

References


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Over the last year or so the National Coalition of Mental Health Professionals and Consumers has been going through a period of change and renewal occasioned, at least in part, by the transition in the office of president from our founder, Karen Shore, to our new president, Deborah Peel. This change was begun last June with our conference “Shaping the Future of Mental Health Care: Let Your Voice Be Heard.” That was a heady beginning celebrated, at least in part, with the appearances of Representatives Richard Gephardt and Patrick Kennedy to signal a renewed commitment to political activism from the Coalition. We planned to build on the momentum afforded by the success of the conference to launch a new campaign devised by our president—Inform America. When the world changed on September 11th, we postponed many of these plans since so many of us, especially our New York members, felt that more urgent business intervened. So we moved from the emotional “high” that was the reward of our successful conference to the sobering realization that the work of the Coalition must go on, despite, even because of, an increasingly uncertain world.

Over the last few months we have been laying the groundwork for the new initiatives. The National Coalition is the only mental health advocacy organization that speaks for professionals, consumers, and their families about the entire range of mental health problems and treatments. Our professional organizations are often too concerned with internal issues or external “boundary” conflicts to really speak to the need for quality mental health treatment. Consumer-oriented advocacy groups in the area of mental health are often narrowly focused on only one aspect of mental illnesses and problems, or on very specific modes of treatment. Finally the large grassroots organizations addressing health care needs often do not address the need for mental health care and, when they do, often do not recognize the unique need for choice and privacy in mental health care.

Only the National Coalition has been a unifying voice for real benefits, choice and access for mental health care. This has been a core part of its mission from its beginnings in Karen Shore’s living room ten years ago. From then until now, the power driving the coalition has been its active and committed membership. Although the Coalition has never lacked for a strong voice and has had significant impact in many ways, it has not had the resources to pursue the greater task of positioning itself as a national force. It has been a catalyst for change and action both legislatively and within the professions. It has often succeeded in “giving away” and sharing ideas and tasks with groups that could implement them at the local level. This has been especially true in sharing legislative and lobbying success stories. Certainly the best example of serving as a catalyst for change was Rescue Health Care Day when we were able to bring together national and local groups of professionals, community advocates and legislators to promote health care reform.

But that is not enough. We have completed many of the tasks of raising the consciousness of the professions and public to the dangers of managed care, written and helped pass laws to protect consumers from the worst excesses of managed care. It is now time to implement a broader ambition for the Coalition. At the February meeting of the Coalition board we had the opportunity to plan goals and strategies that will take the Coalition to this new level.

The centerpiece of the weekend board meeting was a strategy session with Doyle Fellers, the eponymous director of the second largest marketing firm in the Southwest. We spent several hours each day brainstorming with Doyle how to grow the Coalition to the point that we can begin to have a national impact. Doyle took us through a sort of “Capitalism for Non-Profits 101,” a mini-course on the value of seeing what we offer, and how we present ourselves to the public, is no different from how any successful company must market itself, “package” its product in a way that makes sense to its audience, and be determined to win sizable market share.

The Coalition has already done a good job over the years in developing a “product” that has value and integrity. The Inform America campaign offers a service that anyone would say is both valuable and gives value. Quality, choice, privacy and access to real mental health care is a value that has been consistently found to offer benefits, real, substantial, economic benefits as well as the qualitative benefits of relieving needless human suffering and restoring dignity to emotionally troubled and mentally ill individuals. What we have not done is think about our work and our “product” in these ways. We can have the best product in the world but if we do not market it well then no one knows what we have to offer.

The next task for the Coalition is to grow to the point that every person in this country has the opportunity to learn that there are real emotional problems and mental illnesses that can improve, ameliorate, and, yes, even be cured when treated properly. Our task will be to make everyone in this country aware that the mental health system currently in place is not only cumbersome, demeaning and often unsuccessful in helping people with mental and emotional problems, but is economically wasteful and inefficient as well. This is information the public simply does not have; and there are powerful business interests invested in convincing people that mental illness cannot, in many cases, should not
be possible when the Coalition is a major force in this
country and the main vehicle for that will be the work of
the Foundation. One of the emotional high points of the
meeting was the decision to “cut loose” the Foundation from
the Coalition. In the next few months a new board will be
formed to run the Foundation as the money-raising arm of
the Coalition. It is an exciting prospect and in future issues,
and on the web site, you will learn about those individuals
who have agreed to volunteer for this service and will help
the Coalition realize its goal of becoming a viable organiza-
tion financially.

For me the high point came in an interaction with
Karen Shore and Doyle Fellers. It may be somewhat dra-
matic but an underlying tension of the weekend was the
change in the Coalition’s “voice” from what I would describe
as the prophetic stance of its founder, Karen Shore, to a more
corporate/capitalist model. In the meeting Doyle certainly
epitomized this model with his unabashed love of the “game”
of gaining market share and sharpening a message so that the
audience can grasp it easily. So there was some tension
as each politely “grilled” the other about their hopes, inter-
ests and desires concerning the future of the Coalition. At
one point, Doyle asked Karen what she wanted by aligning
the Coalition with the vision he had been describing. She
replied, simply, “I want to win!” Doyle grinned broadly and
announced that this, too, was his sole motivation in any
enterprise in which he has engaged and that he would have
his doubts about getting involved with any organization that
would rather be “right” than win.

Make no mistake about it. The focus on winning can
be a problem. It can lead to a loss of vision. Doyle observed,
however, that the same is true for capitalist enterprises: in the
long run a business must have a vision as well as a desire
to win, it must have integrity while pursuing market share.
As the Coalition, and now the Foundation, move toward this
more expanded mission it will be important that we retain
the vision that began the Coalition in that living room ten
years ago: that quality mental health care is possible only
when people have real access, real choice and real benefits.

We can accomplish this only with a passionate
and dedicated membership. This is where you come in.
Division 39 has been a strong supporter of the Coalition
since its inception. Last year the Division contributed signi-
ficant funds to allow the Coalition to develop some of the
plans noted above. Our president, Jonathan Slavin, called this
an “investment” that the Division made in its own future.

Many of you are Coalition members. For those
of you who are not, please join! We need your energy,
ideas, and, yes, your money. You can learn more about the
Coalition and how to join by checking out the web site at
www.TheNationalCoalition.org, or call 1-888-SAYNOMC,
or send $100 to PO Box 438, Commack, NY 11725 and start
your membership in the Coalition today.
In October 2001, the Committee for the Advancement of Professional Practice (CAPP) and Integration Work Group (IG) met during the Fall Consolidated Board and Committee meetings. This means that our meetings were held at the same time and place of several other APA Boards and Committees, which gave all participants an opportunity to interact with APA members who serve on other Boards and Committees. There was a plenary session and some open meetings. Since the Fall meetings were held on October 26th through the 28th, the atmosphere was heavily influenced by the tragic events of September 11th and the anthrax attacks. It was unsettling to see the Capitol and Supreme Court building cordoned off. They were devoid of the usual tourists as well as the people who work in these buildings. It was eerie for me to see these buildings and the White House virtually empty except for the guards who stood outside.

Of course, much time was devoted to the effects of terrorism on psychology as a profession and psychologists’ responses to these tragedies. The plenary session was devoted to APA’s response to the tragedy and media requests for information. APA coordinated volunteers who wanted to help and put out reliable information on the APA website on the psychological effects of terrorism and coping with these psychological effects. Especially good information was put out on how to help children cope and how parents could talk with their children during these stressful times. The central office of APA responded to many media requests for information. APA members volunteered in large numbers (including Division 39 members) and some were on national network news shows. APA and its staff responded very well and there was a feeling at these meetings that people were proud to be psychologists and proud of how well the dedicated staff responded and put organized psychology’s best foot forward.

The APA Board of Directors has established a task force on terrorism. This task force is made up of psychologists with diverse perspectives on terrorism, i.e. researchers and practitioners. The purpose of the task force is to develop a scientifically valid knowledge on terrorism in its many facets that can be used to educate APA members, policy makers and legislators, as well as the public.

At the CAPP meetings, it was pointed out that the APA Disaster Relief Network (DNR) is a volunteer network of qualified psychologists who are called upon to respond to disasters. This is a program that APA runs with the Red Cross. The Red Cross requires that each DNR volunteer complete Red Cross training for disaster response. I urge all interested members of the Division to obtain the Red Cross training so that when they want to volunteer they will be part of the DNR and they will be assigned to disaster relief work as the occasion arises.

The integration work group (IG) met the evening before the CAPP meetings began. This meeting was largely devoted to how various divisions and state associations responded to the tragic events of September 11th. It was interesting to see how various constituents of APA largely responded in the same way—volunteering their time and professional skills to help people in need.

I suggested as an agenda item (to be forwarded to the CAPP) that we use the PracticeNet to get information from practitioners on the use of tele-health modalities in clinical practice. I think it is essential that we get an idea of how much tele-health in its various modalities is being used by practitioners. Only with a database of this sort, will we be able to move forward to conduct meaningful research on mental health tele-health and advocate for appropriate CPT codes and third party reimbursement for such services.

The PracticeNet is an Internet based information network using real time behavior sampling. Members of APA can sign up to participate. Periodically during the year, the PracticeNet system will send an e-mail message to participants enrolled in the system. Practitioners are then directed to a secure web page for responding. The practitioners are asked a series of questions about a patient (no identifying information is requested) and a specific clinical session. It is very important for our Division members to participate so that the psychoanalytic perspective is incorporated into the database that provides periodic “snapshots” of practice. These data will be used to plan CAPP activities and will be used for Federal and State advocacy efforts. To find out more about the PracticeNet, go to practicenet@apa.org. I signed up and participated (it was easy and user friendly) in a real time behavioral sampling in October. The questions asked about a specific clinical hour and how it was affected by the events of September 11th.

At the consolidated meetings, there was an open meeting of the APA task force that is studying membership retention and recruitment of new members. APA is beginning to experience an erosion of membership retention and some challenges in recruitment of new members especially new psychologists. This meeting was interesting because of the innovative approaches being discussed by the APA.
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involving graduate students in APA matters and governance.
poses a problem. It seemed to me that the sentiment favors
members to vote when one of our members is running for
members are the future lifeblood of APA and our Division. How to
in APA governance. But to have a seat on the Board of Direc-
the Graduate Student Association to be re-
was the desire of the Graduate Student Association to be re-
reasons:
1. As membership declines in APA, fewer resources are
available. This has begun to have an impact on the
APA budget. Division membership is affected by
APA membership. So we can expect to deal with
reduced membership and we already have experi-
nenced erosion in membership.
2. Erosion in a membership base will affect the budget
of the Division and it's many activities. We need to
be alert to what APA does to cope with membership
issues and learn what might be effective for the Divi-
Secondly, the budgetary implications for the
Division need to be carefully assessed and planned.
CAPP has partnered with the state associations to
promote joint membership, i.e. APA membership and
state association membership. This effort has ignored
promoting Division membership. We will need to
work on our own to increase Division membership.
Another major issue that came up at the CAPP meetings
was the desire of the Graduate Student Association to be re-
presented on the Board of Directors. This is quite controversial
because many people want graduate student representation in
APA governance. But to have a seat on the Board of Direc-
tors and not be represented in the Council of Representatives
poses a problem. It seemed to me that the sentiment favors
involving graduate students in APA matters and governance.
The question is how to go about doing so within the current
APA organizational structure. Clearly, the graduate students
are the future lifeblood of APA and our Division. How to
integrate them into APA's organization is a challenge.
The CAPP continues to pursue legal cases that are
selected to strategically impact managed care. The Government
Relations office continues to lobby on behalf of psychol-
ologists on various legislative issues. This Fall much of
congress' usual calendar was put aside, as focus was placed
on bills related to developing a response to terrorism. Yet
CAPP is working to make sure that psychology is included
in these new bills as they relate to mental health issues
associated with terrorism and their sequelae.
The major points of the Winter Meetings held in
January are: The Practice Organization presented a preview
of a new website which is called a portal. The portal is being
developed by the Practice Organization and will be available
to all APA members who pay the special assessment. The
portal is designed to enhance our practices by providing
services that are relevant to our practices. For example, it
will be able to give us up-dates on new laws that we must
follow regarding such things as privacy of patient records,
rules regarding electronic record keeping, etc. Also one can
sign up for special alerts that would be e-mailed regarding
specific topics that one is interested in such as updates on
a specific treatment modality, the results of APA's lawsuits,
the progress of prescription privileges legislation in various
states as well as information on recent research. The portal
would also help us in our advocacy efforts both at the
national and state level, when legislative action is needed,
and it would also permit us to communicate with our col-
leagues and APA. Other features of the portal would include
practice management enhancement tools, e.g. one could
print out material that could be handouts for patients. The
presentation of this preliminary model of the portal was very
professional and this looks like a great member benefit.
The Government Relations group has been success-
ful in certain Capitol Hill efforts. In particular, the recent
bill, called the Post Terrorism Mental Health Improvement
Act passed by the Senate to fund recovery from the terrorist
activities of 9/11, psychological services, were included in
the legislation. This is an important step for our profession.
APA Members who are in the practice community
were urged to vote in the upcoming APA elections. There
is some speculation that a low proportion of practitioners
are voting in APA elections and thus candidates for APA's
presidency who are practitioners have not done well in the
last two elections. It is especially important for Division
Members to vote when one of our members is running for
President or other APA offices.
The Practice Organization is continuing to raise
funds to support carefully selected lawsuits against managed
care and for pursuing prescription privileges legislation in
various states. Efforts to raise money for the Legal Defense
Fund have been more successful than for prescription privi-
leges. The Virginia Blues case is moving forward to trial.
Please make contributions to the Practice Organiza-
tion when you are asked. The Legal Defense Fund has been
very successful at changing laws regarding managed care.
These changes have a direct impact on our practices.
The next public education campaign that the APA
will launch will focus on the theme of resiliency. This is
a major mental health theme that has been identified by
APA in the focus groups that have been run after 9/11. This
campaign will build on prior successful public education
campaigns. We, in the Division, need to become more active
in our public information efforts to help people understand
what is contemporary psychoanalysis and in so doing build
upon the APA public education effort.
Lastly, members are urged to sign up for and par-
ticipate in the real time behavioral sampling, called Practi-
ceNet (see above for details), that assesses how we actually
practice. The preliminary results of the first data collection
process are available and briefly reported in the Winter
PractitionerUpdate.
The Committee for Multicultural Concerns of Division 39 has been busy preparing for the National Multicultural Conference and Summit, 2003 and recruiting new members. We are pleased that Lisa Orbé, Teachers College, Columbia University and Lucy Takagi, Rutgers University, two graduate students, have joined us. We look forward to more involvement and interaction by the division membership. As we begin this year, we find ourselves as a committee struggling with the questions: Self and Other: Where are we in the continuum? What color is the couch? What are the struggles in the development of cultural competence in psychoanalysis? How do we understand the issues of similarities and differences within the analytic dyad? Is prejudice used as a defense? What are the unspoken issues related to cultural diversity and prejudice?

Our hope is that as a community we will engage in challenging ourselves to address some of these questions and open ourselves to the dialogue, which will unfold, re-examining our perspectives about our clients and ourselves as analysts around issues of race and culture. There are several venues, which could be the springboard for this dialogue, mail-in or e-mail, our annual spring and summer meetings and a ListServ. Let us know of your interest and preference. Please contact either or both of us: Dolores Morris, 290 Riverside Drive, New York, NY 10025, domorris@worldnet.att.net; or Lisa Orbé, Teachers College, Columbia University, 525 W. 120th Street, Box 102, New York, NY 10010, orbe@exchange.tc.columbia.edu

The Continuing Education (CE) Committee was established as a way to assist local chapters and other component groups in the Division to be able to offer APA-approved continuing education programs under the broad “umbrella” of the Division while allowing a measure of autonomy in program planning to suit the particular needs of the group. My role is that of a program administrator in that the various program committees are responsible for developing and documenting CE activities that meet the requirements of APA and I collect and archive relevant information. As a result, I have a responsibility to APA to make sure that the many program committees operate correctly, and to psychologists who earn CE credits to retain documents to verify completion of activities.

Sixteen local chapters participate in the Division’s CE Program. The coordinators are: Ronda Reitz (Appalachian Psychoanalytic Society), Gemma Ainslie (Austin Society for Psychoanalytic Psychology), Jeff Seiden (Chicago Association for Psychoanalytic Psychology), Les Greene (Connecticut Society for Psychoanalytic Psychology), Nancy Rizzo (Florida Organization for Relational Studies), Claude Brunell (Kansas City Association for Psychoanalytic Psychology), Bob Goodkind (New Mexico Psychoanalytic Society) Janet Scarborough (Pacific Northwest Psychoanalytic Society), David York (Philadelphia Society for Psychoanalytic Psychology), Cynthia Fredricks (Rhode Island Association for Psychoanalytic Psychology) Amy Horne (San Diego Society for Psychoanalytic Studies), Bonnie Hopkins (Southeast Florida Association for Psychoanalytic Psychology), Sharon Dennett (Vermont Association for Psychoanalytic Studies), and Joel Rosen (Western Massachusetts and Albany Association for Psychoanalytic Psychology). Reuben Silver is the coordinator for Section V. Both Northern California Association for Psychoanalytic Psychology and Southern California Chapter have asked for CE Handbooks but have not identified a coordinator. Pat Strasberg serves as CE coordinator for Division 39 Annual Meeting. In other words, this year there will be eighteen, and perhaps twenty, program committees offering continuing education credits through the sponsorship of the Division.

Through February there were at least 44 scheduled programs although I have only received information on 31 of those programs. In total, there were over 500 participants with 300 psychologists attending these activities. Attendance at activities ranged from 3 to 58. This probably accounts for only one-third of the CE activities offered through the Division during the program year. So you can see we are a very busy bunch of folks!

Jaine Darwin established the position of CE Coordinator and we are currently finishing out the second five-year plan. Every year I must report on the CE activities and provide documentation that the Division has complied with APA rules. This is an ongoing challenge in making sure that program committees are operating within the guidelines set down by APA. It can be a particular challenge with small chapters that rely upon volunteers who may come late to the process and not understand the need for documentation. I have developed a CE Handbook and a Timeline for Completion of CE Documentation that local chapters can use. Please contact me if you wish additional information at drmacg@bellsouth.net, or phone 865-558-5675.
This committee grew out of the Division’s Sexualities Interest Group, which was conceived of by Maureen Murphy and Jonathan Slavin. Members of the committee are: Barbara Artson, Victor Bonfilio, Randi Kaufman, Bethany Riddle, and John Rosario-Perez.

There were two organizing meetings of the Sexualities Interest Group, one held in Santa Fe at the 2001 Spring Meeting and one in San Francisco at APA. Participants in the organizing meetings were enthusiastic about an entity that served the needs of LGBT members of the Division. Jonathan Slavin facilitated the evolution of the Interest Group into a formal committee of the Division 39 Board of Directors this past January.

The mission of the Committee on Sexual Identity and Lesbian, Gay, Bisexual, and Transgender Issues (SILGBTI) is:

1. To conduct an assessment of the needs of the membership of Division 39 regarding LGBT concerns and issues, including finding ways to give all members with an interest in this topic a voice in the affairs of the Division (for example by networking, doing a survey in the *Psychologist-Psychoanalyst*, etc.)
2. To make contact with APA Division 44 (The Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues) and look into: joint programming, providing an updated view of psychoanalysis to LGBT psychologists in APA who may have felt, for very good reason, antipathetic to psychoanalysis, and inviting members of this and other divisions with like-minded interests to join with us.
3. To make recommendations to the Board for actions that need to be taken regarding the place and needs of LGBT members, the name that such a committee might have, and to have programming at Division meetings sponsored by this committee.

At the first SILGBTI meeting in March, committee members discussed ways to provide educational resources regarding Sexual Identity and LGBT issues to Division members. One endeavor in this area is SILGBTI’s sponsorship of an ongoing discussion group on the topic of sexual object choice at each Spring Meeting and each meeting of APA. The ongoing discussion group will involve a brief paper and brief responses on the topic of sexual object choice. Then, ample time will be allocated for the discussion of issues raised in the paper and responses by presenters and attendees. The committee will also consider initiating other ongoing discussion groups.

SILGBTI will meet again at the Spring Meeting in New York. Also at the meeting, we will kick off our ongoing discussion group on sexual object choice with a paper by Elisabeth Young-Bruehl entitled, “On Bisexual Objects.” Dianne Elise and Dennis Debiak will be discussants.

SILGBTI would appreciate input from members of the Division. Please contact Dennis Debiak at ddebiak@aol.com with comments, questions, or suggestions.

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The Ethics and Professional Issues Committee of Division 39 is composed of 5 members: Kirby Ogden, Minnesota, Marylou Lionells, New York, Elliot Jurist, New York, Karen Tillman, the student member, New York, and Arnold Schneider, Chair, Florida.

Last year the committee’s efforts were focused on the revision of the American Psychological Association’s Ethics Code, offering several changes which are included in the revision which protect psychoanalysis, our analysts, and the educational process. Also, last year we attempted to gather from the membership a list of ethical dilemmas that we had planned to submit to analysts, ethicists, and attorneys and to publish their discussion in a book. Unfortunately, very few dilemmas were offered and that project was shelved. However, we understand that the American Psychoanalytic Association has published something very similar to what we were proposing; we plan to review that book to determine its merits for Division membership.

This year we are planning a symposium for the Division 39 2002 Spring Meeting. Again, we plan to have a psychoanalyst, ethicist, and attorney address several psychoanalytic ethical dilemmas. The committee is open to suggestions for future activities from members.
The publications committee of the Division of Psychoanalysis recommends policy affecting the three publications of Division 39: our journal, Psychoanalytic Psychology, our newsletter, Psychologist-Psychoanalyst, and our review of book and journal abstracts, Psychoanalytic Abstracts, once known as PsyScan. When Ira Moses resigned as chair as of December 31, 2000, Maureen Murphy asked me to replace him. Publications account for over one-third of the budget of the Division, and reading its printed communications is the main or only mode of participation in the Division by a vast majority of members. Consequently, the responsibility of the Publications Committee is significant. Members meet in person annually at the Spring Meeting and otherwise conduct business by phone and e-mail.

My first challenge was getting up to speed on the history and functions of the committee. I had conversations with Ira Moses, who sent me detailed archival material; with Joseph Reppen and William MacGillivray, the editors of the journal and newsletter, respectively; and with Gary VandenBos from the APA central office and Robert Lane of the Division, who had jointly handled Psychoanalytic Abstracts. I also talked with several veteran committee members.

**Committee Composition and Terms**

The Division bylaws specify that the committee contains six regular members appointed for six-year terms, plus the editors of the journal, the newsletter, and the abstracts, and the Division President and Treasurer, ex-officio. It should include representation from each section. Jonathan Slavin added two regular members and a graduate student member to the committee, making its current composition as follows:

<table>
<thead>
<tr>
<th>Chair</th>
<th>Term of Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nancy McWilliams, Chair</td>
<td>2001-2006</td>
</tr>
<tr>
<td>Ricardo Ainslie</td>
<td>1998-2003</td>
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<tr>
<td>Judith Ruzumna</td>
<td>1998-2003</td>
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<td>Martin Schulman</td>
<td>1998-2003</td>
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<td>Jane Tucker</td>
<td>1999-2004</td>
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<tr>
<td>Karen Maroda</td>
<td>2001-2006</td>
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<td>Mary Gail Frawley O’Dea</td>
<td>2002-2007</td>
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<td>Frank Lachmann</td>
<td>2002-2007</td>
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<td>Sylvia Gosnells</td>
<td>2002-2007</td>
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<td>Joseph Reppen</td>
<td>1998-2003</td>
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<td>William MacGillivray</td>
<td>2000-2005</td>
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<td>Arnold Schneider</td>
<td>2001-2006</td>
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<tr>
<td>David Ramirez</td>
<td>Ex-Officio</td>
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<td>Jonathan Slavin</td>
<td>Ex-Officio</td>
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**Psychoanalytic Psychology**

In 2001, the most pressing issue confronting the committee was a disturbing lag (up to a year and a half) between acceptance and publication of articles in Psychoanalytic Psychology—a backlog that resulted at least partly from its successes. As its prestige increases, submissions to the journal tend to go up. Publication there appeals to authors on the basis of its reputation and because it is arguably the only psychoanalytic journal that welcomes manuscripts from all points of view. Despite its small annual page count, it is second only to the Journal of the American Psychoanalytic Association in number of American subscribers. As an APA peer-reviewed organ, it must accept any article its reviewers deem worthy. To find space for articles, Dr. Reppen was making extensive edits to accepted manuscripts and had omitted most book reviews and panel reports.

In recent years, the Division Board has been willing to grant the editor additional “signatures” (bundles of pages) on a year-by-year basis. At its 2001 meeting, the committee agreed to appeal to the Board to make this expenditure permanent lest the publication lag deter authors from submitting. At its August meeting, the Board generously and unanimously approved funding a permanent increase of six signatures (192 pages per year) at a cost of approximately $15,000. Assuming a continued high rate of submissions, the publications committee will consider in New York whether, as of Winter 2003, to publish Psychoanalytic Psychology in a 7 x 10 instead of 6 x 9 format, thus making room for more articles at no additional cost. More good news about journal expenses concerns negotiations between David Ramirez and Susan Knapp of APA, who agreed on an attractive flat rate rather than a laborious per-person assessment for providing Psychoanalytic Psychology to Division members.

Dr. Reppen’s first six-year term as editor will expire on December 31, 2003. The publications committee will therefore be taking up at its April meeting the recommendation that he be appointed for a second term.

**Psychologist-Psychoanalyst**

The main issue the committee addressed in relation to the newsletter was its lack of a copyright policy, in contrast to the journal and to some newsletters of other APA divisions. The absence of such a policy has caused the editor some headaches. In the January Board meeting, a motion was passed establishing that Psychologist-Psychoanalyst holds copyright on articles accepted for publication. In April, the publications committee will hammer out specifics of the policy, including issues such as whether the author’s approval is needed for every reprint request. I will report to
the Board on its recommendations in August.

Other upcoming newsletter topics to be discussed by the committee include the possibility of offering continuing education credits for reading *Psychologist-Psychoanalyst*, the question of whether to raise rates for trade advertisements, and the development of an overall policy about ads, especially those that involve an informal agreement to “swap” ads regularly with certain publishers. Dr. MacGillivray has also floated the possibility of having a newsletter section devoted to intellectual and/or professional autobiography and will solicit committee members’ suggestions for other special sections. If time permits, the committee will consider whether to post the newsletter on the Division web site. Finally, it will take up the question of whether the editor deserves more remuneration, in light of both his workload and his having saved the Division considerable money by applying his computer expertise to the editing and publishing of a now-expanded *Psychologist-Psychoanalyst*. If the committee decides it is justified in such a request, I will present their position to the Board in August.

**Psychoanalytic Abstracts**

Arnold Schneider, Joe Reppen and I attended the 2001 Editorial Board meeting of *Psychoanalytic Abstracts*. At this annual meeting, Alvin Walker, APA’s manager of the journal, seeks direction on which books and journals to include and covers topics such as subscription activity and marketing efforts. Reportedly, attendance by representatives of Division 39 has dwindled over the past years, as has attendance by APA representatives other than Linda Beebe, Senior Director of PsychINFO. The editorial board of *Psychoanalytic Abstracts* is supposed to contain members appointed by both the APA Publications and Communications Board and the Publications Committee of Division 39. Its published list of members contains several people who have not been active for some time.

Gary VandenBos reports that *Psychoanalytic Abstracts* has been operating more or less independently under Walker’s capable leadership and would appreciate more help. He and I, in consultation with Maureen Murphy and Jonathan Slavin, to establish a new editorial board of six individuals assigned by APA and six appointed by the Publications Committee. At the August meeting, several Division members with experience in publication were suggested as candidates. In April the Publications Committee will make appointments and establish by lot the staggered terms of members. Upon the retirement of Robert Lane, Arnold Schneider was provisionally appointed as chief editorial liaison. We will seek Board approval for his title at the August Board meeting, where Division officers can review this arrangement.

**Miscellaneous**

I also learned from Dr. VandenBos that in 1994 Charles Spezzano, then chair of the publications committee, signed a contract with APA establishing a “collaborative relationship” to develop a book series. Division authors would publish with APA under a special Book Series Editor. The agreement is specific and comprehensive about the responsibilities of both the Division and APA, as well as about royalties, design, complimentary book copies, pricing, and publication time, but no books have issued from it. The publications committee will consider whether and how to reactivate such an arrangement.

There has been a lot for me to assimilate in taking on this job. Overall, I have been impressed with the health of our publications and the competence and dedication of the people responsible for them. The existing members of the publications committee have been very responsive to my efforts to tap their expertise, and the new members have shown considerable enthusiasm for taking on the work of the committee. I am grateful for the generous support I have received from Maureen Murphy, Jonathan Slavin, David Ramirez, and the Division 39 Board as a whole.

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**Call for Papers**

Proposals for the Summer 2002 Division 39 meetings, to be held in Chicago, should be submitted by filling out the official APA convention form found in the Fall issue of the APA Monitor.

*No separate call for papers* will be issued by Division 39 and, it should be noted, due to a significant reduction in programming hours allotted by APA for our division, there will be a much lower than usual probability of acceptance of panels and papers for this meeting.

Any questions may be directed to:
Christine C. Kieffer, PhD, Chair
122 South Michigan Avenue, Suite 1432,
Chicago, Illinois 60603
Tel (312) 922-7274
E-mail: CCKPHD@aol.com
I would like to acknowledge the members of the newly formed membership committee as they have already begun to work very hard on behalf of the division. Those members are: Robert Keisner, PhD; Tal Lee, graduate student; Steven Luz-Alterman, PhD; Tamara McClintock Greenberg, PsyD; and Ellen Westrich, PhD.

As our membership recruitment efforts continue to expand, it is becoming increasingly clear that we must also turn our attention in a very serious way toward developing and then implementing division membership retention strategies. Currently we send letters to those persons APA identifies for us as nonrenewed division members (after they have been held on the rolls for up to two years). This year we participated in APA division services division-specific postcard mailings to all division members who did not renew as of January 1. This program has the advantage of contacting nonrenewed members immediately with mailings going out in both January and March.

The committee’s efforts to develop recruitment and retention strategies will be aided by both the report of the APA’s Task Force on Membership, Retention and Recruitment and by our very recent signing on with the APA’s Membership ListServ which provides an ongoing forum in which to share ideas about recruitment and retention with other division membership committee chairs as well as APA division services personnel.

The development of a nationwide communications network with professional psychology graduate degree programs will remain a part of the committee’s efforts. As a result of those efforts, and the work of the Graduate Student Committee, sixteen graduate degree programs in the New York area were sent flyers/invitations to this year’s spring meeting. The Membership Committee will continue to work closely with the Graduate Student Committee to coordinate future efforts to increase graduate student interest and membership in the division.

Membership survey letters for the new directory are scheduled to be mailed just prior to the spring meeting and we are on target to have the directories published and ready to be mailed out by the end of June, our original target date. When your survey letter arrives be sure to read it carefully and make sure the information is correct. I would encourage all of you to list your current e-mail address if you haven’t already, as this will become an increasingly important mode of division communication.

I would like to end this report by encouraging each division member to consider yourself a member of the membership committee, knowing that in order for the division to flourish, membership recruitment and retention must be a focus of attention and action by every member.

Accompanying this report is a list of our new members. In the next column are the psychologist, allied professional and graduate student members who have joined the division in the last few months. Please take some time to look over the list and see if you recognize a colleague. Perhaps you will take the trouble to welcome them into the Division. It is important to recognize that we all play an important role in membership development. Equally important is that members should begin to see themselves as part of a larger community that works to support our common efforts and goals. The editor.

**New Members 12/01 - 3/02**

Brian S. Andres, MSW, MA
Amy Bandera
Eleonora Bartoli, PhD
Steven Baum, PsyD
Michal Ben-Meir, BBA
Mikaela Bernthal-Kolb, PsyD
Donald Brown, MD
Dana Carciuamaru
Alexis Zoe Chavis
Emily Cunduff, BS
Derek Davidson, MD
Doreen Di Fiore
Ruth Drasin, PhD
Mark Egit, PhD
Milena Fallowes, BA
Susan Fine, PsyD
Malcolm Gaines, MA
Alexandra Gerson, MS
Nancy Gubman, MSW
Judith H. Gurtman, PhD
Desnee Hall, PhD
Bruce Herzog, MD, FRCP
Katherine Kahr, MSW
Marie King, PhD
Lindsey B. Kupferman
Judith Lieberman, PsyD
Lily W. Ly, PsyD
Katerina Marnerakis, BS
Karen Mayes, MSW
Jacqueline Neilson, MA
Joseph Rhinewine, MA
Rosa Maria Rigol, PhD
Jeff Savlov, MSW
Susan Schnur
Susan Shachner, PhD
Carol Shyer, PhD
Linda B. Simmons, MEd
Allison Smenner, MS
Jeanne H. Smith, MSSW
Nancy Spohn, MSW
Cornelia St. John, MEd
Wendy N. Stapen, MA
Clive Thomson, PhD
Lisa L. Twilling, PhD
Robin Ward, MA
Riva Westlund
Suzanne Wiggins
Timothy Zeddies, PhD
**Section III: Women, Gender and Psychoanalysis**

Jane G. Tillman, PhD

Section III is now nineteen years old. At the Board meeting in August 2001 we took the opportunity to review the creation and the history of the Section, renewing our commitment to the Section and its mission to provide quality programs and opportunities for Division 39 members interested in women’s issues, gender and psychoanalysis. Current Section activities include publishing a newsletter biannually, organizing panels for the Spring Meeting and the APA Annual Convention, sponsoring a dissertation award to support a graduate student, honoring a colleague each year for outstanding contributions to the study of women and gender, and providing a space for ongoing discussion of issues of interest.

Recent activities of the Section include a standing-room-only crowd at the 2001 APA Annual Convention for a panel chaired by Nancy McWilliams, PhD. This panel, on intersexuality, explored the clinical, political and academic aspects of gender role, biology, the history of the medical community response to intersex infants, and the ramifications of surgical assignment procedures on psychic development.

At the 2002 Spring Meeting in New York, the Section will sponsor a panel on mentoring. Our presenters are Elisabeth Young-Bruehl, PhD and Hedda Bolgar, PhD with a discussion to be led by Adrienne Harris, PhD. We have structured the panel so that plenty of time is available for audience discussion. On Friday April 12, 2002 the Section will host a cocktail reception with Section II. At this time we will honor Elisabeth Young-Bruehl, PhD for her outstanding contributions to the study of women, gender and psychoanalysis. We invite all members of the Division to attend this reception to honor Elisabeth.

In August 2002, at the APA Annual Convention in Chicago, the Section is fortunate to have Tanya Luhrmann, PhD speak to us about “An anthropologist’s consultation about applying psychoanalytic concepts to non-Western cultures: Women in America thinking about women in Afghanistan.” This topic was chosen in the Fall of 2001 shortly after the September 11 attacks. At that time there were heated ListServ and media discussions “analyzing” the situation we found ourselves in. Some of the discourse seemed like “wild analysis,” completely understandable given the horrific events. With some time and distance we hope to be able to revisit this topic and become more educated in our understanding of the difficulties presented by cross-cultural analysis. Dr. Luhrmann is a professor at the University of Chicago, serving on the Committee on Human Development. She has written on a variety of topics, with a recent book *Of Two Minds: The Growing Disorder in American Psychiatry*. Dr. Luhrmann is an expert in anthropology and holds a deep knowledge of psychoanalytic principles. A leading public intellectual, her talk will occur on Friday August 23, 2002 from 1:00-3:00 pm.

Membership in the Section continues to be an ongoing challenge for us. We certainly need to do a better job of recruiting and retaining members, but we also need your support to continue providing the quality programs as we have in the past. If your membership has lapsed or you are interested in joining the section, please contact our Membership Secretary, Yasmin Roberts, Psy.D at yasmin.Roberts@austenriggs.net for information and a membership form.

**Section VIII: Couple and Family Therapy and Psychoanalysis**

Susan Shimmerlik, PhD

Since our last report, Section VIII’s ListServ has been initiated and is now up and running. In addition to facilitating communication among members, the ListServ has been the vehicle for our first on-line discussion based on a paper that was distributed to all members of the Section. We are planning to distribute a paper several times a year for discussion. As I write, our spring newsletter, with its focus on the aftermath of 9/11, has just been completed. We are now soliciting articles for our fall newsletter, which will focus on the topic of sexuality. The deadline for submissions is July 15th. At our board meeting in January, we strengthened and expanded our committee structure, paving the way for wider participation in Section activities. Many members have already volunteered to serve on one of our committees and we hope more will consider doing so. In addition, we are interested in facilitating the development of local Section VIII groups around the country. For more information about any of our activities please contact me by e-mail at SMS@psychoanalysis.net or by telephone at 212-877-3857. Anyone interested in joining the Section can contact Carolynn Maltas, Chair of the Membership Committee, by e-mail at cmaltas@attbi.com or by telephone at 617-497-2124.
On behalf of Section IX I want to thank Neil Altman for launching this Section as its first president. Neil provided a steady source of leadership and support to all of us, in good times and in bad times. His role as dispatcher of information to Section members in the aftermath of September 11 is just one example of his generous leadership. During his term as president the Section has grown to over 175 members.

The Section held its second election. Nancy Hollander was elected President-elect and the new Board members include Stuart Pizer and Lynn Layton. The remaining Board members include Rachael Peltz (President), Neil Altman (Past President), Ruth Fallenbaum (Secretary), Lu Steinberg (Treasurer) Ronnie Lesser, (Newsletter editor), Muriel Dimen, Karen Rosica and Steve Seligman. The board will meet at the Annual Meeting at which time, among our many tasks will be the development of more autonomously functioning committees that will include many more Section members.

Up to now the Section has served as a forum for planning and soliciting participation in new social projects, and disseminating information about social action projects occurring in our communities. We have regularly participated in the Division conferences with panels, presentations and co-sponsored events. This year at the 2002 Annual Meeting we will be sponsoring a panel on The Different Faces of Terror featuring papers by Nancy Hollander, Maureen Katz and Nina Thomas. We will also be offering a poster session with representatives from several innovative programs from around the country presenting information about their programs. They will be available for discussion. We plan to offer future poster sessions to similarly expose Division members to innovative psychoanalytic programs offering clinical services to underserved populations. The Section is also co-sponsoring a program with Section VIII on The Transgenerational Grip of Socio-Political Trauma.

One of Neil’s many contributions was establishing a Section ListServ, which has permitted the members to begin communicating with each other. Several possibilities for group discussion have emerged including discussing the lead article in our newsletter, The Psychoanalytic Activist, edited by Ronnie Lesser. We encourage members to use the ListServ.

There have been several events on both coasts sponsored by Section IX. Following September 11th, we in the Bay Area co-sponsored an event entitled Terror and Mourning, which local mental health workers attended and shared poetry, music and discussion about how the events of September 11 affected them as clinicians. We are planning another conference in San Francisco on the Psychic Consequences of American Health Care. The program is scheduled for November 2, 2002. The West Coast (Los Angeles and the Bay Area) members are also planning presentations on The Consequences of Globalization in Argentina, with Juan Carlos Volnovich a child psychoanalyst and consultant to the group, Grandmothers of the Plaza de Mayo. These programs will take place in the Fall 2002.

The New York members are co-sponsoring a conference on racism. Several new projects are underway including a video project organized by Nina Thomas, in which several members will travel to Northern Ireland and interview mental health workers and psychoanalysts working there concerning “the Troubles.” Lu Steinberg is working on several joint projects on the transmission of generational trauma.

As the Section grows with members across the country we want to encourage people to come together locally to think about what kinds of activities would be meaningful to organize. Since September 11 many mental health workers with a desire to become more politically involved have been acutely aware of their isolation. Section IX brings people together to coordinate their efforts.

Section VI is offering funds to graduate students for dissertation research. Proposals must have implications for psychoanalytic theory or practice. The awards will range from $1000-$1500. Potential applicants for the Psychoanalytic Research Fund may write for Proposal Guidelines. Three copies of the proposal must be mailed by November 1, 2002 to: E. Lisa Pomeroy, PhD, Chair, Psychoanalytic Research Fund, 11911 San Vicente Blvd, Suite 280, Los Angeles, California 90049

All winners must acknowledge The Psychoanalytic Research Fund’s support in any presentation or publication of the study. The Psychoanalytic Research Fund committee, chaired by Dr. Pomeroy, includes Gwen Gerber, PhD, Robert Bornstein, PhD, Harold Cook, PhD, Michael Sperling, PhD, and Pamela Foelsch, PhD. Section VI hopes to receive a number of applications.
PRESENT: M. Murphy, President; J. Slavin, President-Elect; L. Wagner, Past President; M. Jacobs, Secretary; D. Ramirez, Treasurer; J. Darwin, President-Elect Designate; Council Reps: J. Alpert; N. Altman; H. Kaley; N. Stockhamer; Members-at-Large: R. Dattner, Mary-Joan Gerson, S. Gerson, F. Goldberg, B. Karon, D. Morris; L. Pomeroy; Section Reps: J. Reppen, Section I; D. Ehrensaft, Section II; M. Kelly, Section III; E. Rosenberg, Section IV; H. Davis, Section V; G. Gerber, Section VI; C. Maltas, Section VIII; N. Thomas, Section IX; Graduate Student Reps: T. Feldman, K. Kotov

GUESTS: K. Saakvitne; N. McWilliams; D. Hill; L. Zelnick; M. Manosevitz; C. Keifer; S. Orfanos, S. Schmerlik, J. Couch, M. Scherlinger; M. Cresci, W. MacGillivray; C. Fahy; K. Isaacs, G. Sticker, J. Northman

ABSENT: G. Ainslie, M. Lionnells, Members-at-Large

I. CALL TO ORDER: President M. Murphy called the meeting to order for 9:00 am.

A. PROXIES: The following proxies were submitted to the Division Secretary, M. Jacobs: C. Kieffer for A. Brok; J. Reppen for A. Brok (when C. Kieffer is not in attendance); M. Jacobs for G. Ainslie; S. Gerson for M. Lionnells; S. Dattner for M. Gerson (when M. Gerson is not in attendance)

B. MINUTES

ACTION: PASSED UNANIMOUSLY

C. ELECTION RESULTS

President Elect: Jaine Darwin
Council Reps: Bryant Welch, Judith Alpert, Bert Karon
Members-at-Large: Nat Stockhamer, Nancy McWilliams, Mary Beth Cresci

D. LAURA BARBANEL ENDORSEMENT: N. Thomas encouraged the members to assist in L. Barbanel’s quest for nomination as APA President for 2002.

Dr. Thomas gave a brief summary regarding Dr. Barbanel’s qualifications and platform, and her strong commitment to the Division. She stated that Dr. Barbanel is an effective spokesperson for psychoanalysis as well as being involved in multicultural and school psychology. Other members expressed confidence in Dr. Barbanel’s candidacy and qualifications. Members were also encouraged to speak to other Division members asking for their support in placing Dr. Barbanel on the APA 2002 slate.

ACTION: PASSED UNANIMOUSLY

II. TECHNOLOGY ISSUES: Report Of The Task Force On The Impact Of Technology: President Murphy gave a brief summary of the discussion to be held. L. Zelnick discussed his report and set the tone for the discussion. Electronic communications is a growing media for reaching members—and it is now time to identify the needs of the Division regarding electronic communications. He discussed the current website for the Division, and the ways it needs to change to accommodate the many areas and issues of the Division, of psychoanalysis, public information, etc. The Division needs to look at long-range plans for the use of the website and the Internet to communicate with the membership.

D. Hill reported that the task force members are: F Goldberg, M. Manosevitz, M. Murphy, S. Orfanos, H. Seiden, N. Simon, L. Zelnick.

Dr. Hill reviewed the activities of his task force and summarized his written report. He the current website and stated it was a first effort and has served its purpose. He feels now it is time for a more up to date website to be developed to provide information with a large cost savings to the Division. Some of the areas of savings would be an interactive Membership Directory, where members could log in and make corrections to their information; a “find an analyst” section for the public; a literature search tool for members; publication of Division committees reports; Spring Meeting information and registration on-line; update of legal services; update of newsletter; and, Journal information. A successful site will require an investment of money, time and resources. A comparison of current costs of mailings, publications, etc. and the cost of an interactive, informational website should be done to assist the Division in making decisions.

Dr. Hill gave a description of the different electronic communications methods. He recommended the “message board” system as the most effective and most responsive system. ListServes tend to be too cumbersome. He explained how the message board works. He referred to this technology as “pull technology”.

The task force was very concerned about the ethical and legal ramifications of having services on the website. Reports by task force members indicated that strong guidelines should be developed for members use of the website. The task force strongly recommends that a set of guidelines on the use of the website be developed and distributed to the membership.

He summarized the task force recommendations:

• Cross comparison analysis of costs.
• Establish goals for cost savings and establish goals for accomplishing.
• Education key people about the changes.
• Expand the Internet committee to administer different sections of the website - including a “list master”.
• Hire an outside service to build and maintain the website— with a “cyber office” (an individual to oversee what the service is doing and maintaining the integrity of the site).
• Aggressively publicize the new service to the members, education the members on how to use them.
Discussion was held regarding the transition - and that it would probably have to occur over a 3-5 year time frame. The first step in the transition would be to determine the percentage of members who are able to accept electronic communications, as well as the desire of members to receive their information electronically. Several suggested that receiving information electronically be on a voluntary basis. A survey of the members is essential prior to moving forward in this endeavor. It is a sustained financial commitment and all groundwork must be done prior to the initiating the entire procedure. It was recommended that a one-way ListServ for the Division, as well as a Board and Executive Committee message board be established immediately, as a starting point.

MOTION 3: To establish a Division Board ListServ, unmoderated through APA.

ACTION: Yes - 3, No - 22, Abstain - 1

FAILED

MOTION 3a: To establish a Division-wide, one-way ListServ, through APA.

ACTION: Yes - 24, No - 1, Abstain - 1

Carried

MOTION 3b: To establish a task force to examine and make proposals to the January 2002 Board Meeting regarding the establishment of a message board system for the Board, Executive Committee, Graduate Students, and other Division committees; investigate cost for development and maintenance, cost comparisons, etc., and to begin the search for a company/webmaster to assist the Division in moving forward on this technological endeavor.

ACTION: Yes - 25, No - 1, Abstain - 0

CARRIED

MOTION 4: To initiate Division online voting procedures for Board matters as described in appendix pg. 14.

ACTION: Yes - 20, No - 2, Abstain - 3

CARRIED

III. FELLOWS PROCESS: G. Sticker reviewed the Fellows process as outlined in his report (appendix pgs 15-18). His committee is active and has taken into consideration the need to maintain high integrity of the Fellows process. Next deadline for the Division to receive applications for Fellow Status is November 1.

Dr. Sticker urged members who are Fellows in other Divisions to apply for Fellow status in Division 39. He also discussed the process of applying for Fellow status to the Division as a first Fellow status for a member. Also discussed was the benefit to the members to become a Division 39 Fellow.

IV. CONVERSATION ON THE EXECUTIVE STRUCTURE OF THE DIVISION: President Murphy discussed the issue of extending the term of office of the Division president. A question had arisen regarding the need for the presidency to be extended to a two-year term, to assist in continuity and consistency, as well as giving the president the necessary time to accomplish the goals for their term of office. Discussion also included concern regarding a two-year commitment and the willingness of members to make a longer commitment than one year. It was noted that Section V recently changed their bylaws to extend the term of office of the president to two years. Additional discussion will be needed as well as researching the bylaws.

V. APA COMMITTEE APPOINTMENTS: M. Manosevitz was appointed to the APA Membership Committee. N. Thomas was appointed to the APA Finance Committee. H. Kaley was appointed to the APA Committee on Function and Structure of Council.

VI. FINANCIAL ISSUES

A. 2001 Budget update - D. Ramirez distributed copies of the updated 2001 budget. He discussed information regarding the savings of the Division. Currently the Division has approximately $200,000 in the savings account.

Dr. Ramirez referred to the income section of the budget update. He indicated that the Division is doing well in generating income for 2001. He stated that the Division is close to having achieved the income goals.

MOTION 5: To approve the updates for the 2001 budget as recommended by the Finance Committee.

ACTION: WITHDRAWN

B. Memorial to Stephen Mitchell, PhD - N. Altman briefly summarized the Foundation purpose—dedicated to assisting individuals in obtaining psychoanalytic training—and asked for support to assist in funding this organization. Members voiced support, questions, concerns, e.g., criteria for choosing scholarship recipients, theoretical orientation restrictions, structure of the foundation, etc.

MOTION 6: To make a total contribution of $10,000 over a three-year period to the Stephen Mitchell Foundation.

ACTION: PASSED UNANIMOUSLY

C. Publications Committee Request - N. McWilliams spoke strongly and effectively to the desire of the Publications Committee to permanently increase the total number of signatures per volume of the Journal each year. The Committee is anxious to be a strong, active committee and asks for support of the Board in increasing the size of the Journal, as well as the effort involved in producing the Journal. She reported very impressive statistics regarding the Division's Journal. Additionally, she discussed the challenges Dr. Reppen, Journal Editor, has faced and how he has met those challenges and continues to work to make the Journal a strong representation of psychoanalysis and the Division. He has increased the bar for rejections and looks for only papers of the highest quality for publication.

MOTION 7: To increase the number of pages for the Division Journal, Psychoanalytic Psychology. The Board will make permanent the granting of the up to six additional signatures of 32 pages each (192 pp) per volume year, the approximate cost of which is $15,000.

ACTION: PASSED UNANIMOUSLY

D. Section V Bylaws changes.

MOTION 8: To approve the Section V Bylaws changes as distributed.

ACTION: Yes - 22, No - 0, Abstain - 1

PASSED

Special Acknowledgement: At this time in the meeting Dr. Murphy thanked S.
VII. PUBLIC INFORMATION CAMPAIGN WORKSHOP: C. Fahy reported on the activities and focus of her committee. She commended the work of her committee and asked that members consider joining the committee as they work on their goals. She discussed the need to work with a professional in public relations. She indicated that she had researched costs, effectiveness and cost comparisons. She spoke to four public relations firms. She sent requests for proposals to three firms. In the RFP she gave a synopsis of the activities that public relations would be needed. She strongly recommends that the Division hire a public relations firm to assist the Public Information Committee accomplish their goals and the goals of the Division.

A professional firm managing the activities would benefit the Division by offering consistency and integration of methods of communications. She felt that the immediate needs of the Division were “talking points” and developing a brochure. She estimated that $15,000 - $25,000 would be the budget dollars her committee would need to accomplish these items. Dr. Fahy distributed a summary report of information and needs.

J. Peterson from the Public Education Department of APA’s Practice Directorate addressed the Board in the area of public relations and how to address the issues and questions of promoting psychoanalysis nationwide. She stressed the importance of developing a consistent message to assimilate to the public, legislators, etc.

Comments were made regarding the type of product needed, the audiences that need to be targeted, and how to address the issues and where to begin. The Public Information Committee was given the information that came from the Board Meeting in Santa Fe regarding target audiences. It was suggested that the Committee develop specific proposals and submit that to the Board prior to the January 2002 Board of Directors meeting for their review and consideration.

VIII. PRESENTATION BY RUSS NEWMAN, PhD APA PRACTICE DIRECTORATE: President Murphy introduced Russ Newman, PhD, of the Practice Directorate of APA. She welcomed him and Randy Phelps to the meeting and asked them to make a few comments to the Board of Directors.

Major issues that are being pursued by the Practice Directorate include the Patient Protection Legislation. Dr. Newman discussed the progress of the legislation and the particular language that is in the bill. The House of Representatives were more receptive to the language in the bill, with the Senate less receptive. Liability, protection language, although weaker than the language in the bill in the House, language was included in the Senate. The change of parties by Senator Jeffords of Vermont made a vital and relevant change in the atmosphere of the Senate. The make up of the House has changed with the new administration, and caused a weaker language again on this piece of legislation. Additionally, President Bush had stated he would veto a strong language bill. Consequently, the dynamics are very diverse. There are several possibilities including, no bill, a strong bill produced by strong Senators, a weaker language bill or compromise bill, etc. He indicated that APA will be “in for a fight”, but are “up for the fight” — and will continue to work diligently on this legislation. Once APA knows who the conferees are they will quickly distribute an action alert to the members.

Dr. Newman also gave a brief summary of the Blue Cross/Blue Shield lawsuit. At present they are preparing to go to trial. They had hoped to be at trial by now. Due to unexpected circumstances, a new judge was appointed, delaying the timeline. A positive thing that has developed is the media coverage surrounding the “phantom network.” This has given some exposure to the issues and educating the public on the problems. R. Newman expects to use this media coverage to make this the first public trial regarding the “phantom network” issue. He will keep the Division informed on the progress of this lawsuit.

Dr. Newman also discussed technology issues within APA. One of the issues is the use of electronic communication to provide services. The other area is the use of technology to educate the public. There is some movement on the rise to addressing the administrative transactions of healthcare problems. Through the use of technology it is believed that efficiencies can be placed in the system to reduce the inefficiencies currently in the system today. A need to standardize claims submissions to reduce cost brought about the HIPAA rules. These rules include privacy protection. Dr. Newman believes that this will finally be accepted, although insurance companies will not be in favor of it. Healthcare needs to be moved toward cost effective, excellent patient care and move away from the high administrative costs that keep patient care at a lower level.

IX. GRADUATE STUDENT COMMITTEE: President Murphy summarized the new structure for the Graduate Student Committee, with K. Rosica and J. Schwartz chairing and graduate students as liaisons. This committee will develop the charge of this committee and will assist in developing programs and activities for the graduate students. This new structure was developed with input from the current graduate student chairs.

X. COMMITTEE REPORTS

Special Thanks: J. Slavin thanked and commended President Maureen Murphy for her work as President of the Division.

XI. CALENDAR OF 2002 EXECUTIVE COMMITTEE AND BOARD MEETINGS

A. Executive Committee Meetings
1. October 6, 2001 - New York
2. January 17, 2002 - New York
3. April 12, 2002 - New York
4. August 23, 2002 - Chicago

B. Division Board Meetings
2. April 13, 2002 - New York
3. August 24, 2002 - Chicago

XII. ADJOURNMENT: There being no further business to come before the Board at this time the meeting was adjourned at 4:52 p.m.

Secretary: Marilyn S. Jacobs, PhD
Recorder: Ruth E. Helein
**GRADUATE STUDENT PAPER AWARD**

**JOSEPH REPPEN, PHD, ABPP**

I am pleased to announce a new award for an outstanding graduate student paper. Established by *Psychoanalytic Psychology* and the Board of the Division of Psychoanalysis, it is to be named the Stephen A. Mitchell Award. The award will honor our esteemed colleague as well as a graduate student whose paper has been deemed exemplary by a panel of judges. The award includes a $500 cash prize, airfare and registration at the Division Spring Meeting at which the paper will be read, and publication of the paper in *Psychoanalytic Psychology*. The judges for the award will be members of the Division who edit psychoanalytic journals.

Deadline for submission is July 1, 2002, and presentation of the paper will be at the 2003 meeting. Five printouts of the paper should be submitted to me according to the procedure for submission to *Psychoanalytic Psychology* and should include a cover letter indicating that the paper is being submitted for the Stephen A. Mitchell Award. Division members with academic affiliations, in particular, as well as all members are strongly encouraged to invite graduate students to submit papers. There are no restrictions as to topic or theoretical orientation, although the papers must be of a psychoanalytic nature. Questions and papers should be addressed to the editor:

Joseph Reppen, PhD, ABPP

*Psychoanalytic Psychology*

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**ANNOUNCEMENTS**

- Doctors of the World seeks medical doctors and mental health professionals in the New York, Phoenix and San Diego metropolitan areas to volunteer for the Human Rights Clinic. Clinicians provide interview, clinical exam and documentation of the evidence of torture for asylum seekers. Entails a commitment of one or two days (or more) a month. Training provided. For New York, send CV & cover letter to: HRC Recruitment, e-mail to borensj@dowusa.org, fax 212-226-7026, or mail to: Doctors of the World, USA, 375 West Broadway, New York, NY 10012. For San Diego, e-mail walif@dowusa.org, or mail to Flouran Walif, Doctors of the World, 3990 Old Town Ave, Suite C201, San Diego, CA 92175. For Phoenix e-mail, choud@dowusa.org, or mail to Dana Chou, Doctors of the World, 1610 West Camelback Road, Phoenix, AZ 85015.

- Conference: *Treating Addictions: Contemporary Perspectives from Psychoanalysis and Neurobiology*, Cinéma De Sève, Concordia University Saturday, May 4, 2002. Contact Richard Karmel, PhD, e-mail: rlkarmel@ego.psych.mcgill.ca, or (514) 934-8010 for additional information.

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**DIVISION LISTSERV**

**Jonathan H. Slavin, PhD**

We are currently updating e-mail addresses for our newly established ListServ. At this point we have correct addresses for only a small number of Division members. If you want to be added to our ListServ, which will enable you to get prompt, breaking information (but NOT junk!) please e-mail the following data to our central office (div39@namgmt.com)

YOUR NAME (Put your full name in the body of the e-mail)

PREFERRED E-MAIL ADDRESS

(Note: Go to www.divpsa.org if you want to check to see if the e-mail address we have for you is correct.)

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**Congratulations**

- To Mark Hilsenroth of the Derner Institute of Advanced Psychological Studies, Adelphi University upon receiving a research grant from American Psychoanalytic Association for a study that will empirically evaluate the reliability, validity and clinical utility of the psychoanalytically derived Defensive Functioning Scale (DFS).

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