FROM THE PRESIDENT

Where Have We Been?

Ten years ago I had the privilege of serving as President of Division 39. I did not imagine that 10 years later I would serve again in this capacity. So I would like to begin this column by thanking the membership for the confidence that permits such an unusual, “repeat performance.” I hope to be able to provide the kind of leadership that justifies it.

For more than 20 years Division 39 has been my professional home. We have faced many challenges and had our share of controversies. But through it all our unity as psychologists - psychologists who represent a psychoanalytic perspective within APA and in the larger psychoanalytic world - has been strengthened. And the friendships garnered and developed during these years have been one of the great rewards of my professional and personal life.

In preparation for writing this column I found, buried in the depths of my computer, the president’s columns I wrote ten years ago. As psychoanalysts we know that it pays to look back in order to move forward. Much has changed in these ten years.

Ten years ago we were just emerging from the successful settlement of the lawsuit, spearheaded by Bryant Welch (who joins the Division Board this year as an APA Council Representative), and we were reaping the benefits of it. Independent institutes which had many Division 39 members successfully joined the International Psychoanalytical Association (IPA); the American Psychoanalytic Association (APsaA) had abolished the waiver requirement for psychologists; new independent institutes with founders closely affiliated with the Division were established; the Psychoanalytic Consortium, representing the three major mental health professions (psychology, social work and psychiatry) was established during my term; and our efforts to develop our own Board certification (ABPP) in psychoanalysis was successfully revived.

In the intervening years Division 39 has grown and flourished. Thanks to the commitment of our membership - and readiness to express it by voting - we have one of the largest Divisional representations in APA Council. Within the Division we established new committees to reach out to the diversity of our membership, including the Committee on Multicultural Issues and the Graduate Student Committee. Our Sections increased from 5 to 9, representing more fully the broad interests of our members. With the initiative provided by Fellows chair George Stricker we have been able to establish a Fellows category in our membership, which recognizes outstanding career contributions to psychoanalytic psychology.

Our publications are thriving, most recently under the leadership of the Publications Committee chair, Nancy McWilliams. Through the capable efforts of our journal editor Joe Reppen, Psychoanalytic Psychology has expanded its offerings and now represents the broad perspectives that mark the vitality of psychoanalytic psychology. As you see in this and past issues, our newsletter has become extraordinarily meaty, thanks to the work of its editor, Bill MacGillivray and his predecessors. Psychoanalytic Abstracts continues to offer the membership exceptional access to what is being published in the psychoanalytic world. Our local chapters, now numbering 30 have flourished, providing a professional home both to psychologists around the country and to allied mental health professionals in many localities. The Division has recognized this valuable contribution by adding a category of membership, with voting rights, for allied professionals.

As a result of an enormous amount of dedicated work by many of my predecessors (Lew Aron, Spyros Orfanos, Laurie Wagner and Maureen Murphy) the Psychoanalytic Consortium has been successful in producing a standards document on psychoanalytic education upon which all four member organizations of the Consortium (The American Academy of Psychoanalysis, the American Psychoanalytic Association, Division 39, and the National
“From logotherapy we learn to forget about self, and put our whole heart into someone or something greater.

In the love story of Viktor and Elly Frankl we see how they did that....” — From the Introduction.

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Available wherever books are sold.
Membership Committee on Psychoanalysis in Clinical Social Work) could agree. There is always a danger in singling out individuals for recognition, but the risk is worth it in noting the extraordinary contribution made by Laurie Wagner, who stayed on top of every detail and found a way through complex political and conceptual thickets, and by Nat Stockhamer, whose steady wisdom, garnered through years of experience, informed every step of the process.

The adoption of this statement of standards by all four primary psychoanalytic groups in this country is an accomplishment whose significance cannot be underestimated. This document, published in our most recent newsletter (Fall 2001, Vol. XXI, No. 4), represents an articulation of the vital elements in high quality psychoanalytic education, while providing flexibility for differences in training traditions and educational methods. It was hammered out through literally years of discussion and debate both within the Division and with our sister groups. The document will form the foundation of the work of the Accreditation Council for Psychoanalytic Education (ACPE), which has already been incorporated, and which will function independently of the Psychoanalytic Consortium. It is, as Murray Meisels asserts in an article published in this issue, a mainstream document, one that is absolutely in keeping with Division 39 and APA policy, that psychoanalysis is not another independent mental health profession - alongside psychology, social work and psychiatry - but represents an advanced specialization of recognized, licensable, mental health professions. It is a document that will allow institutes offering serious training to mental health professionals to receive broad validation of their training practices, while encouraging others to raise their standards.

Where Do We Go From Here?

Speaking frankly, we are in no position to rest on our accomplishments. Division 39 faces some real challenges for the future, and it is on the future that I would like to focus my efforts in the year ahead of us. One year is not much time. Our most recent past presidents established important goals for our Division, and rather than reinvent the wheel, or take us in yet another direction, I plan to maintain continuity with their initiatives to further strengthen the work of the Division. In doing so, I plan to focus on what I believe are limited and attainable goals, rather than grand ideas whose implementation will never actually occur.

What are the challenges? For one, our membership is slowly aging and, as a result, declining in numbers. This attrition is occurring in all of psychology, and in all professions, as the baby boomer generation nears retirement. This fact raises the question of the future of our Division and the future of a psychoanalytic voice in psychology. This issue is given even greater urgency by the precipitous decline we have seen in our graduate student membership in the last two years (from nearly 10% of our membership to less than 5%). The reasons for such a significant and rapid loss of graduate student members are not clear and I have asked our Membership Committee to contact graduate students whose membership has lapsed try to understand what happened. But in addition, I believe we must focus our efforts on a more comprehensive effort to insure the future for our Division and for the vitality of psychoanalytic ideas in psychology.

To this end, I will be undertaking, as my presidential initiative, a series of steps, some of which were begun in the term of Past-President Maureen Murphy. The aim of these steps will be to renew an interest in the study and teaching of contemporary psychoanalytic ideas in undergraduate and graduate psychology courses and programs, assist interested faculty in acquiring the tools for including psychoanalytic ideas in their curricula, and reach out to interested graduate students for involvement and participation in our Division. At the same time, we will be trying to increase the diversity of our membership and provide them with the kind of contact, interaction and services they want and need.

Here are some of the plans we have developed:

I. Insuring the Future:

A. Teaching Psychoanalysis: It is difficult to expect that there will be another generation of psychologists with an interest in psychoanalytic psychology if undergraduate and graduate students have little or no exposure to a contemporary view of psychoanalysis, one that is - as we in the Division know - vital, controversial and exciting. With a few exceptions, most texts used in both undergraduate and graduate courses (not just clinical ones, but those which deal with development, personality, psychopathology, as well as psychotherapy) represent psychoanalysis, if they do so at all, as it was construed 50 and 100 years ago. Even faculty who may wish to include psychoanalytic ideas in their teaching often are unaware of current developments across the full spectrum of psychoanalytic thinking and/or have little access to useful reference material.

To address this, I have asked the newly reconfigured Education and Training Committee (ably led by former president Spyros Orfanos) to develop several “model curricula” both for “stand-alone” courses in psychoanalysis at the graduate and undergraduate level, as well as for the inclusion of psychoanalytic material in graduate and undergraduate courses in psychopathology, psychotherapy, personality, development and other relevant courses. These “model curricula” will not be one final, set-in-stone idea of what psychoanalysis is or how it should be taught. Rather they will represent a range of ideas and suggestions, circulated among our many experienced teachers in the Division; a menu, so to speak, from which faculty can select what they may wish...
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to include. These model curricula will provide not only a digest of the diversity of ideas in contemporary psychoanalysis, but perhaps most importantly, access to the materials.

This initiative will include sending model curricula out to major clinical, counseling and professional psychology training programs around the country, contacting program and department chairs and soliciting their interest in receiving such materials, and distributing it to their faculty. Some of this work has already begun under the auspices of our Membership Committee, chaired by Joe Couch, which has been in contact with faculty, program chairs, and others around the country to collect the basic data we will need to move this process forward. The Education and Training Committee will have funds for the distribution of model curricula, relevant reference material, and in certain instances instructors’ copies of texts for faculty who are interested in looking further.

In a related step, we have already planned a workshop to be held at the next APA meetings in Chicago in August, for faculty interested in learning about incorporating psychoanalytic ideas in their undergraduate and graduate courses. This workshop will acquaint faculty with the current range of issues in psychoanalysis and enable them to integrate these ideas into their courses. We strongly encourage members of the Division who have ideas on these issues, and suggestions about those we might contact, to be in touch directly with Education & Training Chair Spyros Orfanos and Membership Chair Joe Couch (e-mail addresses on the back page of this newsletter).

B. Outreach to Graduate Students: Until this past August, the Graduate Student Committee had been led by graduate students who very ably planned some of the most interesting programs we have had at our Spring meetings and at APA. Their plans for the coming Spring Meeting in April are an example of the creativity they brought to this effort. However, working alone, with insufficient resources, and with other burdens as graduate students, did not permit the continuity of leadership that is necessary if we are going to take seriously the idea of nurturing our graduate student members and insuring the future.

Following consultation with the most recent chairs, our Past president, Maureen Murphy, and I undertook a reorganization of this committee. The Graduate Student Committee is now chaired by Karen Rosica and Joe Schwartz, both experienced members of the Division who have agreed to take on the role of guiding this committee in the coming years. They will be assisted by a committed group of graduate students representing a range of programs around the country. In addition to planning programs at our meetings of interest to graduate students this committee will work closely with the Education & Training Committee and the Membership Committee in outreach to graduate students, to identify individuals and programs where psychoanalytic interest can be nurtured, and graduate students encouraged to be involved in all aspects of the Division’s endeavors.

As part of our commitment to graduate students we have already established the Stephen A. Mitchell Graduate Student Award for an outstanding graduate student paper to be published in our journal (contact journal editor Joseph Reppen, e-mail on the back page, for further information). In addition, it is my intention as president to include graduate student members in every working committee in the Division. As the year begins, we have new graduate student members on the Education & Training Committee, the Membership Committee, the Publications Committee, the Committee on Multicultural Issues, the Internet Committee, and, of course, the Graduate Student Committee. In future columns I will ask some of these graduate student members to comment about their experience in the Division. I also encourage all interested graduate students to
contact our Graduate Student Committee chairs and me (e-mail addresses listed on the back page) to become involved.

II. Working FOR our Membership:

A. The Internet: It is time to use the full functionality of the Internet for the Division’s programs, initiatives and communication. Several steps were undertaken during Maureen Murphy’s term and it is my plan to bring them to completion this year.

At the Board meeting in January, the Internet Committee, chaired by Larry Zelnick, will present a request for proposals (RFP) to enhance the Division’s web site so that it is more user friendly, provides full access to necessary and useful information, and allows the establishment of message areas (bulletin boards) for committees, sections and other Divisional groups. The web site will also provide access to current and past issues of our newsletter and abstracts of articles in our journal. The Internet Committee is also well into the process of establishing a one-way list serve for the posting of important messages and information to the membership.

In addition, we will be using the coming year to move our membership directory to the web (along with a printed directory), a change that will permit members to update their contact information in a timely way. Those who do not want contact information available on the web will be permitted to opt out of the directory.

B. Diversity: Our Committee on Multicultural Issues, chaired by Dolores Morris, has been actively involved in the Division’s involvement in the biannual Multicultural Summit, sponsored by several Divisions in APA. The Division was a major sponsor of the past multicultural summit and held one of its Board meetings at the summit. We will be planning similar participation for 2003. I especially want to encourage and strengthen the Division’s commitment to multicultural issues and outreach to a truly diverse membership.

In addition, an Interest Group on the Sexualities was established during the past year. At the January Board meeting I will be asking the Board to formalize our investment in this area through the establishment of a Committee on Sexual Identity and Lesbian, Gay, Bisexual and Transgendered Issues. The charge to the committee, if the Board approves it, will be to conduct an assessment of the needs of our membership regarding LGBT concerns; to work closely with the APA Division on LGBT Issues, including joint programming; to provide an updated view of psychoanalysis to LGBT psychologists in APA who may have felt, for good reason, concerned about the attitudes of psychoanalysis; and to make recommendations to the Board regarding programming at our Spring and APA meetings.

C. Psychoanalysis in the Real World: Under the leadership of Maureen Murphy, the Division Board had undertaken an assessment of some of its mission with regard to services to our members. One of the central concerns we identified was the very narrow - and inaccurate - view of what a psychoanalyst is and does among members of the public and the media. We do much more than treat patients one-on-one in our offices. Well before September 11, our members were involved in community-based projects that bring us out of our offices and into a much broader connection with groups, organizations and essential social services. Since that infamous date, this has been even more the case, as our membership will see at an exhibition at the forthcoming Spring Meeting being arranged by President-elect Jaine Darwin and Treasurer David Ramirez. But too often, little is noted about these kinds of efforts. In the coming months we will be reorganizing our Public Information Committee to make it an effective vehicle for assisting

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Submissions, including references, need to be in APA style. E-mail your submission in an attached Word or WordPerfect file to the Editor. If you do not have attached file capabilities, mail the disc to the Editor. Hard copies are not needed. Please write one or two sentences about yourself for placement at the end of the article and indicate what address information you would like published. Submissions should be no longer than 2500 words.

All materials are subject to editing at the discretion of the Editor. Unless otherwise stated, the views expressed by the authors are those of the authors and do not reflect official policy of the Division of Psychoanalysis. Priority is given to articles that are original and have not been submitted for publication elsewhere.

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Deadlines

Spring issue - April 1, 2002
Summer issue - July 1, 2002
Fall issue - October 1, 2002
Winter issue - January 1, 2003
our members in talking with the public and the media, and in representing the full range of what we really do, in the real world.

Much more will be happening in the coming year, but I need to reserve some space in this issue for other articles! Some plans will be more accurately reflected in forthcoming columns. Until then, be sure to look for the program for the Spring Meeting in the mail and on our web site (www.divpsa.org). Elaine Martin and her committee have done an extraordinary job, as you will see. And do feel free to email me with reactions and suggestions at any point.

FROM THE EDITOR

The holidays are over and it is a long time until spring, at least in large parts of the country. This issue should help pass the time until the snow melts. So curl up before the fireplace, or sit out by the pool if you are more fortunate, and enjoy this issue.

The last issue evidently stirred some members to respond and it is gratifying to be able to present the articles by Murray Meisels and Robert Margolies even as they take issue with ideas expressed in these pages. Dr. Meisels addresses the implementation of the Consortium Standards document and certainly speaks for a number of members who have concerns about the trends implicit in developing common training standards. At the risk of misrepresenting his argument, I would observe that his remarks serve as a counterpoint to a tension central to the psychoanalytic enterprise between those who want to advance psychoanalysis as a profession with a need for greater public accountability and standards of training and practice, and those who see psychoanalysis as a craft passed along through mentorship, ineffable, and in a certain sense un-teachable. This tension has been present within psychoanalysis from the beginning and it is clear that if Freud could not resolve this tension within his own mind, it is unlikely that anyone else will do so for our craft and profession.

Robert Margolies takes Karen Shore to task for not conducting a scientific study of the character of managed care executives before writing the article that appeared in the last issue. His observations and conclusions certainly are at variance with what he describes as Karen’s “prophetic voice.” Yet I would risk trivializing his and Karen’s argument to observe that they are speaking from very different “places” in the necessary tension central to our work as psychoanalytic psychotherapists. One the one hand, as professionals in collaboration with a wider social context, we have a responsibility to have standards of training and practice that can be seen as valuable to society. For want of a better term, the so-called “medical model” is a shorthand description of this way of seeing our work as connected to a wider social good. On the other hand, the intensely personal and private nature of our work leads us to value autonomy and privacy above all. I think each of us negotiates this tension in a different way and with different consequences.

From the Editor

The contributions from Gerald Donnelan and Philip Kaufmann also serves as a reminder that the Division has formed a special committee to develop a program at the Annual Meeting in New York dedicated to illustrate contributions of our members to assist in coping with these terrible events. Jaine Darwin and/or David Ramirez would like to hear from members who have been involved in these efforts through both direct service to victims and indirect work in communicating to the media the need to understand the effects of trauma and need for psychological and emotional, as well as physical and economic recovery.

There are four book reviews and one author interview as well as the annual list of Division 39 Authors. I hope this inspires readers to get out there and buy books written by Division authors! In addition to research columns by Anne Hersoug and J. Christopher Perry, there is a Special Section on Family Therapy edited by Mary-Joan Gerson, and a history lesson from Jeff Golland on the Freudian Society. Finally there are a plethora of reports from committees, sections and local chapters. Good reading.

And now for some corrections: In Maureen Murphy’s last presidential column, she mentioned the Trauma Response Database and attributed development of it to Lew Aron and Neil Altman. Inadvertently she omitted Todd Essig’s leadership role in this endeavor and would like to acknowledge his contribution to setting up the design of the system. In Isaac Tylim’s recent article, Film Documentaries: Truth and Fiction, he omitted the names of the co-creators of the documentary from the LA Psychoanalytic Institute. They are: Robert C. Jones (Academy Award Winner), Dr. Sylvia Jones, and Deborah Stern.

Many members may be unfamiliar with her name, but Perla Apodaca has played an important part in the smooth running of the Division. She and her employer, Ruth Helein, have been the secretaries, mailroom personnel, technical assistants and all around factotums for the Division. She handled requests ably and with dispatch and was unfailingly gracious in her response to requests. Perla was with us for four years but has decided to return to Arizona State University to pursue her teaching certificate. She will continue assist Larry Zelnick on updating the website. I wish to express both the Division’s and my thanks for her work and efforts.
I do not borrow the title for this piece without at least a nod to Freud's essays, *Thoughts for the Times on War and Death*, written in the spring of 1915, six months after the outbreak of “The Great War.” In the two months since the terrorist attacks of September 11, anthrax mailings, and in light of the most recent crash of a jet in New York City, I have been at a loss to find an adequate container, for lack of a better word, for the emotions engendered by these events. This brief essay is an attempt to share some of my own thoughts and feelings regarding such an enormous tragedy. There is no solution, expert advice, nor “the big picture of life” grand view offered here. Rather, I do believe that we all have our own histories and experiences, which have shaped who we are and how we process personal and national loss. It is in this spirit that I offer what follows.

Not being of a mind most days to pick up Freud’s *Standard Edition*, searching for some guidance about clinical work, I have, since that fateful September day, found myself thinking about and finally re-reading several of Freud’s papers, among them the above referenced essays. I suppose I was looking for some soothing, some word or insightful phrase, which would somehow set me right, bring things “back to normal” or at least offer the illusion that they were so. I read the essays hoping there would be something, anything that would help. I had read these papers more than 25 years ago, in the midst of the other “great war” of my lifetime, one light-years away in the jungles of Southeast Asia. I had begun psychoanalytic training in New York and had just purchased the *Standard Edition* at the Strand Bookstore. Freud had awaited me, piled on the dining room table. I stumbled upon these essays, hoping then that I would find some meaning, solace, whatever, buried in the words from the genius’s mind. I thought, “What I really need to understand is here. I guess I will have to read the other 23 volumes before I will truly comprehend this.” I was disappointed. But the endeavor helped, at least in the sense that I knew Freud had used his great intellect attempting to comprehend his world of 1915.

Let me share some of his words, along with some of my own. On the disillusionment one experiences in the midst of war, he writes,

“The individual who is not himself a combatant...feels bewildered in his orientation, and inhibited in his powers and activities. I believe that he will welcome any indication, however slight, which will make it easier for him to find his bearings within himself at least.” (SE XIV, p.275).

The loss of one’s bearing rings true, given the current circumstances. Although I have lost my bearings several times in my life, I suppose I have always reemerged at some point, declaring that I had gotten through it, that I had learned something, absolutely convinced on some level that I would never, ever again be affected so deeply, or lose my bearings so completely as I believed I had. Thus, armed with the comfort that I had learned some life lesson, about death and life’s tragedies, I could assure myself, “Aha, now I really know how to handle this grieving stuff -- I got it.” Somehow accepting the illusion that I would never again be touched so deeply or so horribly calmed something deep inside me, at least for a time.

Of course, this strategy fails in waking life. We are always touched by “life” in some way -- unexpectedly -- without preparation, particularly when we maintain our silly thoughts that we have learned The Great Lesson, are now prepared and will not be taken off guard. Freud is correct. We welcome any indication, however slight, to find our bearings. Surely, Freud understood that “being lost” implies the conviction of “being found.” Clearly, we need some belief that allows us to collect ourselves, knowing we “will get through this,” and “pick up the pieces.” When I searched for the answers in Freud’s essay, back then and now, I hoped that I would grasp that ephemeral insight, which I thought I had captured, which would fortify me to “get through it.” Although Freud’s emphasis on “disillusionment” provides some structure to the experience, it
BEING A SOCCER DAD AND THE POIGNANCY OF LOSS

The terrorist attacks of September 11th have traumatized us all. Their unexpected brutality has haunted us with indelible images of destruction and human suffering and undermined our basic sense of security, maybe forever. In addition, they have churned up feelings from the particular traumas of each of our respective pasts, putting us on edge, making concentration difficult, interrupting sleep. Working as a psychologist with my patients, I struggle with these effects of September 11th all day, day in and day out, Monday through Friday. I expect that and am buoyed by it, my own small effort at rescue and recovery. But the poignancy of the loss that we sustained really hit me during a time I least anticipated it, during my daughter’s weekly, weekend soccer game. This was supposed to be a sanctuary from these cares, a world elsewhere where you could lose yourself in the immediacy of a save made or a goal scored. But yet....

Before I explain what happened, let me provide some background. I am a proud urban soccer dad. While we may not wield the same political clout as the famous suburban soccer moms, we are definitely a type. Unrepentant and sometimes former jocks, we derive great pleasure from yelling for our sons and daughters during their weekend soccer practices and games. Sometimes coaching them seems, at least to me, rather removed and artificial. Perhaps the experience he wrote of in 1915 reflected his own disillusionment regarding national pride and the beauty of civilization. Perhaps our current national experience is utterly different. Regarding our own illusions, though, he offers some direction,

“We welcome illusions because they spare us unpleasurable feelings and enable us to enjoy satisfactions instead. We must not complain, then, if now and again they come into collision with some portion of reality and are shattered against it.” (SE XIV, p.280).

This shattering, he suggests later in the essay on death, is about confronting the reality of death,

“Death will no longer be denied; we are forced to believe in it. People really die; and no longer one by one, but many, often tens of thousands, in a single day. And death is no longer a chance event” (SE XIV, p. 291).

Written so long ago, these words seem a chilling, eerie commentary on our most recent events. I wonder, then, when we listen to those now offering consolation, that “we will get through this...this is part of grieving,” you are still in shock, that on some level, perhaps unconsciously, we perceive the illusory hollowness of the words. Indeed, the structures enabling us to organize our experience and make sense of the world and our place in it, have been, in actuality, shattered.

We do need to make sense of our lives and our world. We cannot stay at sea. We must find our bearings. I believe this develops in relationship with others, through a sense of shared experience, and a communal coming-together in some form. Certainly, many of us have sought this in our houses of worship, and with families, friends and loved ones. We all struggle with the pieces strewn about us and inside us. What I have offered here is an initial attempt to share something of my own experience, in that struggle that we all now share, to not create yet another illusion (although this may prove futile) but to face, as best we can, the realities of our lives here, in this world, together.

Gerard J. Donnellan, PhD is President of the Massachusetts Association for Psychoanalytic Psychology. He is a graduate of the Massachusetts Institute for Psychoanalysis, where he supervises. He is Past president of the New England Society of Applied Psychology, the region’s largest organization of corporate and applied psychologists and is co-founder of Big Leap Performance Solutions, a management consulting company (www.big-leap.com). He practices in Lexington, MA.

PETER KAUFMANN, PhD

The victory of the U.S. Women’s team in the 1999 World Cup, girl’s soccer took on a new luster. Girls could now think of themselves as their favorite stars and directly, always strategizing about how the game should be played, we can feel at one with our kids during these times. Our children feel more mixed about this arrangement. Appreciating our involvement and secretly relishing our flattery, they can feel put off by the loudness of our zeal and wonder at times who is it really for. I would argue that these moments are for both of us, creating heightened times of togetherness that can become memorable. My older daughter was a staunch fullback who anchored a coed team with her long clear-out kicks that won five games in a row to reach the league finals one year. You know, like the comeback Mets and Yankees with their FDNY and NYPD hats. I remember her running down the best player on the opposing team and kicking the ball out of bounds to preserve the 2-1 win which got us into the finals, the breath from her exertion showing in the cold air of that late November dusk. (Close to Derek Jeter making “the play,” the improbable back up which caught the opposing player at home and kept the Yankee play-off run going.)

With the victory of the U.S. Women’s team in the 1999 World Cup, girl’s soccer took on a new luster. Girls could now think of themselves as their favorite stars and yes, fathers too could dream. With her gymnastics-honed muscle, my younger daughter powered our intramural girl’s
team to an undefeated season with her goal after goal. She’s become a mainstay of her under-12 girls travel team with her long passes, defense and clutch goals. When she weaves down the field with her tight, dark ponytail bobbing up and down, visions of Mia Hamm do dance through my head. But before you dismiss me as just another exaggerating dad, let me report that her gym teacher at school has dubbed her, “Mia Interruptus.” (All right, she does talk almost as much as she scores goals). In one travel team game, she got the ball at midfield, kicked it, retrieved the rebound and made a cross which totally reversed the flow of the action and set up the go ahead goal. When I repeatedly yelled at her about what a great play she had made, she simply glared back at me, conveying that I should be complimenting the goal-scorer and not her. That’s what was appropriate. That’s my girl!!

But back to this late October Saturday after September 11th. It was an Indian Summer day, the warmth and clear, sunny skies reminding me all too much of that fateful Tuesday. A fellow soccer dad, Mike, exulted about the beautiful setting, this artificial turf field atop Pier 40 which affords a nice view of the lower West Side and the Hudson. I agreed with him, only to look downtown and see the cranes and dump trucks near Ground Zero. I shuddered at this sudden reminder of the disaster. Mike aptly understated what I felt, “I never thought I’d miss those Towers this much.”

Before the game started, I realized that we were playing Mary’s team. Mary was a star of her under-14 travel team and certainly the anchor of her intramural team. 5’7” and broad-shouldered, she can run all day, dribble, dribble, dribble, pass on a dime and shoot from anywhere. With shoulder length strawberry blond hair, bright blue eyes and freckles, she looks powerfully All-American--sort of a cross between Michelle Akers and Brandi Chastain. (You see, soccer dads always see the potential). While I did not know her or her family well, I had heard that her mother had worked at the World Trade Center and had died in the disaster. A memorial had been held the previous weekend. But, here she was, looking ready to play, a daunting opponent. I suddenly felt divided in my loyalties, whom did I want to win? I hoped that we would win and that Mary would play a great game, not an easy compromise to achieve.

Once the game began and the competitive juices were flowing, I almost forgot about the larger context. Our team worked well together; scratching out four goals, one goal at a time. Mary was fairly subdued. With her stop-start, stop and go dribbling, she did weave through our defenders several times, but our fullbacks were able to kick the ball out of bounds. Our goalie buttressed their efforts with two great saves. As the half ended, our 4-0 lead held. Rudy and New York’s Finest would have been proud.

In the second half, however, Mary just exploded. Twice she dribbled past two defenders into the left corner, faked a shot, turned around and crossed a beautiful pass into the center where a teammate belted it into the goal. Twice she got passes twenty-five yards from the goal and hit line drive shots into the top of the net, once into the left corner and once into the right corner. I swear the balls were still rising when they hit the net. She had brought her team back, single-handedly tying the score. It was 4-4 because Mary had taken over the game. But my Mia came to the rescue. She broke through on the right side and chipped a nifty pass to the right wing who was open near the goal. She tapped it in just before time expired. So we won, despite Mary’s comeback heroics. My wished-for compromise couldn’t have been better scripted!

Right after the game, I saw Mary’s dad come onto the field and give her a quick, well-deserved, congratulatory hug. The clinician in me wondered if this was a way through which they both contained and expressed their grief, with Mary’s play being an eloquent tribute. Then, I had a memory of Mary’s mother running along the sideline, rooting “Mary, get the ball! Thatta girl.” She had Mary’s strawberry blond hair, her same bright eyes, the same determination, conveyed through her cheering that matched Mary’s high-stepping strides. I felt my cheeks, which were wet with tears. I thought about what it would be like if I couldn’t yell for Mia Interruptus, chattering down the sideline, and my wife was left alone to cheer. I started to cry harder. Then, it really hit me, the power of these losses - all those moments of flowing togetherness that can never happen again - never, forever.

I heaved a deep sigh and looked over the Hudson where the sun was beginning to set. It was getting colder. The next game had started. Behind the parental yells and the ref’s whistle, I could hear the sirens of emergency vehicles. The wind was blowing north and I caught a whiff of that unmistakable scent of burned plastic from the rubble at Ground Zero. I looked south at Stuyvesant High School, obscured behind the cranes and the police barricades, and thought about my daughter who was going to return there next week and continue her senior year and her engagement in the college entrance wars. There she’d be, three blocks from the emptiness where the Twin Towers once stood.

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For additional information log onto the Trauma Response Database through <www.Trauma Response.org>
COMMENTS ON THE CONSORTIUM’S ACCREDITATION INITIATIVE
Murray Meisels, PhD

The Psychoanalytic Consortium, comprised of representatives of Division 39 and of organizations in psychiatry and social work, has published its Standards of Psychoanalytic Education (the Standards; Psychologist-Psychoanalyst, Volume XXI, No. 4, Fall 2001, pp. 8-11). It has also created the Accreditation Council for Psychoanalytic Education (ACPE) to implement its standards and to accredit psychoanalytic institutes. ACPE would then become the fourth organization to accredit institutes in the USA. This review will highlight some of the positions taken by the new ACPE Standards, then compare them to other psychoanalysis accreditors, and finally attempt to assess ACPE’s potential attractiveness to the institutes it seeks to accredit.

ACPE Standards

The Mental Health Requirement. The Standards specify that admission to psychoanalytic training in member institutes requires that the applicant be trained in a mental health profession, and have experience in psychodiagnosis and psychotherapy (ACPE Standards, 2001, p. 8). Institutes may also admit non-mental health professionals “in certain defined circumstances” (ACPE Standards, 2001, p. 9). Thus, ACPE is attempting to accredit mainstream institutes whose members are predominantly mental health professionals.

The Frequency Issue. The rule of frequency for psychoanalysis is a minimum of three times a week (3x) on separate days for at least 40 weeks a year and a total of 300 hours. The Standards do not specify the length of sessions, so perhaps Lacanians would qualify. Others would not. Thus, ACPE’s focus is on 3x-5x frequencies in mental health institutes.

The Training Analyst. The Standards propose a ‘five-year rule,’ which requires that a graduate wait five years before he or she can be appointed a training analyst (ACPE Standards, 2001, p. 11). There are two problems here.

First, this rule does not address the situation of a start-up institute in which one or two recently trained colleagues launch an institute in a new geographic area. Training in such groups would not meet ACPE Standards.

Second, the examples given on p. 11 indicate that the five years should entail intense analytic experience. One option is to require at least 20 hours per week of analytic work for the five years, a second to require at least four analyses of non-psychotic adults during the period.

These options do not address the realities of the current practitioner: Recent surveys indicate that many analysts now have two analysands, or one, or none. Institutes might not support a criterion which their own members do not meet, or which their new graduates may not be able to meet.

In addition, it is expected that the psychologist training analyst will acquire or possess the Diplomate in Psychoanalysis that is offered by the American Board of Psychoanalysis in Psychology (ABPsAP; see ACPE Standards, Article X, Faculty Development, p. 11). ABPsAP was launched over a decade ago, but only a small percentage of Division 39 members have joined. The other accreditors do not require the Diplomate, and this requirement may be off-putting to psychologists. In summary, the ACPE Standards utilize a mainstream tripartite model that is focused on frequencies of 3x-5x in institutes comprised predominantly of mental health professionals, in which training analysts are appointed according to specified criteria. The number of institutes that meet these qualifications, or would work to do so, is unknown.

Monitoring of Candidates. The requirements of Article II, Practice, (ACPE Standards, p. 9) may not belong in an accreditation document. This article requires candidates to inform analysands that they are in training and to obtain the authorization of their institute to conduct psychoanalyses without supervision, and similar matters. These requirements are unconnected to the task of accreditation.

The Structure of ACPE. The organizational structure of ACPE is yet to be developed. Institutes would want to know whether ACPE would be controlled by a central authority or by the institutes themselves, i.e., whether policies would be set by a board of directors or by a congress of institutes. One imagines that many institutes would take a wait-and-see attitude--wait for ACPE’s leaders to be selected and its policies set, and see which institutes actually apply for accreditation.

The Competition

Bottom-Up - ABAP: There exists an accrediting body in psychoanalysis in the USA that functions in a collegial manner under the authority and purview of its member institutes. It is called the American Board of Accreditation Psychoanalysis (ABAP), and it evolved from the National Association for the Advancement of Psychoanalysis (NAAP). ABAP accredits about 15 institutes, many of which are Adlerian, Jungian and Modern. Assume that there are 150 psychoanalytic institutes in the country, a common assumption: Then, ABAP has accredited 10%.

Note that ABAP has empowered institutes, who set and
change standards, and that ABAP is structured to change depending on the will of its member institutes. ABAP is listed in The Association of Specialized and Professional Accreditors (ASPA; www.aspa-usa.org), but is not recognized by the Department of Education (DE; www.ed.gov)

**Top-Down - APsaA:** There exist two top-down accrediting groups in the USA, the American Psychoanalytic Association (APsaA) and the International Psychoanalytic Association (IPA). These organizations set rules, enforce them, have not empowered institutes, and are not readily open to change. APsaA only accredits its own member institutes, approximately 30 in number (or 20% of the estimated 150 institutes countrywide) and does not accept applications from non-APsaA institutes. It is possible that APsaA’s institutes would be folded into ACPE.

**Top-Down - IPA:** IPA does accept applications from freestanding institutes, but imposes onerous requirements for admission. IPA uses the 4x-5x rule of frequency, and has not admitted institutes with training analysts who were analyzed at a 3x frequency. Hence, most institutes have not applied, resulting in only five USA institutes becoming members of IPA. Neither IPA nor APsaA is listed as an accreditor by the Association of Specialized and Professional Accreditors, and neither is recognized by the Department of Education (see above).

**Overview of Psychoanalysis Accreditation in the USA**

Table 1 summarizes psychoanalytic accreditation in the USA and uses the frequently heard estimate that there are approximately 150 institutes in the country. The breakdown in Table 1 is that 15 institutes are accredited by ABAP, 30 by APsaA, and 5 by IPA. Approximately one institute in three is accredited, and unaccredited autonomous institutes are the great majority.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Accredited and Unaccredited Institutes in the U.S. (All numbers are estimates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Institutes in the USA:</td>
<td>150</td>
</tr>
<tr>
<td>Accredited by ABAP</td>
<td>15</td>
</tr>
<tr>
<td>Accredited by APsaA</td>
<td>30</td>
</tr>
<tr>
<td>Accredited by IPA</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
</tr>
<tr>
<td>Unaccredited</td>
<td>100</td>
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As Table 1 shows, there are three accreditors for 50 psychoanalytic institutes. There may be four when the Consortium’s ACPE is up and running, depending on whether or not APsaA is folded into it. Compare this to the six regional accreditors of colleges and universities, each of which accredits all of the hundreds of institutions in its geographical area, or to one psychology accreditor for all of America’s applied doctoral psychology programs. This comparison indicates that accreditation in psychoanalysis is fragmented, and that its accrediting groups have not organized or unified the field. In psychoanalysis each accreditor has a particular ideology, history, and set of policies, such that APsaA does not accept applications, the IPA presents forbidding requirements, and ABAP has not attracted the mainstream of apparently disinterested institutes.

Apart from the institutes of APsaA, only 20 of 120 autonomous institutes are accredited, or one in six. APsaA’s institutes are required to be accredited, and it may take some external requirement, such as licensing laws or government pressure, to stir the main body of American autonomous institutes to seek accreditation.

**Licensing.** As a result of NAAP initiatives, the states of New Jersey and Vermont now license psychoanalysts. NAAP is also pursuing licensure in the New York, and has a lawsuit for licensure in progress in California. It could be a pressing and important matter for an institute in a licensing state to be accredited, but less important in a non-licensing state.

**Will Autonomous Institutes Join the Consortium’s ACPE?**

**Preparatory Phase.** There would be a preparatory phase before an institute decided to seek accreditation. The institute would determine its purposes for seeking accreditation, seek input from other institutes and the various accrediting organizations, and then make an application.

**The Task.** Accreditation is mostly a process of self-study and documentation, and requires one or two years of preparation. Every analyst and candidate is required to develop a vita that includes the kind of information required by the accrediting body. In addition, for ACPE accreditation, psychologists may be required to join ABPsA. The accreditors require documentation about the legal status of the institute, its bylaws and their changes, tax returns, financial statements, and lists of officers past and present. They require course outlines, lists of instructors and candidates in courses, and minutes of board and committee meetings. They require registrar records for each candidate, and documentation of their personal analysis and supervisory experiences. There is a self-study phase in which the purposes and goals of the organization are identified, and various reports are written. If the accreditor, after review, finds this information acceptable, then a site team will visit and interview analysts and candidates, and perhaps observe classes and institute meetings. Later, a decision is taken and the institute is accepted, accepted with certain stipulations (for example, to acquire a library), or not accepted. This is a
major undertaking for an institute and its membership, and there are financial costs involved.

The View from MPC. The Michigan Psychoanalytic Council (MPC) recently reviewed this issue to determine if it wished to seek accreditation, and its deliberations and reactions describe one institute’s view of the accreditation issue. Michigan does not license psychoanalysts, nor is there any momentum to move in that direction, so MPC addressed accreditation apart from a state-licensing requirement.

MPC is a 3x-5x institute comprised entirely of mental health professionals (non-mental health professionals have not sought psychoanalytic training in MPC). It offers a mainstream tripartite psychoanalytic education with a diversity of viewpoints but with an overall contemporary object-relations perspective. Three features of the MPC program should be noted. First, MPC is comprised of non-analysts as well as candidates and analysts, all of whom may be elected to office and serve on committees. For example, MPC’s first treasurer was a nonanalyst, and its second treasurer was a candidate. Second, all MPC analysts, including new graduates, are training, supervising and teaching analysts. Third, MPC offers a three-year cycle of courses open to both candidates and noncandidates, and upon admission candidates may take whatever courses are being offered (they also receive credit for courses taken prior to admission). In November 2001, there were 39 analysts (all training analysts) and 13 candidates in a total membership of about 111.

After one or two years of study and reports at various meetings, MPC devoted 90 minutes to the discussion of the accreditation issue at its triennial retreat in June 2001. At the retreat there was a presentation of the pros and cons of accreditation, and details about the accrediting groups. In the ensuing discussion IPA was the only accrediting body that attracted any interest, and the other groups were barely on the radar screen. Even those favorable to IPA wanted all MPC analysts to retain their training analyst positions, and the idea that MPC might change its frequency requirement from 3x to 4x was not even suggested. Some reported hearsay that IPA was changing and would admit 3x frequencies and MPC could therefore apply, but others doubted the rumor was true, some disliked IPA, and yet others had not formed an opinion. There followed a discussion about whether MPC should employ some type of ‘five-year rule’ for training analysts: Some said new analysts need experience; others said that all analysts could do analysis. After 90 minutes, it was apparent that there was no consensus or enthusiasm to seek accreditation, and no motion was developed for MPC’s Board of Directors to consider. In the absence of a motion or interest, the MPC president stated a few months later that the matter was effectively tabled. MPC had entered the preparatory stage, and stopped.

Prognostications

To date, only a small percentage of the autonomous psychoanalytic institutes in the USA have sought accreditation. In economic parlance, this means that the Consortium’s ACPE will be one of three or four suppliers of accrediting services in a market with very limited demand. ACPE may not do well in such an environment. For it to succeed, the supply-demand situation would have to change, probably because of licensing laws or some kind of government pressure. If New York should require licensure for the practice of psychoanalysis, this could increase the demand for accreditation. If demand grows, ACPE might gain member institutes, but other accreditors (such as a coalition of institutes) might enter the market and the psychoanalytic community could become more fragmented.

Reference


Murray Meisels was active in Division 39 during its first decade or so, and was Division president in 1987-88. He practices psychoanalysis in Ann Arbor, Michigan, where he is a member of the Michigan Psychoanalytic Council.
Karen Shore states in *What Does Character Have To Do With It?* (Fall, 2001), drawing on Erich Fromm’s work, that virtually everyone working in managed care organizations has a particular character she describes as “sadistic,” “murderous,” and “evil,” and that the psychoanalytic community should “fight” them. Recent socio-psychoanalytic research, reported below, studied the character of leaders in exemplary healthcare systems as a part of a holistic organizational analysis. This Robert Wood Johnson Foundation-sponsored research indicates the need for systemic change, rather than focusing on isolated elements. Therefore it is important to understand the systemic models of work, values, rules, beliefs, and organization underlying different healthcare systems. This research suggests psychoanalytic practitioners can creatively respond to the national healthcare crisis through research and innovative action.

The full report is online at www.maccoby.com/PTWC. It was distributed by the Association of Academic Healthcare Centers to all Presidents and Boards of universities with medical schools and academic healthcare centers, and the heads of these centers. The healthcare systems studied were selected by a distinguished board of physician and nurse leaders. Some of these systems have HMOs, and the model underlying them is critically analyzed.

Fromm’s work is rich and complex. The research reported below is based in part on his concept of social character, which can be helpful to psychoanalytic psychologists as a guide to research and action. Maccoby (1996) has distinguished the prophetic and analytic sides of Fromm’s ideas. To be sure, Shore writes in a prophetic voice, and her article bristles with moral superiority. However, unlike Fromm and Maccoby (1996), Maccoby (1995), and the study discussed here, she did not report on studying or interviewing in person any of the people she characterized. Fromm’s analytic side is missing from her approach.

As psychoanalytic psychologists we can participate more effectively as scientists in the national debate on the future of our healthcare system, than as outraged stakeholders. It is important that we go outside the consulting room and use our skills to study the healthcare world as it is evolving and then contribute based on our analysis. The national debate seeks the optimal combination of quality, cost, and access. No one stakeholder is believed to be responsible for all that is not right in the system, or to have all the answers for designing the ideal system.

**The Study**

Leadership for Healthcare in the Age of Learning was directed by a psychoanalyst and anthropologist, Michael Maccoby, PhD. The research team consisted of two psychoanalytic psychologists, the author and Douglas Wilson, PhD; a psychological anthropologist, Barbara Lenkerd, PhD; and a physician, Dr. Stanley Pappelbaum. The research studied the University of Rochester Medical Center; Intermountain Health Care (Utah); Penn State Geisinger; Aetna US Health Care Southeastern Region; University of Michigan Medical Center; Shands-University of Florida; Mayo Clinic (Rochester, MN and Scottsdale, AZ); Vanderbilt University Medical Center, and Kaiser Permanente (Oakland, CA).

The research showed that healthcare systems are best understood in terms of the mode of production on which they are based. In anthropology the mode of production describes a productive system that includes tools, beliefs, rules, relationships, and organization. The normal character of doctors, leaders, and employees is best understood by its fit, or lack of fit, with the mode of production.

In the craft mode, doctors are sole practitioners conducting their own practice as a specialized craft they controlled. They are self-reliant, independent professionals with no one really to answer to. Many psychotherapists operate in this craft mode of work today.

When the craft mode of work is dominant doctors are trained to be autonomous and they are taught little about interdependence, teamwork, or the value of organization. Learning is individual, and quality is based on a loose network of peer review. The doctor-patient relationship is based on caring, expert authority and the patient’s submissive-trusting attitude. The model of care is biomedical.

In the manufacturing mode, many doctors are employed by organizations, or are members of organizations of doctors (PPO’s) that contract services to other organizations. When employed by organizations they are salaried employees, and are part of a social system with other professionals. Their work is evaluated by criteria of efficiency and cost, and patients are moved through the system as quickly as possible, like on an assembly line. Most managed care organizations are based on the manufacturing mode of production, and some healthcare professionals, such as Regina Herzlinger of Harvard advocate “focused factories” that specialize in particular ailments.

In the manufacturing mode doctors become pro-
providers, and some become also managers of others. The status of doctors as independent professionals is diminished and many resent this. Doctors’ autonomy changes as the mode of production creates new responsibilities. In the new mode of work described next opportunities arise for them to design the systems of healthcare.

The knowledge and service mode, or the age of learning as we describe it, has been developing for perhaps 15 years. In this emerging mode of production the healthcare system is designed around the health of the community served and continuous improvement. Pathways of best practice are designed by the doctors and practitioners and based on outcomes research. The professionals are actively involved in the design and management of the healthcare system. Health is understood as a consequence of social factors and lifestyle, as well as genetic and biological factors. Providers and patients are both learners, and the provider educates the patient about health. They are partners in health creation.

Different health systems we studied excelled in specific areas: the biopsychosocial model (Rochester and Mayo); the epidemiological approach (Kaiser Permanente, Northern California and Intermountain); advanced medical informatics (Vanderbilt).

In this mode of production the doctor becomes a leader and a stakeholder in the system. In the craft mode healthcare was a cottage industry, in the manufacturing mode a bureaucracy, and in the knowledge-service mode it becomes a complex self-organizing adaptive system (a learning organization). In this learning culture the autonomy of the individual doctor is not as important as being a part of designing the evidence-based clinical pathways that embody best treatment. Ultimately the individual doctor, along with the patient, determines the diagnostic and therapeutic approach.

With the rise of organizational medicine, government involvement, insurance companies, and HMOs the manufacturing mode today is still dominant. But other factors are bringing in the learning-service mode: complex new technology, IT, the Internet, new medicines, procedures, biomedical genetics, and other advances in scientific understanding. Also driving the learning-service mode is the higher educational level of the patient population who demand to be informed and a part of their own treatment.

The manufacturing mode brought useful ideas. Quality management, statistical process control and informatics help address variability in practice, control costs, and improve outcomes through clinical pathways. However, in the manufacturing mode doctors resist limitations to their freedom.

Complexity theory and advanced organizational thinking seen in the most effective professional service organizations point the way to an alternative mode of production of healthcare. For doctors this requires leadership skills and understanding the whole systems approach to change management and the design of organizational learning. Doctors, healthcare professionals, and administrators must work together to develop evidence-based systems of care using new technology, including informatics and the Internet.

Will the character of doctors drive or impede the development of this learning and service mode?

Character, Erich Fromm, and Research

Perhaps the most significant of Fromm’s concepts is social character, the normal character types that a culture requires and creates. Fromm and Maccoby (1995, 2nd edition) demonstrated the analytic power of this concept in a ten-year study of a Mexican village, and Maccoby (1996, 2nd edition) studied the modern workplace partly from a social character perspective. In the RWJ healthcare leadership study the dominant social character of doctors was found to be expert-helper. A short survey of psychoanalytic clinicians (Margolies, 2001) suggests that they are helper-experts, the same social character except the dominant and secondary elements are reversed.

The expert’s main values are mastery and achievement. Their self-esteem comes from status and professional respect, and the walls in their offices are often filled with their diplomas and certificates for all to see. They enjoy the craftsmanship of their work and the recognition of others. They have a strong need for autonomy. They value professionalism and bring high standards to the workplace. When the organization of work and the systems they work within do not involve them in exercising their positive motivations in a collaborative and productive way, they can be obsessive, inflexible, controlling, and nit-picking. In organizations that are not well led, experts can seek control over their functions and do not value the empowerment and involvement of other health professionals.

Expert’s professional development is formed through a system of master and apprentice (senior and junior clinician, supervisor and supervisee) where knowledge is based on experience. Today with the explosion of new knowledge and the easy access to information and knowledge, what the expert knows can be quickly outmoded. To stay current they must be interested in continually learning and developing their competence. Thus, the social character of experts can become a roadblock to the very social systems at work that the learning-service mode requires, if they insist on autonomy and control rather than co-designing those systems with other professionals. Experts tend to not see organization as a value added to
what they do personally in their work.

The helpers’ dominant values are helping others and building relationships with those they want to help. Empathic understanding and emotional intelligence are important to them, and their self-esteem comes from being appreciated for their help. In the fading patriarchal industrial-bureaucratic culture the father was the expert whose job earned the family’s income, and the mother’s work was caring for the young. In that culture the father as expert and the mother as helper seemed natural, although our research found that social character is not gender specific. The expert was the dominant social character of the manufacturing mode of production, and the helper was the largest secondary type. There were others: the defender and the innovator, but these were each less than 5% of the population.

In the new mode of production, knowledge-service, the rising dominant social character type is the self-developer (Macoby, 2nd edition, 1996), a variant of Fromm’s marketing social character (Fromm, 1947, 1955, 1976). With the decline of the patriarchal family, equalizing gender roles, and many mothers in the workplace, children are being socialized more by their peers. They grow up realizing that organizations no longer guarantee a life-long job, and they must continually develop their marketable skills. Self-developers value adaptation, continual learning, teamwork, fun in work, fitness and a balanced life between work and play.

Some doctors want to be continual learners and create a more interactive relationship with patients. As more self-developers become doctors this may become the dominant attitude toward patients. Within psychoanalysis the relational and interpersonal and intersubjective are expressions of the move away from the doctor as expert / blank screen. Increasingly, patients today do not have the patriarchal culture’s type of transference to the clinician, and they do not want the expert-patient kind of working alliance (Margolies, 1996). Since psychoanalytic theory has not shown much interest in character, this is a fruitful field to research.

Shore (2001) draws a picture of a split world in which clinicians are empathic and those working in managed care are controlling. Those in managed care are “bullies” and patients and clinicians are “victims” of their “abuse.” Patients and clinicians are said to be “helpless” and enraged. Certainly there are egregious errors and narrow-minded systems within managed care. Certainly better healthcare systems should and will be created. But our research has not found that the healthcare system is so dichotomized between all-good clinicians and all-evil-
doing organizational employees and leaders.

One can be a helper motivated by empathy and also being controlling. Do all therapists work actively to empower their patient’s independence and make treatment as short and effective as possible? Is transference always analyzed so that dependence does not perpetuate endless treatment, to benefit the therapist’s income? How many therapists regularly communicate to their patients: “this is a voluntary relationship in which you hire me to assist in your growth of independence, creativity, capacity to love, work and be happy, whenever you feel ready we should end this work?” Claiming that one is empathic or helpful hardly disproves the presence of control, as in the joke: “I’m from the government I’m here to help you.”

In our research we found caring professionals in organizations who are deeply devoted to their patients’ well being. We have interviewed and studied professionals who have dedicated their lives to creating innovative healthcare systems based on “truly human” values that Shore advocates. We also saw that their organizations have others who do not share their vision. The research report describes what a change strategy requires, including how to address resistance to change.

Therapists, doctors, and professionals are only abused if they let themselves be. They are helpless only if they do not create better systems to work within. Rage is a dangerous fuel. It is more helpful to be motivated by a vision of a better world. What can we do?

The Role of Psychoanalytic Practitioners

1. Inform ourselves. We need to understand and study the innovative best practices being developed in today’s healthcare system. The problem is that many therapists remain in their own therapy office, rather than working in or even becoming familiar with organizations. It is also useful to explore our own social character. How much do we long to preserve the craft world epitomized in a “private practice?” How much do we want to assist the birth of a knowledge-service healthcare culture based on values of quality, cost, and access? How much do we want to understand and work within organizations to support innovation?

2. Speak out/write in our clinical forums. Clinical professional journals, meetings, and forums resemble academia, where the norm is often over-worked ideas with small differences obsessively discussed. How often do we hear about the dynamic changes possible from interdisciplinary collaboration, new sciences, and innovative social experiments in healthcare?

Within psychoanalysis, a subspecialty of American medicine for decades, the official establishment had to be forced by legal action to admit psychologists. Today psychoanalysis relies on non-psychiatrists for a majority of its students. Mental health treatment has shifted away from the craft world of psychoanalysis. Can psychoanalysis adapt to the modern context? The current state of psychoanalysis has been attributed to the insular, self-validating attitudes and the mismanagement of the profession by its practitioners (Bornstein, 2001). Psychoanalysis needs a vision of its ideal future that is not based on the defense of its own autonomy (as in Shore, 2001).

3. Participate in / initiate innovations. In medical schools, institutes, social and healthcare institutions we can contribute to the policies, systems, and experiments that embody our highest values and deepest understanding. Psychoanalytic thinkers and practitioners can learn, do research, and innovate, rather than retreat like angry victims of the modern world.

References


Richard Margolies, a clinical psychologist, works with high-functioning adults in psychotherapy, and consults to leaders interested in developing innovation and the culture of their organization. His address is margoliesr@aol.com.
On Psychoanalysis

The On Psychoanalysis panel webinar and discussion is one of the most important initiatives from the current journal Symposium Series. The webinar features presentations by leading experts in the field of psychoanalysis, providing an opportunity for attendees to engage with experts and contribute to ongoing discussions in the field. Topics covered include the latest research in psychoanalytic theory and practice, as well as the application of psychoanalysis in various clinical settings.

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Our two columns are both concerned with research relevant to the concept of the Working or Therapeutic Alliance. Anne Grete Hersoug, a researcher studying in Oslo, Norway, looks at therapist training and experience, therapist early parental bonding, and therapist interpersonal problems (all self-report) as they influence the Working Alliance. This research represents an attempt to determine if, among other variables, there are personal qualities of therapists that influence psychotherapy outcome.

J. Christopher Perry interprets research, for which he served as consultant, about the creation of the Therapeutic Alliance early in the treatment based on therapist designed early interventions which are dependent on the patient's level of defenses.

On another note, we want the readership to be aware that the American Psychoanalytic Association, during its December meetings, had its Inaugural Research Poster Session during which a dozen researchers, including us, were able to present our work and discuss it with interested members of the analytic community. The session was well-attended and generated enthusiastic response. The editors.

## Quality of Working Alliance in Psychotherapy: Therapist Contribution

Anne Grete Hersoug

Working alliance has been a consistent, though modest, predictor of outcome in therapy (Martin et al, 2000). Patients' ratings of working alliance tend to correlate higher with outcome of therapy than therapists' ratings. In our study (Hersoug et al, 2001) in the Norwegian Multisite Project on Process and Outcome of Psychotherapy, we explored therapists' professional background and their personal characteristics (based on self-reports) as possible predictors of working alliance. Both therapists (N=59) and patients (N=270) rated the alliance in the 3rd and 12th sessions (Working Alliance Inventory, short version).

In general, previous studies have not yielded consistent results with regard to the associations between therapists' professional experience, formal training, competence as a psychotherapist, and working alliance. In a review of 12 studies, a small, positive relationship between the therapists' experience and the quality of working alliance was found (Auerbach et al, 1977). However, this was not found in a more recent study (Dunkle et al, 1996). The lack of distinction between experience, training and acquired competence, and the difference in the instruments used, may have reduced the consistency of the results. This also makes comparisons with previous studies difficult.

Therapist characteristics that have been associated with better working alliance include less self-directed hostility, higher degree of comfort with closeness in interpersonal relationships, and more perceived social support. Patients of therapists with hostile introjects have been found to report no change or negative outcomes in short-term psychotherapy. In a review of studies of interpersonal complementarity, a repeated finding was that hostile-dominant acts are frequently responded to with further hostile-dominant behavior, i.e., noncomplementary behavior (Orford, 1986). Empathy, non-possessive warmth, and genuineness, on the other hand, are quite likely necessary, even sufficient, in establishing an optimal therapeutic relationship.

The relationship between therapists' values and the development of working alliance in psychotherapy has not been explored, but previous studies indicate that therapists communicate their values to patients. In a study on value similarity, patients rated sessions as more negative and less engaging with therapists holding dissimilar values. Therapists' judgments of patients' improvement in psychotherapy have been found to correlate with the extent to which patients appear to adopt the values of their therapists. Patients' and therapists' perceived similarity of personal characteristics was not correlated with their assessments of progress in therapy.

In our study, we wanted to explore whether therapists' self-evaluation of skill and progress would have a positive impact on the quality of working alliance, and whether therapists' training and experience with psychotherapy had any impact, without expecting a consistent pattern of results for these variables. We also wanted to explore whether therapists' early parental bonding (PBI) would have a positive impact on the working alliance, and whether therapists' interpersonal problems (IIP) or problems with being too aggressive or hostile and having a distant attitude towards others, would have a negative impact. Self-attacking introjects (SASB) should predict less favorable alliance. The last research question was whether patient-therapist similarities in values would be positively associated with the quality of working alliance. Personal
similarity was explored without specific hypotheses.

Our results suggest, at a general level, that none of the therapists’ pre-treatment characteristics were strongly related to the quality of working alliance, neither as rated by the patient nor the therapist, early or later in therapy. Therapists’ self-rated characteristics were weak predictors of patients’ ratings of alliance. A somewhat stronger relationship was found between therapists’ self-rated characteristics and the same therapists’ own evaluations of the alliance.

Quite unexpectedly, more experience as a therapist did not have any significant impact on the working alliance as rated by patients (hierarchical multiple regression analysis). If experience had any impact at all, the trend was a negative one (correlations). Therapists’ ratings of early alliance were lower the more experienced they were. This may simply reflect that experienced therapists are more reluctant to give high ratings to the quality of working alliance early in therapy. They may believe that alliance building takes more time. More experienced therapists may have increased preparedness for fluctuations and ruptures in the alliance, even if there are signs of a high quality of early alliance. Therapists with more experience may also be reluctant to give higher ratings until they are convinced that the therapeutic process works according to the tasks and goals of therapy.

We found that amount of professional training as reported by therapists themselves was significantly related to better quality of working alliance as rated by the same therapists. This may reflect therapists’ confidence in having acquired the competence that facilitates the therapeutic process. However, patients tended to hold the opposite view: the trend indicated that they rated the alliance less favorably the more training the therapists had (correlations). Therapists’ self-ratings of higher skill and progress as therapists were positively related to alliance rated by the same therapists. From the patients’ point of view, there were no such associations.

Overall, the findings indicate that patients and therapists tended to have different perceptions of the therapists’ training, experience, skill and progress and their impact on working alliance.

Our findings indicate that, generally, outpatients tend to favor the style of less trained and less experienced therapists. Training in dynamic therapy should be alert to possible negative aspects of current training programs and emphasize a more active and supportive attitude in the beginning of therapy. Useful methods may include: teaching the patients about the nature of his/her disorder, role preparation for the therapeutic process, and active involvement of the patient in treatment planning. Psychotherapy research has demonstrated that well-planned, structured treatment is generally better than unstructured therapy.

Therapists’ interpersonal problems on the cold dimension predicted lower quality of working alliance (12th session) as rated by both patients and therapists. Therapists’ warm, parental bonding had a positive impact on assessment of the alliance from both the patients’ and therapists’ perspective. Therapists’ interpersonal problems on the warm dimension (right hemisphere of the IIP circumplex), i.e. problems with being overinvolved, overly nurturant, dominant, had a negative impact on alliance as rated by therapists. In contrast, patients had a positive experience of a dominant style in the therapists, which was associated with higher ratings of the quality of alliance. This may reflect patients’ preference for therapists with a more struc-
tured, active involvement in therapy, as opposed to a neutral attitude. The therapists’ memories of a caring mother (warm dimension) had a positive impact on the evaluation of the quality of working alliance from therapists. This was found as a trend also for patients’ ratings. In a study on patient characteristics and alliance, we found a similar association (Hersoug et al, 2002). Our findings are consistent with previous research: The warm dimension facilitates the therapeutic relationship, and the cold dimension has a negative impact. Critical introjects were predictive of lower quality of alliance as rated by therapists but not patients. This indicates that therapists tend to evaluate the alliance as less favorable when they have more self-attacking introjects.

Higher value similarity was related to better quality of alliance only as rated by patients. Patients ranked the following values highest: family safety, inner harmony, genuine friendships, self-respect, and mature love. The values therapists ranked highest were: family safety, self-respect, genuine friendships, and mature love. Except for inner harmony, the values were identical, and the ranking nearly so. Values are not usually explicitly shared between therapists and patients, but may still have an impact on the working alliance. Patients, who are often alert to the therapists’ personal characteristics, may perceive some cues of similarities in values. Their positive evaluation of similarity was reflected in higher ratings of working alliance.

We did not find any associations between similarity in personal characteristics and alliance. This may reflect that there was too little variance in the sample to have any significant impact on the results, or that our methods were not appropriate in order to find possible impacts. Whether there is an optimal match between personal similarities and differences remains an issue for future research.

Summary

More experience as a psychotherapist is neither a guarantee of better quality of working alliance, nor a consistently negative predictor. Therapists’ experience, professional training, skills and progress did not have any significant impact on patients’ ratings of working alliance, but a negative trend was found for experience and training. A dominant style in therapists’ self-evaluations had a positive impact on alliance as rated by patients, indicating that patients prefer actively involved therapists. Personal similarity variables did not have any impact, but value similarity predicted the patients’ ratings of alliance.

Patients and therapists had different perspectives on the working alliance (14-18% shared variance). Therapists’ self-evaluations on the cold-warm interpersonal dimension predicted alliance as rated by both patients and therapists. We have reported the same pattern in a study on patient pre-treatment characteristics and alliance. These findings are consistent with the main trends in previous research. Therapist training in dynamic therapy should be alert to possible negative consequences of training programs emphasizing exploratory techniques over supportive techniques. Continued education in psychotherapy may be advisable, also for experienced therapists. In the initial phase of the therapy, more emphasis on role preparation, education, reassurance and support might have a positive impact on the working alliance.

References


Anne Grete Hersoug is a clinical psychologist, trained in psychodynamic psychotherapy with children and adults, currently with a part-time private practice. She has been involved with psychotherapy research since 1997 at the Department of Psychiatry, University of Oslo; starting a post-doctoral research project with qualitative analyses of patient defensive functioning and therapist interventions in 2002. E-mail: a.g.hersoug@psykiatr.uio.no
The therapeutic alliance is one of the most robust predictors of outcome in psychotherapy. The Lausanne Psychotherapy Research Group, directed by Jean-Nicolas Despland, has examined what predicts the development of the alliance in a unique investigative setting. The investigators are conducting a study of the development of the alliance during the four sessions of a Brief Psychodynamic Investigation, a special form of evaluation and crisis intervention. In doing so they have confirmed some parallel findings on the development of the alliance in short-term psychotherapy, but extended our understanding of how alliance is influenced by the relationship of therapist interventions to patient functioning.

There are two qualitatively different phases of the alliance in the course of psychotherapy, indicating that early alliance appears to be a slightly more powerful predictor of outcome than alliance averaged across the treatment or in mid-treatment. In general, therapists’ interventions foster a high therapeutic alliance when there is a good match between therapist’s activity and patient’s receptivity. The therapist’s actions themselves address the patient’s issues, but their influence on alliance depends on how attuned they are to certain patient factors. Defense mechanisms are one such set of factors. The aim of this study was to examine the adjustment of the therapist’s interventions to the patient’s defense mechanisms as it influences the early development of the therapeutic alliance.

How early and late alliance emerge in the patient-therapist relationship is a question crucial for learning how to influence alliance development. Crits-Christoph et al. empirically demonstrated that maintaining a positive alliance and repairing negative elements during treatment are intimately connected to the technical interventions made by the therapist. However, the nature of the relationship between interventions and patient’s characteristics still has to be clarified.

Patients’ defensive functioning may affect alliance development. Vaillant suggested that intermediate level defenses, such as rationalization, reaction formation and intellectualization, might interfere with an individual’s capacity to engage in self-exploration. If such defenses play a fundamental role in affecting a therapeutic alliance, any change in them may depend on the frequency with which the therapist addresses or interprets these defenses. Some evidence of this was found by Foreman and Marmar, and Winston et al. We wished to determine how the adjustment of the therapist’s interventions to the patient’s defense level predicted alliance outcome. We hypothesized that, as part of addressing defense mechanisms, it is important that the psychotherapist adjusts his or her interventions to fit the patient’s level of personality organization and ego strength. The level of defensive functioning is one measurable facet of the level of personality organization.

From the perspective of dynamic psychotherapy, two broad types of intervention can be distinguished: those that offer support and those that foster psychological exploration and understanding. Gaston suggested that when patients have difficulty in establishing an alliance, a greater proportion of supportive interventions would be more beneficial. Researchers such as Piper and Hoglund have demonstrated that some psychological measures can identify individuals for whom high levels of exploration are relatively counter-productive.

We believe that the therapist has to choose the appropriate proportion between supportive and exploratory interpretations, giving consideration to the level of defensive functioning as an immediate indicator of personality organization and ego strength in a given session. We therefore hypothesized that the therapist will influence the early development of a positive alliance when there is a positive adjustment of therapeutic interventions to the patient’s defensive functioning defined as follows: whenever the patient’s defensive functioning is low the therapist must be more supportive, whereas whenever the patient’s defensive functioning is high the therapist should use more interpretive techniques. Lower defensive functioning would include defenses such as acting out, passive aggression, splitting, denial and projection, whereas higher level defensive functioning would include defenses like repression, intellectualization, undoing, self-observation or suppression.

This study considered two questions. First, does the patient’s defensive level affect early alliance building (specifically, would lower defensive functioning be associated with poorer alliance development)? Second, is the development of alliance influenced by the level of adjustment of therapist interventions’ to defensive functioning (specifically, will the optimal adjustment of intervention types differ with level of patient’s defensive functioning)? This latter is a specific case of the more general proposition that alliance will improve when the therapist optimally adjusts his or her technique based on the patient’s level of functioning.

The study took place in the outpatient department of the University of Lausanne, Switzerland, and included consecutive adult outpatients requiring psychiatric or psychotherapeutic assessment. Each had at least one anxiety,
depressive or personality disorder diagnosis. Exclusion criteria included any psycho-organic, serious substance use, psychotic or bipolar disorder, mental retardation or antisociality. An independent researcher ascertained diagnoses on the basis of a semi-structured interview, using DSM-IV criteria. Five experienced therapists with extensive backgrounds in both long-term and short-term psychoanalytic psychotherapies participated.

Considering how rapidly alliance develops, we chose to study it as early as possible. Developed in Lausanne, Brief Psychodynamic Investigation (BPI) is a formalized 4-session technique of assessment for psychodynamic psychotherapy that focuses on the patient’s reasons for the consultation and the early interaction between the patient and therapist. The main objectives of the BPI are to establish a diagnosis, further the development of the early alliance, and develop an optimal plan to resolve any crisis situation with which the patient presents. The therapist helps the patient view his or her difficulties in a deeper way, in order to facilitate choosing the best treatment relative to his or her disorder and expectations. This often subsequently leads to entering psychotherapy. After the first or at the beginning of the second interview, the consultant offers the patient an initial interpretation built on a hypothesis about the crisis. The therapist proposes three more sessions to discuss it, followed by an evaluation after the fourth interview. The interviews are non-directive, encouraging free association. Training for BPI was based on a manual and involved continuous participation of therapists in a 4-year supervision seminar employing videotaped sessions with Dr. Gilleron, the author of the method.

The study sample (N=12) had a mean age of 28.5 (SD=12.5); 11 were women. After the BPI, 10 patients decided to continue with a psychotherapy, and 2 decided not to pursue further treatment. Each patient completed Luborsky’s Helping Alliance Questionnaire, HAQ-1, at the end of each interview. Examination of the first 21 patients showed that the mean alliance improved at each successive BPI session while values at each session were strongly inter-correlated (range of Pearson’s r = 0.65 to 0.85). We defined the level of the alliance for each subject at each session as either low or high based on whether his or her score was below or above the mean for the whole sample combining all four sessions. This resulted in three clearly different patterns of the evolution of the alliance: pattern I: a high, stable alliance (N=7); pattern II: low alliance that continuously improved during BPI (N=10); pattern III: an alliance which remained low and stable (N=4). Although theoretically expected, no decreasing or unstable profile of evolution was observed. We subsequently confirmed the three patterns both by visual inspection as well as by cluster analysis. We then selected the first four subjects in order of admission who showed each profile in order to study the contribution of defense mechanisms and therapist interventions for each pattern group (N=12).

We rated defense mechanisms using the Defense Mechanism Rating Scales (DMRS) of Perry with quantitative scoring. A rater identified each of 28 individual defenses as it occurred in each session. We summarized each session by calculating the proportion of defenses at each of seven hierarchical levels (action defenses at the low end, high adaptive defenses at the upper end). A weighted average then yield a 7-point Overall Defensive Functioning (ODF) score. Both had high reliabilities (intraclass R = .80), in line with other studies.

Therapist interventions were classified using The Psychodynamic Intervention Rating Scales of Bond and Cooper (PIRS), which identify nine types of interventions based on psychodynamic psychotherapy, broadly divided into three categories: interpretive (defense and transference interpretation), supportive (clarification, reflection, support, offering associations) and therapy-defining (contractual arrangements, work-enhancing strategies). Each intervention is identified throughout an interview transcript, and the raw count is expressed as a proportion of all interventions, which attained good reliability (kappas greater than 0.75).

We devised the following method to measure the adjustment of therapist interventions to the level of patient defensive functioning. First, the patient’s level of defense functioning was summarized by the ODF, ranging from 1 (low level action defenses) to 7 (high adaptive level defenses), following the hierarchy of defenses. Second, in an analogous manner, we constructed an Expressive-Supportive Intervention Level (ESIL) summary score for the PIRS, by rank ordering the intervention scores from the most supportive (1) to the most exploratory intervention (7), and then taking a weighted average. Third, we examined the therapist’s interventions (ESIL) and the patient’s level of defensive functioning (ODF) in each session together, by calculating their ratio (ESIL/ODF), designated the Adjustment Ratio (AR). We then examined the Adjustment Ratio for each session as a predictor of alliance development.

In examining the initial BPI sessions, the subjects had an ODF spanning the personality disorder and neurotic range (mean 4.5, range 3.4 to 5.6). The intervention score was slightly tipped to the lower, supportive end (mean ESIL 3.8, range 3.4 to 5.5). The mean HAQ-1 alliance score rose successively across the sessions, yielding an effect size of 0.58, reflecting improvement between the first and the fourth session. At the first session, the Profile I High-stable group was significantly different from the others. However, by the third and fourth sessions, the Profile II low but continuously improving alliance group had significantly
differentiated itself from the Profile III low and stable alliance group, while it became close to the Profile I high stable alliance group. This was a striking change in the Profile II group after just three sessions.

Next we examined predictors of alliance profile in the first session. Beginning with patient defenses, neither ODF nor any of the seven defense levels differed across the three alliance profile groups. Next we examined interventions. Therapist ESIL in the first session predicted alliance in the first session. At the first session, the Profile I group (high, stable alliance) had the highest ESIL score, although non-significant, suggesting that the therapists were already somewhat more exploratory with high alliance patients at this session. However, first session ESIL did not differ across the three profile groups, indicating that therapist interventions alone did not determine the change in the alliance.

Finally, the Adjustment Ratio (ESIL/ODF) in the first session predicted alliance at both sessions three and four (both p=.02), as well as the mean alliance across the four sessions (p=.009). Furthermore, the AR was significantly different across alliance profile groups at the first session: Profile I and II AR means did not differ from one another (0.94 and 0.93, respectively), while both differed from profile III mean AR (0.75), the low-stable group. This clearly indicates that for patients with a low stable alliance, at any given level of ODF, those therapists offered a greater level of support and lesser exploration than did those in the other profile groups. This suggests that using too small a proportion of exploratory interventions may have contributed to a failure of a low alliance to improve.

The article includes several clinical case examples. One Case was a 25-year-old secretary. She presented with strong feelings of jealousy toward her sister who was pregnant, and with depressed feelings following a series of unsuccessful affairs. She was not satisfied at her job, and described some overly ambitious professional projects. She reported being treated poorly by her mother and father, but had only recognized it relatively recently. She was tall and dressed without any attempt to appear attractive. Her affect was depressed and she cried a lot initially. The patient’s four-session evaluation as a naturalistic experiment. The results, when theoretically predicted, have some confirmatory value for the overall theory: therapist’s interventions must be adapted to the patient’s level of functioning to produce a desirable effect.

The first finding, that patients’ alliances differentiated very rapidly over the four-session Brief Psychodynamic Investigation into three patterns, concurs with the observation by O’Malley et al. that alliance was formed by the third session in short-term psychotherapy. A high stable alliance (Profile I) would be considered the most desirable, reflecting a therapy that starts with a good therapeutic alliance and stays on course. However, to improve the therapist’s conduct of BPI, it is more informative to understand the factors predicting the differentiation of the other two alliance profiles. Patients with a low alliance at the first session diverged by the third session into those with either an improving alliance (Profile II), or a continuing low alliance (Profile III).

The patient’s initial overall level of defensive functioning alone did not differentiate these alliance profiles, suggesting that even patients with low initial ODF can develop a good alliance. Defense mechanisms can be considered as an aspect of the subject’s personality organi-
zation, and it is widely believed that poorer personality organization would be associated with more difficulty establishing a positive alliance. However, our results suggest that the level of defensive functioning per se is probably less significant for alliance formation than how the therapist chose to intervene, given the patient’s presenting level of defensive functioning. Even patient’s describing episodes of acting out, splitting, projection or denial, will respond better if initial supportive interventions like reflection, clarification or suggestion are followed by more exploratory interventions, such as the interpretation of defense or motive. This helps the patient see that he or she can make better sense out of what may feel like a drama unfolding out of his or her control.

There was an association between Expressive-Supportive Intervention Level and patient alliance at session one only. This indicates an initial association between a relatively enriched or high proportion of exploratory interventions and high alliance, whereas a relatively richer proportion of supportive interventions was associated with lower alliance. This may reflect the therapist’s general style or his or her initial judgment as to which mix of interventions would be best for the patient. However, this initial mix of interventions considered alone did not predict subsequent alliance building.

It may be necessary for the therapist to be supportive, but it alone is not sufficient to contribute to alliance building. Rather, at each level of a patient’s defensive functioning, there appears to be some optimal range of exploratory interventions which are necessary to facilitate growth of the alliance. As defensive functioning increases, the optimal proportion of exploratory interventions rises proportionally. This was exemplified in our findings. The patients in both Profile groups II (improving) and III (low, stable) received about the same proportion of exploratory interventions, but because of differences in defensive functioning, the Adjustment Ratio of profile II (improving) was far closer to that of Profile I (high stable), than the significantly lower AR for Profile III. Thus, groups I and II received a more optimal proportion of exploration for their given levels of defensive functioning, leading to the development of equally good alliances.

By contrast, Profile group III received relatively fewer exploratory interventions, despite a slightly higher given level of defensive functioning, resulting in no improvement in alliance. These findings support our hypothesis that development of a strong alliance requires adaptation of therapeutic interventions to the patient’s defenses.

Together, our empirical findings are consistent with Winnicott’s (1955) warning that supportive techniques are no substitute for interpretive techniques, even with regressed patients. Support has to be understood in psychoanalytic psychotherapy as aiming to support ego functioning, including defensive functioning, in order to minimize regression and reinforce ego boundaries. While very important, supportive interventions alone do not appear to have the power to improve the alliance, which a more optimal mixture of supportive and exploratory interventions does have. Furthermore, this research suggests that at higher levels of defensive functioning, a proportional increase in exploratory interventions by the therapist will yield better alliance development.

We also expected that a low alliance could be associated with too high a proportion of exploratory interventions for a given patient, yielding too high an AR in the Profile II group (low and stable). We did not find this. It is possible that the extensive training of participating therapists may have reduced the likelihood of the overzealous use of exploration. A larger sample might yet yield such examples. It is also possible that extensive interpretation only occurs whenever the patient has given enough material to the therapist, which may require a longer treatment time frame, or an already developed good alliance.

While the therapeutic alliance is a concept common to many forms of psychotherapy, we formulated the idea of adjustment using specific, psychodynamic measures. Nonetheless, it could be adapted to other treatments or patient measures. Finally, training clinicians to conduct a dynamic investigation or psychotherapy may be very different depending on one’s view of the role of alliance. Some might believe that developing a good alliance is an explicit, primary goal of therapy, while others may view the alliance as an important indicator of how well the therapist has adjusted his supportive-expressive interventions to the patient’s level of defensive functioning, or some other salient, patient characteristic. Further confirmation of the present results might suggest that training manuals and training programs give greater consideration to the latter position, of adjusting intervention levels to fit the patient.
References


**Dr. Perry is Professor of Professor of Psychiatry, McGill University and Director of Research at the Institute of Community & Family Psychiatry of the SMBD Jewish General Hospital in Montreal. He holds adjunctive appointments in psychiatry at Harvard Medical School at the Austen Riggs Center, and in psychology at the University of Montreal. His research interests focus on assessing psychodynamic change in long-term process and outcome studies of psychotherapy with treatment-resistant disorders, such as depression or personality disorders. He has developed methods for assessing defense mechanisms, motives, conflicts, Axis II disorders, and therapeutic alliance. He had the pleasure of training some of the authors and subsequently consulting with them on their study.**

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**Reuben J. Silver Receives APA Award**

In August, Division 39 member Reuben Silver joined the ranks of previous honorees such as Carl Rogers, David Wechsler and Zygmunt Piotrowski in receiving an award from APA for Distinguished Contributions to Applied Psychology as a Professional Practice. According to the citation accompanying the award:

During his 50-year career as a practitioner, an educator and a supervisor, Reuben J. Silver has been an outstanding advocate for psychology. He has been a role model to a multitude of interns and to scores of others. His contributions as a leader on state and national levels include serving as chair of the New York State Board for Psychology, a member of the Commission of Education’s Task Force on Training, chair of the New York Health Department’s Medical Access Review Committee, and a founder of the Association of Medical School Psychologists. He pioneered opportunities for psychologists nationwide with his groundbreaking appointment as director of a medical school psychiatry clinic. He is highly respected and admired by his colleagues.

Dr. Silver can place this award alongside numerous others he has received over the years including the Karl Heiser Award from APA, and a Lifetime Advocacy Award from the Association for the Advancement of Psychology. He was also the inaugural recipient of the Distinguished Psychologist Award from New York State Psychological Association.

There is a more extensive biography and bibliography included in the report in the November issue of *American Psychologist*. Reuben Silver was one of very few psychologists who were able to make a place for psychology in medical schools and in particular within psychiatry by demonstrating that psychologists had the skills and ability to not only teach but to perform and supervise psychotherapy.

Reuben recently retired from his work at Albany Medical College, where he maintains an appointment as professor emeritus, and has moved to Wilmington, North Carolina. He has continued to be active in tending to psychology’s affairs and his recent efforts have been directed toward developing the continuing education program of Section V, a web-based program unique to the Division.

Congratulations are in order for Reuben Silver on the occasion of this Award, with gratitude for his contributions to the Division of Psychoanalysis as well as to psychology as a profession.
CONTROVERSIAL DISCUSSIONS

Gabbard

INTRODUCTION TO: "THE ANALYST'S PARTICIPATION: A NEW LOOK" BY JAY GREENBERG

THE ANALYST'S PARTICIPATION: A NEW LOOK

Commentaries by Casement, Crastnopol, Kantrowitz, Michels & Pizer; Response by Greenberg

White
THE INTERPERSONAL AND FREUDIAN TRADITIONS: CONVERGENCES AND DIVERGENCES QUESTIONING THE PSYCHOANALYST'S AUTHORITY

Tuch
THE ANALYST'S KNOWLEDGE AND AUTHORITY: A CRITIQUE OF THE "NEW VIEW" IN PSYCHOANALYSIS

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LIFE-THREATENING ILLNESS IN THE ANALYST

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Greene
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Lloyd Mayer
ON "TELEPATHIC DREAMS?": AN UNPUBLISHED PAPER BY ROBERT J. STOLLER

Gabbard, Peltz, & the COPE Study Group on Boundary Violations
SPEAKING THE UNSPEAKABLE: INSTITUTIONAL REACTIONS TO BOUNDARY VIOLATIONS BY TRAINING ANALYSTS

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I am extremely pleased to sponsor a series of articles on couples therapy for the Psychologist-Psychoanalyst. In the following three essays we will try to provide a glimpse of the richness of working with couples from an integrated systemic and psychoanalytic perspective.

Psychoanalysts are interested in couples therapy today, for a variety of reasons. It is a therapeutic modality that has acquired a new acceptability—even attractiveness in the general population. (Gerson, 1996). Why is this so? For one thing, sweeping changes in social ideology (represented most forcibly in the feminist revolution) has deconstructed time-honored assumptions and expectations regarding family structure. What is commitment in post-modern culture? Is exclusivity possible in an age of distracted consumerism? Each couple has to cobble together its own schema. It probably has never been easy to share your life with someone. However, the psychic challenge of “togetherness,” i.e., integrating developmental anxieties, issues of separation, unresolved identifications, without clear consensual guideposts, becomes overwhelming for many couples. Analysts are more frequently asked for referrals to couples therapists or more readily consider making a referral themselves. Thus developing a personal grasp of the therapeutic action of this form of therapy is useful, even if one has little personal interest in conducting it.

Sheila Sharpe’s article, The Development of Couple Relationships is a rich presentation of the patterns that facilitate connection as well as separation. For Sharpe, our culture’s mythology of “romantic love” has inhibited attention to the necessary adult developmental processes that allow for the enhancement of lifelong needs, such as the reception of nurturing. Sharpe stresses that certain patterns can become rigid or defensive and dominate mature relating. The therapist, aware of a collusive transference construction, i.e. to a benevolent or controlling parent, and her attendant countertransference reaction, can help dissolve the rigidity of the pattern.

I have always believed that working with couples invites us to reconsider many of our assumptions regarding transference, countertransference, and self-formation—practically every important concept we work with. The shift in context generates questions that lead to new perspectives and discoveries. In Shelly Goldklank’s article, Couples and Countertransference, we are presented with a creative look at transference and countertransference. Goldklank broadens her geometry of these concepts to include their action between members of the couple as well as with the therapist. For Goldklank, the fulcrum of couples treatment is a shared conflict, masked in the couple’s initial attraction by different and often opposing defensive styles. When the therapist is drawn into the conflict, and investigates it with the couples, each partner has “the opportunity to find the analog” of their own, personal and restricted solution.

I find that couples work is often described as pleasurable by analysts. A classically oriented colleague of mine once suggested it to a class I was teaching that couples therapy provides a wonderful release for the “aggression” one can’t express in individual treatment. An interesting idea, but not one I would personally proffer. Rather I think that working with dynamics in “real relationships,” adds a different kind of vitality to our therapeutic experience. We are all generally more informal, more overtly “active,” and more playful in couples work partly because our unit of treatment—the couple—shares a life beyond us which is bounded and somewhat exclusive of us. We are offered a different set of degrees of freedom in couples treatment.

There is a panoply of approaches to couples work and every orientation within psychoanalysis—from the classical to the existential—offers unique possibilities for exploration and expansion of experience. In a subsequent issue, an integrative perspective will be presented in relation to other clinical situations and problems. Most of all, I hope these articles invite you to think with us, and perhaps join us in Section VIII, Couples and Family Therapy and Psychoanalysis, founded in 1996, to house this challenging and enriching area of clinical thinking.

References

In this article, I’d like to think about the following question: What is unique about the process of couples therapy? For one thing, I think that the lens of couples therapy offers a sharp clarity about one’s “personified self,” in Sullivanian terms. Sullivan (1950) described the envelope of the “personified self,” a reified, sanitized version of oneself, which remains unaffected by interpersonal feedback because of the protective radar of security operations. When partners are facing—not imagining or recollecting each other—and the therapist helps penetrate the collusive shield of anxiety, self-protection is buffeted. The effect can be one of acute and fresh self-recognition and expansion.

I am working with a couple that includes a wife who chronically and poignantly wonders whether she has any powerful feelings towards her husband. Was their union exclusively a pronatal venture, a wish to share parenthood and little else? Of course there exists a plethora of relevant issues: her childhood history of physical abuse; his nurturance which is parentally healing but inevitably desexualized; his compulsive caretaking which blindsides him to other of her needs, etc. In their most recent session she said she felt she had to raise—though with reluctance to hurt—the fact that she no longer currently desired him at all. Because this followed another session in which she had questioned her basic love for him, her husband became utterly defeated and hopeless. I asked him whether he could, in spite of his distress, recognize her revelatory statements as possibly expressing commitment and concern for their marriage—after her own fashion. She truly believes, as she has said in our sessions, that one must “clean wounds” before they can heal. He is so non-confrontational and solicitous that entertaining this hypothesis took every bit of his effort, and in doing so he inevitably had to face his own restricted repertoire of “loving.” I didn’t have to urge her to reflect on her behavior. She was visibly alarmed and shocked at the wake of devastation her remarks produced. She had lost sight of his raw and real emotional attachment to her. Because she always had her saber drawn, she assumed he was merely frightened of her. She had felt unlovable, which only made her more strident.

This material lends itself to what I am most interested in conveying as the essence of the “good enough” couples therapy hour. For me, the therapeutic action of couples therapy lies between the couple, generally carrying with it heightened emotionality (though with highly reactive couples, a moment of cooled-down irony can be most mutative). It is a moment in which each person temporarily loses his/her moorings of personified self, and reemerges with a reshaped contour. Though the plasticity of self-experience has become a hallmark of postmodern psychoanalytic theory, and both Mitchell (1993) and Bromberg (1999) have emphasized shifting boundaries, our culture privileges self-definition and self-containment. Couples therapy provides the arena for perhaps our most challenging existential task—that of articulating ourselves while recognizing that we are inexorably embedded and defined by the reflections, the longings and the perceptions of significant others. Intimacy is the natural habitat of our psychoanalytic “two person psychology.”

I’ve felt the need as I’ve worked with couples to find a representation, an arbor to house the co-construction of two lives, of two sensibilities. Our therapeutic language of “self” and “other” constrains, rather than expresses, this psychic reality. Minuchin (1981) suggests that our language system generally fails us in capturing this reality, proposing, for example, the term “mochild” or “chother” to signify the mother-child unit. When I researched the roots of drama, I became more and more interested in its origin as cultural ritual; drama has always provided a means of providing spectacle and intensity to strengthen prevailing belief systems or articulate newly arisen conflicts. Ultimately, it seems to me that the dramatic impact of a couples session emerges from its power as ritual (Gerson, 2001a). When I researched the roots of drama, I became more and more interested in its origin as cultural ritual; drama has always provided a means of providing spectacle and intensity to strengthen prevailing belief systems or articulate newly arisen conflicts. Ultimately, it seems to me that the dramatic impact of a couples session emerges from its power as ritual (Gerson, 2001b). In the case of couples in a post-modern, secular and hyper-autonomous culture, the ritual power of couples therapy lies in its subversion of the prevailing ideology that “I should be my own person,” or “I can reinvent myself” to an experience that our identities are co-mingled and, yes, co-dependent. How each partner co-constructs each other’s reality becomes a new field of exploration, akin to Ogden’s (1994) “third” in dyadic treatment.

Here’s the rub. I think that psychoanalysts who work with couples experience disequilibrium as well. I believe that since we can’t unpack the transference experience of each member of the couple fully (it is complicated enough with the individuals we work with!), and because our own counter-transference experience cannot be adequately decoded in a true analytic sense (to each person? with the couple as unit?), we index these crucial dimensions in our work but we inevitably develop a different stance towards therapeutic action. For if the couple is to interact with fluid boundaries, the therapist has to move out of their field, at least temporarily, and we are used to being at the
center, the fulcrum of change. Psychoanalysts, who have developed some of the richest developmental theories, can help couples find their intersubjectivity by zooming into to present experience, and granting it as much drama as genetic connections. Psychoanalysts often find that they have to focus on the pragmatics of communication, what individuals are doing with each other, how they are using language, as much as on the symbolic meaning of communication. When a husband says, “I’m damaged goods,” to his wife, a supervisee feels enormous compassion towards him. But his statement preempts his wife from making any emotional demands on him! And, lastly, we have to tolerate individuals being central protagonists of change for each other, when we have been drawn to this work because of its possibilities for a kind of wrestling intensity.

How to proceed? Let me sketch some of the approaches I take in my couples work. After all, I began with a proposal about the “uniqueness” of couples therapy. It’s a choreography of multiple possibilities, but let me give you a sense of my own notation.

1. I think that focusing on present circularity intensifies therapeutic exploration. The classic circle is distance/pursuer (generally he runs and she chases). But circles have infinite variety, e.g., he is innocent because she is accusing; she is evasive because he is invasive, she loves his “holier than thou-ness,” because she can withdraw to more sinful distractions. There are obvious and veiled circles, primary and secondary loops. Often the most generative way to identify a circular dynamic is so let an image or metaphor float into awareness.

2. I am always interested in past experience, and in fact take a genogram history of each partner (lasting for one session), in approximately the third or fourth session. However, here I fuse my systemic and psychoanalytic approaches and follow a line of spontaneous inquiry, “Do you think that your mother was so hysterical (or nasty, or alcoholic) partly because your father dismissed her? People rarely think of their parents as co-constructors! I generally try to interrupt what Donnell Stern (1997) calls “narrative rigidity” (p. 129), and formulate the “unformulated” which will hopefully then extend to looking at surprising interpersonal influence within the couple’s relationship.

3. I think that we as psychoanalysts, whose founding father was a renegade trained in the medical model, still carry remnants of that tradition in our clinical approach. We simply don’t pause often enough to ask, “What’s right about their relationship?” “What’s resilient, or even admirable about their relationship configuration?” Removing the filter of pathology often liberates new thinking and new experience.

4. I think that in addition to focusing on the pragmatic of communication between the couples, i.e., what he is doing by what he is saying, which is enough of a symbolic loss for us as psychoanalysts, there is a necessary minimalism in successful couples work. We know how complicated one psyche is, and how exponentially complicated looking at our interaction with someone is. Two people? Impossible if the lens stays fully open all the time. We inevitably will overexpose our image. I think that following one reciprocal image, one theme, one surprising discovery of the other for a period of time, a number of sessions, provides a transitional space for a couple to expand their relationship. Being fully open to association and psychic meandering, the pleasure of analytic work, often leads to exhaustion, discouragement and entropy in couples therapy.

I truly see this field as open—to new movements and new compositions. In fact our analytic efforts would benefit from new couples choreographers.

References


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The Development of Couple Relationships

Our culture has steeped us in two dichotomous ideals of love and marriage. The first is the ideal of romantic love. In this fairy tale, you fall in love, marry joyously, and live happily ever after. The second is the ideal of devoted love. The couple, in this saga, also falls in love, but only as a brief interlude of madness before getting down to the real business of loving, which is to struggle side by side through years of hard work, raising children, self-sacrifice, and compromise.

A tenacious myth keeps our understanding of marriage from advancing. It could be called the myth of Athena, because Athena sprang from the head of Zeus as a fully-grown, perfectly formed goddess-fully armed as well. We view the marital relationship similarly, as springing into being, fully formed, when two people marry.

This lack of a developmental perspective can be attributed not only to the ideals of romantic and devoted love but also to early psychoanalytic theory that viewed individual development as essentially completed by late adolescence. While psychoanalytic theory is in the process of integrating the concept of adult development, society is still under the influence of the earlier version. Most conceptions of adult development focus on the individual adult’s journey through the life cycle and not on the marriage relationship as having a distinct evolution of its own.

In my recent book, The Ways We Love: A Developmental Approach to Treating Couples (Guilford, 2000), I present a formulation of how love relationships develop and a treatment approach based upon this conception for therapists working with couples. Marriages and other committed love relationships are viewed as consisting of multiple patterns of relating that develop in parallel over time in an interrelated fashion. I have identified seven central relationship patterns that appear to be universally expressed in adult love relationships in our society. The patterns promoting connection are: nurturing, merging, and idealizing. The patterns promoting separateness within the relationship are: devaluing, controlling, competing for superiority, and competing in love triangles. Each of these patterns has its developmental course, subject to certain derailments.

These patterns reflect everyone’s relational needs. We need to be nurtured and to nurture, to feel cared for, and to care for others. We need to be able to merge, at times, to feel fundamentally connected and part of a greater whole. We need to idealize our partners and to be idealized to stay attracted and to feel cherished. We need to devalue at times of serious disappointment in our partners and ourselves, so that necessary changes and greater acceptance can be integrated. Sometimes, we need to control, dominate, and oppose to feel powerful and independent. At other times, we need to compete with our partners to define and test our strengths and weaknesses. We also may need to contend with outsiders (e.g., children, parents, work) in order to preserve the priority of the bond with our partners.

However, there is also a downside to each of these patterns, a painful, potentially destructive aspect. A relatively sturdy relationship that continues to grow in spite of difficulties can usually tolerate the stress of these negative potentials. However, when one of these patterns dominates and rigidifies into a primarily defensive form, a couple relationship will become stagnant or actively destructive.

The very few previous contributions to a developmental conception conceptualize marriage as one entity that develops in a linear progression of stages, each stage involving the partners’ mastery of certain psychological and interpersonal tasks. While building on these conceptions, my conception aims to capture the greater complexity of couple relationships. Rather than a single developmental progression evolving in serial stages, I conceptualize multiple developmental lines evolving in parallel, though interrelated, ways. Additionally, in contrast to the idea of a linear progression, I’ve observed that this evolution occurs in the form of a spiral, wherein the steps are repeated, or recapitulated, at more mature levels throughout the life of the relationship.

In earlier efforts (Sharpe, 1981, 1990, 1997), I applied the stages in a child’s development of object relations described by Mahler, Pine, and Bergman (1975) to the evolution of couple relationships. This conception also incorporated the pioneering work of Henry Dicks (1963) and other object relations theorists. Working with this model for several years, I have found it to be limited in its overemphasis on a single developmental process, separation-individuation, with insufficient regard for couples’ needs for varying kinds of connection. Viewing troubled couples solely in terms of pathological syndromes also seemed to interfere with the creation of a safe, growth-promoting environment. Partners are more responsive to this approach, which emphasizes the positive, normal aspects of relationship development and incorporates a balanced view of couples’ ongoing needs both to create a deeper connection and to be separate individuals.

Take mind reading, for example. Many therapists view a couple’s wish to communicate in this fashion as a symptom of pathological symbiosis. Directly or indirectly, couples are prevailed upon to give up mind reading. Many partners then feel criticized and pressured to correct this supposed flaw or risk disappointing the therapist. Many try to give up mind reading for the therapist’s sake, but this
kind of compliance in sessions rarely advances a relationship, let alone the partners’ self-esteem. Clinical approaches of this kind reflect a singular emphasis on separation-individuation of the partners, without adequate understanding of their equal or often greater needs for attachment.

In this developmental approach, mind reading and merging are considered to be universal and normal ways couples relate. These essential features of romantic love are fundamental to feeling deeply and empathically connected. However, if such patterns continue to dominate a relationship well beyond the romantic phase, a disruption in development has likely occurred, and these patterns have become defensive. In treatment, I would initially seek to understand with a couple the wishes and fears (often unconscious) that motivate their mind reading.

Partners often reveal that mind reading and other forms of merging are felt to be necessary to keep them safely attached, rather than feeling abandoned and alone. They preserve fantasies of oneness that seem vital to feeling loved. When these needs and fears are understood and worked with to whatever depth is necessary, a couple can usually move forward developmentally and change the dysfunctional aspects of these patterns, while improving the functional aspects.

The theoretical framework just described is summarized as follows:

-  A couple relationship is a system that develops over time in a way that is distinct from, though related to, development of the individual partners.
-  A relationship consists of multiple patterns of relating that develop in an interwoven, interdependent fashion throughout the life of a relationship
-  Seven universal patterns of intimate relating have been identified: nurturing, merging, idealizing, devaluing, controlling, competing for superiority, and competing in love triangles.
-  Each pattern of relating has its origin in an individual’s early relationship development and can be viewed as an ongoing developmental theme that is reworked in different ways throughout life.
-  Each pattern expresses a distinctive facet of the partners’ needs to be connected yet separate.
-  The optimal result of the developmental progression of these patterns is the couple’s increasing ability to create a mutual relationship that also supports individual development.
-  Each pattern thus undergoes a normative developmental progression that may become derailed at any point in the couple’s life, causing temporary or long-term problems.
-  These patterns become destructive when one or more dynamics become too dominant or rigidly fixed in form, so that development halts and a functional balance is lost between the partners’ needs to be connected and to be separate.

-  Effective couple therapy focuses on understanding the protective meanings of the couple’s particular defensive patterns, as reflecting each partner’s wishes for and fears of intimacy and self-development. The general therapeutic aim is to aid the couple in restoring an optimal developmental process and balance between relationship and personal growth.

Through understanding the optimal development and common pitfalls of each relationship pattern, the therapist can more readily identify which pattern is causing difficulty for a couple and at what point in this development the partners have become derailed, either temporarily or more permanently. This assessment is then helpful in determining treatment difficulty, where and how to focus interventions, and the possibility of a certain kind of relationship forming between therapist and couple that may interfere with treatment progress.

Nurturing is a good example, since most couples who come for therapy have difficulties in this area. One of the most common complaints a couple therapist hears is, “My partner does not meet my needs.” Marital malnourishment is one of the most common problems affecting couples today. This rampant condition is in part the result of a society brainwashed by the myth of romantic love. Capacities of partners to nurture in the particular ways each one needs are not usually present at the outset of a relationship (as this myth leads us to expect); they require development. Just the therapist’s transmission of this basic understanding can reduce the partners’ feelings of failure and shame, as well as introduce the idea that meeting each others needs is not an automatic given in a relationship, has little to do with how much you love someone, but entails a rather difficult developmental journey.

When a couple’s development becomes stalled or stuck and one or more of the basic patterns become defensive, a certain kind of collusive role relationship can rigidify between the partners. Sooner or later aspects of this relationship will be transferred to the therapist and evoke certain countertransference reactions. For example, in the case of severe nurturing problems, the collusive role relationship of caretaker and needful child is commonly seen. The therapist is likely to be viewed by the partners as an all-giving mother and may be drawn into the role of rescuing savior.

If the therapist has an understanding of the kind of transference-countertransference constellations likely to be induced by a certain relationship pattern, he or she is in a much better position to utilize countertransference diagnosis, to recognize changes in the various transferences as therapy deepens, or work out of an impasse (Sharpe, 1997). Many years ago, I was trained to “solve” a couple’s prob-
lems in twelve sessions. Then, I spent the next decade trying to figure out how really to do couple therapy. Today, I hear of treatment approaches that purport to do the job in six sessions. Troubled partners who need to be in treatment longer than the few sessions specified by their HMO or therapist’s approach feel even more like failures. Likewise therapists who cannot fix a couple in six or twelve sessions begin to wonder what is wrong with their skills.

I hope to counter these unhelpful attitudes by speaking to the difficulty of both creating a good marriage and doing couple therapy. By offering an assessment process and treatment approach grounded in the complexities of relationship development and tailored to a couple’s needs, I also hope to encourage more enlightened views.

References


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Couples And Countertransference

As a psychoanalyst who is also a systems therapist, I find concepts from each orientation mutually enhancing. In particular, I believe that clinical couples move from the initial complementarity and symmetricality of their couples fit to a transference countertransference impasse. This mutual countertransference enactment between the partners describes the repeating area of conflict in the couple, a polarized couples fit.

As an integrative therapist, I also enjoy the messy moments when the countertransference is fully enacted among the triad of the couple and the therapist. At least I enjoy them once navigated. Here is an example of a messy moment: A couple could not admit the man’s anger into their discourse. Instead, they would usually focus on the woman’s own fears and disgust with loss of control. In a session we had unbalanced this dynamic openly and to good advantage. I was feeling satisfied. She then casually made an ambiguous remark about my office. He added his own critical comment. I felt quite provoked. She then told me that she had met a friend of mine but did not want to talk about it. I felt more provoked, but also relieved that it was time to end their session and dismissed them. It was, however, 15 minutes before their time should have ended. This is an example of a category of countertransference: the unconscious procedural error. After getting over the first flush of embarrassment, I find that awareness and exploration of these kinds of moments often deepens the treatment. I believe this is because my actions are part of a conversation with the couple in which they are participating fully.
to prove what we already believe.

This takes into account the psychoanalytic idea that perceptions are directed by unconscious meaning and the systems idea that context affects what is there to be perceived. The context both supplies and brings into the foreground those realities most easily interpreted according to preferred worldviews. The idea that the therapist must be directive at times as well as exploratory has to do with creating an environment of safety in the therapy, especially between the couple. It is important to control and reduce destructive interaction. As long as the integrative therapist does not adhere dogmatically to a single posture with all patients, then how and why one is directive or exploratory with a particular couple sheds light on that therapy.

From an integrative perspective then, one can be directive and also use transference and countertransference phenomena in couple therapies. Here is one way I find the concept of countertransference useful for organizing the couple's data. To begin with, I am committed to the idea that transference and countertransference phenomena occur continuously in couples as a framework for interaction. This means that they usually take in information in ways that confirm what they anticipate. To the degree, however, that they are not in a state of psychic emergency, they have some room for the introduction of novelty. The interplay, however, between consciousness and unconsciousness or participation and observation may become too unbalanced. In this event, the plot stalls, and the actions become redundant. This stalled plot is the central dynamic in the clinical couple: a mutual countertransference enactment or polarized couple's fit.

When I hear about one partner's complaint about the other, I know that it is telling about the speaker, the partner and the couple's fit. The systemic idea of couple's fit emphasizes that we pick partners who will have their own personal reasons to send the particular cues we want to select, covertly sharing our fears while overtly resolving them differently. We do not marry our parents, but we do marry people who we think can solve the problems our parents posed. They can because they are enough unlike, and yet also overlap with our parents. They, as the clinical couple soon discovers, share each other's fears. The more unresolved those fears are, the more the interaction narrows to that overlap. They cannot solve the problem; they have become the problem.

What I mean by the couples fit is the similarity of the partner's fears and the complementarity of the styles of coping with those fears. I have found that clinical couples are often drawn to each other initially not only by sexual chemistry, and an identity of certain demographics and values, but because they unconsciously recognize in each other a shared fear, that is personal knowledge of a conflict shared by both. By this fear I mean the difficulty of integrating issues of psychological life, such as balancing selfishness and selflessness, or conformity and rebellion, or even reason and madness. I think of this as Birds of a Feather Flocking Together.

I also see in these same clinical couples that they have been drawn to the other because of the other's seeming comfort with an opposite style of resolving that dilemma, though both have the same problem of integrating those polarities. As a member of the couple, each knows that he or she developed that fear in his or her own family of origin and tried to resolve it in that context. That resolution, however, is constricted and anxiety driven in reaction to certain rules in that family. As a result, each partner has a narrowed psychological life and retains the fear. When they meet they are entranced and hope to be cured by the other because of the other's apparent ease with their contrasting resolution. I think of this as Opposites Attract.

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I believe that what has happened by the time they show up in your consulting room is that each one has discovered that the other’s resolution is as anxiety-driven as his or her own. After the disappointment that they have lost the idealized other, each grows more insistent on his or her own original resolution, and they become polarized over core conflicts, like giving and taking or responsibility and being carefree. They now disavow their similarity. Each remains fearful of the other’s solution and becomes overtly disdainful as well. The other cannot teach them because the other is a lousy advertisement for his or her half of the continuum - anxiety filled and constrained. To be taught by the other would be to have the same fear with a different conflicted solution. A process that we all recognize accompanies this painful disillusionment that is, what initially attracted them to each other becomes the essence of their complaints. They now select only those cues which confirm their worst fears about themselves and what their options are - a collusion of shared fears with neither able to be persuasive of a resolution.

There is often a moment in a couple’s therapy when it is right to say, “Yes, you need to be more of what (your partner) seems to be, but not the way he (or she) does it, that’s not good for either of you.” The original polarities have to be redefined back to their non-polarized form, a form integrated with its opposite. Irresponsibility, for example, has to become (responsible) fun, not the overresponsible seriousness of a polarized partner. Each partner needs to become, not what the other’s role in the couple has been, and what they seem to be shouting at each other to be, but what is whispered under the shout, that third alternative each has been afraid of him or herself. Reavowing the similarity of conflict reduces the accusations and permits both levels to be heard, and, therefore, a wider range of cues to be seen. The impasse resolves and moves back to the ordinary countertransference-countertransference framework. This view then, of the clinical couple’s fit as a polarized transference countertransference enactment is a way that the concept organizes the data for me when the couples open the treatment with their first descriptions of the complaints. I very quickly can ask them to think with me about what each longs for from the other, forbids to him or herself and needs to be redefined for both.

Further uses of countertransference emerge from how it is especially generated in the couple’s context. Here are some ways. I believe that transference and countertransference may be interpreted in their traditional individual sense as occurring between the patient and the therapist. My caveat for couple therapy, however, is that their occurrence in the presence of the partner is such an influential forge that even erotic countertransference to a particular partner may have a triadic source and meaning.

I also think that transference and countertransference events may have their source in the couple allied as a unit so that their communication to the therapist may be taken as a single message. Although couples may have complementary styles, the pronounced similarities in their fundamental fears may join them solidly in their effort to communicate those fears to the therapist.

Lastly, my countertransference may seem to be, at times, with each member in turn. It can be useful then to tactfully discuss the experience so that the partners have the opportunity to find the analog within their couple. Finding and spelling out the couple’s own analogous version of the countertransference enactment with me makes the episode more meaningful for them.

In the couple described at the beginning of this article, these principles played out as follows: the message from the couple as a unit was that they wanted to be sure this was not a case of the blind leading the blind. Would I be willing to do what I was supporting them in doing? That is, would I admit anger into their discourse? They also wanted to be reassured that I was not so pleased with the work that I would consider it finished. In addition, they wanted to know that I understood the seriousness of the issue, before they could, as a couple, sustain the change. We discussed my error. They were very interested in the idea that I could be angry, and though I had been punitive by dismissing them early, I did not want to reinforce the idea that the man’s anger was punishable, and I did not want to collude with their fears of loss of control. This discussion seemed to increase their ability to find their systems analog: when the woman focused on him, he became disqualifying and angry and she in turn became punitive and withholding, as she had done with me. She realized she had helped him avoid integrating his anger by maintaining its status as inadmissible in the relationship. She now saw that her position was maintained at high cost to both of them in that they both lost the chance to accept their own passions. Working with my countertransference experience ultimately allowed the partners themselves to admit into the therapy more curiosity and play with unconscious communication. While these moments certainly are humble, their discussion works to everyone’s therapeutic advantage.

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Construction, Destruction, and the Deconstruction of Dreaming

Consider the soup of the universe. Imagine individual human minds coming to make sense of all that is relevant to their lives. Ponder the task of de-constructing the mental formations and operations we have each employed to construct our phenomenal worlds. Contemplate attempting to retrace our psychic paths far back into their ontogenetic and phylogenetic origins. Envisage disassembling, taking apart, analyzing the infinite mysteries and constructions of psyche. Occasionally comes a book daring enough to encompass such complexity and expansiveness—Freud’s *The Interpretation of Dreams* (1900), Bion’s *Transformations* (1965), Lacan’s *Écrits* (1977)—and now Grotstein’s *Who is the Dreamer Who Dreams the Dream?*

A supersaturated text, Grotstein’s Magnus Opus represents the work of a lifetime linking the diverse psychoanalytic heritages of Freud, Klein, Bion, Lacan, Jung, Kohut and many others. The text integrates traditional as well as original psychoanalytic formulations with knowledge gleaned from the physical sciences, the social sciences, developmental psychology, neuropsychological research, philosophy, and mathematics. Those who have long thought psychoanalysis to be nothing but a conglomeration of ghosts and presences will find in this volume ample confirmation of their biases. However, those who, following Freud, seek after the ever-elusive mysteries of psyche will find the book mind-boggling and provocative. It weaves together Grotstein’s numerous themes that we have been following for decades into a massive and spellbinding tapestry. Those who practice psychoanalysis daily will find themselves, as Thomas Ogden suggests in the forward, on a tour de force, not unlike that undertaken by Dante through the ghostly presences of *The Inferno.* I can only hint at a few of the rich threads that have caught my own imagination.

The Labyrinth and the Arena of Dreams

We have the Labyrinth, ancient representation in many forms of the home or prison house of our unconscious shadow, personified by the Greeks into the half-man, half-beast Minotaur. His sister, Ariadne, alone possesses the thread, the means of connection, that allows Theseus to challenge and triumph over the beast who demands ongoing human sacrifice. Grotstein establishes a developmental line of courage through which we haltingly and alternatingly meet and fail life’s challenges, each of us experiencing triumph and glory, defeat and shame, challenge and nemesis in our endeavors to construct phenomenal worlds that serve our senses and our sensibilities. Through the ineffable worlds of our day and night dreams and our dreaming processes we passionately pursue Ariadne’s delicate thread winding our way through the interminable challenges of the Labyrinth of our unconscious in search of an ongoing sense of aliveness, well-being, wholeness, and safety. Asks Grotstein, how do our phenomenal constructions arise out of the infinite and the ineffable? Who is the dreamer who threads through these dreams?
Dreams are dramatic narrations written, directed, and produced by a composite dreamer who is unknown to us, who employs narrative as the instrument of phantasy and myth and uses neurophysiological perception-namely, visualization-to organize the chaotic, fragmented accretions of mental pain left over as residues of yet one more day of existence. What we commonly call a dream is the visual transformation of a never-ending pageant of events in the internal world...we never stop dreaming. There is a dream audience who anticipates the dream and requisitions it from the dream producer in order to recognize its own problems and resonate with its own hostaged self...which is forged in the smithy of dream work by the Dreamer Who Dreams the Dream...In the rhythmic concordance between the dream actor and the dream audience, the preliminary certification of one’s emerging authenticity occurs preparatory to a real certification through experience in the real world. The Dreamer Who Understands the Dream is the audience that verifies the passion of the dreamer...it is also the barrier that contains the dream...the background that compels the foreground hypothesis to remain in the foreground until it has become sufficiently defined, at which time authentication, correlation, and self-publication are established... (pp 10-12)

Grotstein formulates that within this ongoing dream arena each human hypothesis, attempt, and endeavor to make sense of the truth of the universal soup (Bion’s “O”, 1970) is measured between the ever-eliding I who produces and acts the dreaming, and the audience I who requisitions and certifies the dream hypothesis—that momentary thin thread of resonating meaning and truth. Each sensation (Bion’s beta elements) leads toward dream hypotheses that build on the ones that have gone before (including preconceptions) through an endless series of externally derived containing (alpha) functions-metonymy, synecdoche, metaphor, and metathesis (condensation and displacement) towards yet higher processes of thought (Bion’s Grid, 1977). Against this imaginary backdrop of a passion play in the Labyrinth of the unconscious that can only originate in and evolve through transformations deriving out of Bion’s universal, ineffable O, Grotstein considers numerous historical, theoretical, and clinical issues brought forward through more than a century of psychoanalytic study. I will pick up on two of Grotstein’s themes that have become particularly important in the current trend toward “relational psychoanalysis,” (1) the destruction of the internalized other giving rise to subjectivity and (2) the construction of a diversity of analytic thirds.

The Destruction of the Internalized Other Giving Rise to Subjectivity

Donald Winnicott, pediatrician-psychoanalyst, formulates that babies from conception are caught up in endless relating to others in an almost knee-jerk fashion which proceeds through a series of developmental progressions (1969). Grotstein describes the experiences of fear and pain in early childhood that gradually build up internalized (learned patterns of) persecutory expectation that determine the child’s ongoing organization of perception. At some point the child develops willfulness and starts using others for her or his own purposes—in the words of Heinz Kohut, for confirmation of the sense of self (1971). The child aims its aggressive destruction at these subjectively formed controlling internal persecutory others—images that are projectively superimposed upon real others—in an effort to destroy them as perceived obstacles to its aims and pursuits. After the child’s destructive energy toward the persecutory others is spent and the internal persecutors destroyed there remains (hopefully) a loving, supporting, attuned, patient, and containing real other relatively untainted by persecutory projections. Relational psychoanalysts (such as Jessica Benjamin, 1995) celebrate this moment of survival of the real other as the emergence of full awareness of the subjectivity of the self and of the other. Co-creation and enactment of this emotional moment within the transference-countertransference matrix of psychoanalysis allows the analyst to be experienced with her/his own subjectivity and for the analysand to recuperate her/his lost subjectivity. Grotstein expands our understanding of this process by distinguishing between natural enemies, internal persecutors, and the ultimate enemy-infantile states of trauma during which the child was overwhelmed by experiences with O that could not be adequately processed at the time.

Our fears of our own destructive feelings [projected and then re-introjected] lead to confusion between the persecutor and the true enemy that threatens us and our loved ones. The Minotaur is our persecutor, that is, we have created it through projective identification; it is ourselves. The true enemy...is in the Real...Bion’s O...One’s rendezvous with the metaphoric labyrinth [of the unconscious] and the Minotaur (objects of challenge or nemesis) requires differentiating between the infantile neurosis and the infantile/childhood traumatic state (infantile catastrophe), differentiating between [persecutor and enemy]. (p. 207)

We may properly fear the other as our natural, pro tempore enemy, but we feel persecuted by how we believe we have unconsciously altered the other with...
our projective attributions. (p. 158)

**The Construction of a Diversity of Analytic Thirds**

At the center of the contemporary relational movement within psychoanalysis is the study of a third relational force, vector, entity, or space variously considered and designated by different writers. Ogden’s (1994) well defined Analytic Third Subject of Analysis stands as an unconsciously co-created, reified, and personified third subject of the analysis that actively informs both participating subjects of the state of their unconscious relatedness, especially through the medium of the analyst’s states of reverie. The following brief quotes illustrate Grotstein’s multiple formulation approach highlighting a variety of different and interesting ways of considering thirdness that resist reification and personification.

“Winnicott placed the subjectively created, illusional object in potential space, apart from the real object, while Klein would see a perceptual and conceptual confusion between what the infant or toddler creates and the real object….Ogden (1994b) retains Winnicott’s (1967) concept of potential space and there locates a bivalent subjective object, that of ‘the analytic third’….During the course of analysis it is experienced as a ‘subjugating subjectivity,’ Ogden’s innovative way of designating what may also be called ‘the transference-countertransference neurosis’ (Grotstein, 1994b, 1995a)” (p. 163).

“Internal objects…constitute psychical presence, a third force within the psyche (third in regard to the subject and the external object as the first two). Since they result from splitting, projective identification and introjective identification…internal objects must be thought of as third internal entities, paralleling another thirdness, Ogden’s (1994b, 1997) “intersubjective third” [which] owes its provenance to the analysand’s own subjugating (demanding) id and superego, in addition to those of the analyst” (p. 160).

“The concept of third form comes from the Kleinian notion of the “internal object” and its phantasmal creation via splitting and projective identification….which thereupon is transformed in the infant’s mind-as a third form” (p. 171).

“Insofar as [the subjugating third] is operant as a manipulating or controlling (even if analytically informative) force, I believe that this third subject is the equivalent of what Mason (1994) terms folie à deux or...
comprises a ‘subjugating thirdness’ whose omnipotent power of subjugating His worshipers arises from the projective identification of their ego ideals ‘unto Him’…(p. 277).

The flaw of Grotstein’s rich text (if it is ever correct to speak of extravagant scholarship as a flaw) is its seeming over-inclusiveness which gives the book a sense of over-complexity—when, in fact, the author’s ideas, when considered slowly and carefully are clearly stated, well documented, and highly evocative.

References

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mutual projective identification (mutual hypnosis) and what Girard (1972) terms mimesis” (p.137).

“By psychoanalytic object I understand Bion to mean the unconscious theme that the analysand maximally presents for understanding and interpretation…. That is, the analytic object becomes the ongoing theme which the “subjugating third subject”…presents to both analysand and analyst for them to play out, to understand, and to interpret” (p. 114-115).

“I myself regard the subjugating subjective third subject as a twinship of subjectivities in which that of the analysand normally predominates over the subjectivity of the analyst so that the former can direct the analytic play, as it were…” (p. 108).

A designation other than subjugating third is required, in my opinion, to encompass Bion’s (1970) concept of reverie and transformations, or evolutions, in O. What Bion’s concept refers to is not situated in the mutual force field created by the subjugating third; instead, it approximates the idea of “meditative surrender” (pp 137-138).

“[T]he infantile neurosis of the infant paradoxically exists both separately and inextricably bound to that of each of his parents. The mysterious third subject…is who the infant is supposed to be, from the infant’s and the parents’ perspectives. Thus, the infant, because of developmentally progressive object-usage phantasies, experiences guilt toward the maternal, then paternal, then combined parental superego. Each of the parents, as well as the parents together as a parental group also experiences guilt toward the child, who was given them in “trusteeship.” The Oedipus complex is a complex of guilt and sacrifice involving each member and subgroup of the oedipal family intersubjectively. At issue is how best to conceive and treat patients who have been seriously victimized” (pp 262-263).

“Child abuse implicates the psychology of the abusive family and culture….Numerous researchers have dealt with the apparent transmission of psychopathology from one generation to the other….One aspect of this transmission leads to the concept of the ‘Pietà covenant’ as a covenant of ‘thirdness’….The contributing subjects seek to protect and, unconsciously, abuse or be abused or controlled by this third subject” (p. 263-264).

“We can perhaps conceive that the covenant binding man to God (what Christians call the Holy Ghost)
Psychoanalysis is in crisis, assailed by many opponents, but one of its problems—specifically, the lack of empirical validation for its theories—is of its own making. Thus, empirical research constitutes a minuscule proportion of the thousands of pages that appear in psychoanalytic journals each year, but here is a more personal case in point: Not too long ago, I had the opportunity to participate in a day-long conference on what is mutative in psychoanalysis, and although the conference was fascinating in many respects, only one of the 12 people who spoke that day mentioned that the question being debated was an empirical one, requiring studies of actual psychoanalytic sessions and session transcripts. That speaker was I, and for my trouble, I was told by several of my fellow panelists that empirical research was irrelevant to psychoanalysis and even a perversion of it. Perhaps it was my recognition that perversion is a subject near and dear to the heart of psychoanalysis that kept me from taking offense. Nevertheless, such anti-empirical attitudes are shortsighted in an age in which psychoanalysis must compete with cognitive-behavioral and medication treatments that purport to do what psychoanalysis can do, just quicker, cheaper, and more effectively, and that are supported by a burgeoning literature of published results. But more important, in my view, is that if we want to know what makes psychoanalysis and psychoanalytic therapies work, then we will have to study actual psychoanalytic sessions, not highly subjective case reports, and this is where Enrico Jones comes in.

Jones, like a handful of other investigators (e.g., Hartvig Dahl, Lester Luborsky, Hans Strupp, Wilma Bucci, Joseph Weiss, Harold Sampson, Donald Spence, among others), has devoted himself to the empirical study of the psychoanalytic process. His book, *Therapeutic Action: A Guide to Psychoanalytic Therapy*, is one of the fruits of this labor and is his attempt to render his research efforts accessible to the working psychoanalytic clinician. To a great extent, he succeeds in this aim. Jones conceptualizes the psychoanalytic process as involving what he terms interaction structures: “Repeated, mutually influencing interactions between analyst and patient that are a fundamental aspect of therapeutic action” (p. xv). He further proposes that this construct unites insight and relationship as therapeutic factors in psychoanalysis because insight “can develop only in the context of a relationship where the therapist endeavors to understand the mind of the patient through the medium of their interaction” (p. xvi). In short, Jones argues that insight (or interpretation) and relationship cannot be viewed apart from each other. This is not a new idea, and it is one with which I am in substantial agreement, but the best part of Jones’s book is that he supplies evidence to support his views. Mostly, this evidence is in the form of extensive quotations from session transcripts—transcripts that reveal how interaction structures unfold, how therapists get caught up in them, often despite their best efforts at, for lack of a better term, neutrality, and how therapists might interpret and modify them. The extensive quotations from therapy sessions serve at least four purposes. First, they engage us, as readers, in the clinical material in a way that makes us forget that we are actually reading about the findings of a research program. Second, they present what actually happens in those sessions, not what therapists, via highly processed case reports, say happened. Third, they enable readers to draw their own inferences about the meanings of the interactions that are reported, rather than just accepting the clinician’s (or Jones’s) opinion. And fourth, they teach us as clinicians a great deal about how we might interact with our patients in more therapeutic ways.

Thus, it is the session transcripts that are the heart of this book—what make it useful in a way that most books about psychotherapy are not—but Jones also has quantitative data in support of his views. These data are in the form of Q-set ratings of therapy sessions, ratings that permit a systematic and empirically valid exploration of those sessions. Arguing that the clinical case study is still central
to the psychoanalytic enterprise, Jones thus presents a way in which the single case can be used in a scientifically adequate way. Briefly, Jones’s Psychotherapy Process Q-set comprises 100 items describing patient behavior, therapist behavior, and the nature of therapist-patient interaction. Clinical judges apply these 100 items to session transcripts by sorting them into nine categories, ranging from least characteristic (1) to most characteristic (9), with a neutral category (5) in the middle. The number of items in each category (5 items at each of the extremes, 18 items in the middle) conforms to a normal distribution. For a given psychotherapy, Jones and colleagues subject these session-by-session ratings to factor analysis and then use time-series analysis to identify causal relationships among the identified factors over the course of treatment.

To illustrate this methodology, Jones presents three case studies. In the first, a successful treatment, Jones presents data showing how a specific maladaptive interaction structure, one in which the patient provoked rescue from the therapist, decreased over the course of a therapy and was unable to gain enough emotional distance from it to interpret it in a way that the patient could use. Finally, in the third case, Jones presents data showing how an interaction structure—specifically, a supportive, positive therapist-patient relationship—can result in a reduction in manifest symptoms over the course of treatment. Here, a neutral, exploratory stance on the part of the therapist led to increased patient dysphoria, but the patient’s symptoms decreased when the therapist took a more active stance in challenging her self-criticism. In reading these case studies, I found myself wishing that Jones had presented more of the results of his time-series analyses because it is this statistical technique that he is using to establish the causal relationships he describes. My belief is also that psychoanalysis is a science and that attempts at the psychoanalytic study of psychoanalysis should not be watered down, but it is certainly understandable that the author preferred not to burden his readers with statistical procedures they were likely to find intimidating and difficult to comprehend. Fortunately, Jones presents enough references to his own empirical work that more conscientious readers can track down the actual details of the research if they so desire.

As for those details, I very much admire the combination of empirical and clinical sophistication that can be found in Jones’s work, but I also find myself with many questions about it. For example, I wonder whether ratings of individual sessions taken as a whole unit, rather than ratings of smaller time units within a given session, really captures the nature of the therapist-patient interaction. Jones’s data would say that this is so, but it seems to me nonetheless that much of the clinical richness that other therapy process researchers grasp through the use of smaller units of analysis is lost through the focus on the individual session. Also, I found somewhat problematic Jones’s methodology for arriving at consensus case formulations insofar as it relies heavily, albeit not exclusively, on traditional psychoanalytic categories (i.e., conflictedness, defense-impulse configurations, historical antecedents, wishes, and transference) but does not assess dimensions like level of object relations or capacity for intersubjectivity that are stressed in more recent approaches to psychoanalytic diagnosis and that would be more congruent with the interaction-structure concept (e.g., Auerbach & Blatt, in press; Blatt, Auerbach, & Levy, 1997; Blatt & Lerner, 1983; Diamond, Kaslow,
Coonerty, & Blatt, 1990; Fonagy et al., 1996).

In addition, perhaps because of my own intersubjective and relational leanings, I had many questions as well about Jones’s discussions of the relative roles of past memory and present interaction in the treatment process and of the nature of timeworn and increasingly problematic clinical concepts like neutrality, abstinence, and anonymity. Space precludes an extensive discussion of these issues in this context, except perhaps to speculate that Jones may be uncomfortable with the ways in which his interaction-structure concept, with its emphasis on the bidirectionality of therapist-patient interaction, undercuts the idea that therapist can maintain a neutral stance, at least as this concept is traditionally understood (see Aron, 1996). I would also note that I agree with Jones’s argument that a therapist has much better access to present interaction structures than to patients’ reports of past events, and yet recent research indicates that a child’s attachment style is highly predictable from the attachment styles of his or her parents (van Ijzendoorn, 1995). Thus, the factual validity of patient memories may not be easily ascertainable, but there is now considerable research evidence suggesting that attachment style, something very much like Jones’s interaction-structure concept, has real, rather than fantasy, developmental roots.

But these are relatively minor criticisms of Jones’s work, and besides his discussion of these issues is balanced and fair. Furthermore, his concept of interaction structures does much to obviate the increasingly sterile debate on interpretative versus relational factors in producing therapeutic change, and his highly sophisticated research does much to show how interpretive and relational factors actually interact with each other in the clinical situation. Finally, his many clinical examples, drawn from actual patient-therapist interactions, do much not only to bring alive the interaction-structure concept but also to teach us how to be better therapists. For all of these reasons, I must give this book a most enthusiastic recommendation, perhaps especially to those who believe that psychoanalysis cannot be studied scientifically or has no need of empirical support.

References


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Betrayed as Boys by Richard Gartner, is at once an important and disturbing book that should be read, not just by psychoanalysts, but any therapist working in the mental health disciplines today. It has been written for the therapist encountering patients with histories of sexual abuse, whether trained in psychoanalysis or not. I intentionally have not qualified those patients as male or female because, though the book is ostensibly about the treatment of male patients, many of the discussions could be useful to the treatment of females and additionally, the careful comparisons that Gartner offers between treating males and females are rare to find and very helpful. And what is more important, Gartner does not fall into the trap of the binary by drawing irreversible conclusions regarding similarities or differences between males and females. Rather, he offers a comprehensive review of clinical and empirical data that have been developed over years by many researchers and clinicians which suggest many factors that influence the differences between males and females as patients as well as how they are perceived as therapists. His conclusions regarding these differences generally offer the reader a range of considerations one might take into account in coming to clinical decisions while treating patients who have been “betrayed,” a term which Gartner favors over the more common general usage of the term, abused, though he means to signify the same experience that that term connotes in general.

One of the first and subsequently most pervasive themes that Gartner picks up in his discussion is the “denial of sexual betrayal.” As a telling example he offers a tale of being invited to an international conference to present a paper about the treatment of men who have been sexually abused. The sequence of events whereby, first, his paper which had been accepted for presentation, is left off of the program and later, when arriving at the conference he is placed on a panel at the last minute where the moderator proceeds to leave him little time to present, provides a striking example of the kind of, often unconscious yet embarrassing, denial and avoidance of the issue of sexual abuse which is often accomplished with more subletly than in the example, but nevertheless, is still too common in the mental health professions. Throughout the book, Gartner refers to examples whereby patients he has seen in consultation and often subsequent treatment are met with varying degrees of avoidance and denial of their betrayal in responses from therapists they have either consulted and/or been in treatment with. His point is not to attack the mental health profession so much as to sound a wake up call and offer a large amount of information that can help a mental health professional to confront her own feelings and experiences regarding betrayal and confront the tendencies to avoid and/or deny, first, the occurrence of, and secondly, the severe sequelaes resulting from sexual betrayal. While such a reaction is understandable and probably part of a sense of compassion for such human suffering, particularly, as it is experienced by a child, nevertheless, Gartner is clearly calling for those of us treating patients to work hard or harder in some cases, at being attentive to the signs of sexual betrayal as they emerge in the treatment process, and to develop a repertoire of understanding and skills for responding therapeutically to such clinical challenges.

For me, the most compelling chapters in the book were chapters nine and ten in which the author addresses the vicissitudes of therapeutic relationship with sexually abused men. Again, though writing for an audience larger than just the psychoanalytic community, in these chapters Gartner leads with his interpersonal psychoanalytic lens, which he explains earlier in the book he will be bringing to bear upon many of the issues for its significant usefulness in helping the clinician to understand the relational dimensions of therapeutic treatment. Here, Gartner gets help from Sue Shapiro, another analyst with expert experience and understanding in this area, who co-authors chapter ten dealing with gender and the therapeutic relationship. There, as in the previous chapter, both authors explicate and give ample clinical illustration to the panoply of countertransference experiences which can contribute to
and complicate treatment impasses and enactments. The clinical illustrations are particularly useful as they offer examples of how these gifted clinicians have been able to use countertransference experience in the form of fantasy, feelings, and or intellectual formulations to effectively catalyze awareness in both analyst and patient of such impasses and enactments. Furthermore, in the examples given, the reader is able to see how such use of countertransference experience can help the therapeutic dyad to move through difficult moments and sequences with an awareness that can expand a sense of self-agency and responsiveness from another. Sense of self-agency and the ability to sense a safe and supportive responsiveness from the other become central catalytic foci in so many of the clinical examples offered. And yet, at the same time, the authors frankly discuss and illustrate how difficult it is to achieve such mutative moments and give many examples of how even the best technical responses (at least from an outsider’s perspective) only fuel a powerful transferential pattern of repeating roles and patterns of abuser and abused. And, furthermore, for those who have not learned about this tricky aspect of such treatments (Gartner aptly credits Davies and Frawley (1994) for helping to bring this aspect of treatment into focus for the psychoanalytic community), Gartner’s descriptions are significantly valuable.

Clearly, offering an understanding of the uniqueness of the male patient who has been betrayed is a key objective of the book. Chapters five and six are in many ways the most disturbing and difficult to get through because they provide such detailed and clinically compelling descriptions of the kinds of familial and interpersonal contexts in which sexual betrayal occurs. And most disturbing are Gartner’s descriptions of how these contexts can influence a boy’s responses to sexual abuse. I have to admit that even with the experience I have had in treating patients who report childhood sexual betrayal (or maybe because of it), I found myself in sometimes conscious, and sometimes, unconscious avoidance of reading these chapters as I prepared to write this review. Nevertheless, the range of patients that Gartner’s experience allows him to draw from in painting the scenarios within which sexual betrayal can emerge, are formidable and of invaluable use to any clinician wishing to increase her understanding and grasp of such sequelae, short of the actual experience of conducting such a treatment and hearing these kinds of narratives first hand. Again, Gartner is careful to provide the reader with ample detail from the range of specific cases he has treated and at the same time, point out that while generalizations might be deduced from these illustrations, the uniqueness of the array of contextual factors that shape each particular case are quite idiosyncratic to each treatment, and future patients presenting might offer similar but also quite different narratives.

Chapters five and six are preceded by three chapters within which Gartner offers a range of empirically and clinically based observations for “how boys are likely to encode premature sexual situations with women as well as with men, and how these processes interact with internalized ideas about masculinity and homosexuality” (Gartner, 1999, p. 8). These opening descriptions lay the groundwork for the following sections of the book to which I have alluded earlier. They also hang in the background of the subsequent chapters as the ground against which the kinds of confusion and ambivalence that characterizes the internal
world of so many men betrayed sexually, ultimately brings them to treatment. In particular, issues of masculinity and homosexuality are often sources of confusion for many males because of the tension between normative narratives, social expectations and personal experience. Gartner gives numerous examples of how such confusion and ambivalence lead to a spiral of toxic self-doubt and self-denigration when colored by early childhood sexual betrayal. Further, he shows how such confusion and ambivalence pervades the internal worlds of patients in treatment, another collection of insightful gems for the clinician desiring to better understand this process, and particularly how this kind of affective patterning might emerge within the relational matrix of treatment.

Additionally, in chapter eight these themes are revisited with particular emphasis on how they contribute to the very knotty issues in treatment of boundary violations and dissociation. Building on the contributions of such analysts as Bromberg (1998), Gabbard (1989), and Price (1994), Gartner offers the clinician/reader a complex but clear and useful understanding of the etiologies and twisting paths of boundary violations and dissociative experiences as these serve both protective and destructive purposes, first in the psychic survival of the victim of betrayal, and later in the unfolding process of treatment in which both therapist and patient struggle with the confusion and ambivalent feelings that such patterns suggest about internal experience and meanings for emotional growth or constrictedness.

In effect, this review only skims the surface of what is to be harvested for any reader desiring to know more about these issues and how to harness such knowledge and skill in the treatment process. As such, I am suggesting, here, that one of the best antidotes to begin to offset the kinds of feelings of denial and avoidance which are discussed in the beginning of the book, is to buy the book and read it carefully and slowly, allowing oneself to be moved to the powerful emotional responses that taking on such treatment challenges inevitably entails, in both private reflection and the terrifying enactments of dyadic interaction, avoidance of which only can mute the voices that need to be heard if treatment is to be helpful.

With this book, Gartner establishes himself as one of the loudest, most needed and informed voices within our psychoanalytic community helping us all to learn more about, and develop the personal sensitivity and professional knowledge and skill, to be helpful to male patients betrayed as boys who are more and more approaching our consulting rooms with the hope of getting competent professional help. I thank Dr. Gartner for this, clearly, painstaking and monumental contribution.

References

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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
This is a reissue of an influential 1987 volume that explored the theoretical and therapeutic implications of the authors’ intersubjective approach to psychoanalytic theory and practice. The perspective provided by the years between the book’s original publication and its reissue offers an opportunity to reflect on the place of these authors’ intersubjective approach in the larger context of psychoanalysis today and on the ways in which their approach parallels certain other trends in psychoanalytic thought and the ways in which it is distinctive. In the time since this book was originally published, psychoanalysis has moved very substantially in two (largely overlapping but somewhat distinguishable) directions – toward a two-person model and toward a relational model. Both of these conceptual tendencies – by now very much in the mainstream, and perhaps even the majority viewpoint among American psychologist-psychoanalysts – were still emerging as influential viewpoints at the time this book was first published. Moreover, since the book from the first was essentially a reprinting (with some reworking) of papers that were written even earlier, these two tendencies were even further from full development and acceptance when the ideas of this book’s authors were first being introduced. It is thus easy to underestimate how much in the vanguard many of the book’s ideas were at the time they were written because in certain ways the field has now caught up to them. The intersubjective approach is very clearly both a two-person approach and a relational approach, though its way of embodying each has distinctive features that set it apart from its theoretical cousins.

The clearest and most explicit starting point for the authors’ psychoanalytic approach – the source from which they derived inspiration and, by way of contrast, against which they sharpened and refined their ideas – was the work of Kohut. His debt to him is made very explicit throughout the volume. In contrast, Sullivan is referred to only once in the book, and then primarily to distinguish their approach from his – contrasting their emphasis on the need for the therapist to be cautious about assuming she knows what is “really” true and what is a “distortion” with the quite different epistemology that characterized Sullivan’s conceptualization of parataxic distortion. To be sure, Sullivan’s much more “objectivist” epistemology, his emphasis on the psychiatrist as “expert,” his endorsement of operationism, all do contrast sharply with Stolorow et. al.’s, epistemological stance, and, from this reviewer’s perspective, their critique of Sullivan’s views in this regard is a useful contribution. But it is difficult to imagine the authors having achieved their impressively thoroughgoing two-person stance without having had Sullivan’s prior work to build on. Sullivan’s insights into the problems associated with assuming we can see “the patient” without taking into account the continuous role of our own participation in what we are seeing were an almost inescapable influence on all analysts open to exploration of these issues, especially in America.

The greatest strength of the intersubjective approach lies in its attention to the subtleties of ongoing interpersonal influence – its acute appreciation of the impossibility of “neutrality” – combined with a deep respect for the patient and the patient’s experience. This respect is manifested in the many ways that the authors alert the analyst reader to the danger of dismissiveness that is so troublingly woven into the fabric of analytic discourse. This dismissiveness, Stolorow et. al., point out, is evident not only when the patient is viewed as “distorting,” but even when the analyst acknowledges the role of her “actual” behavior but does so in a way that reserves to her the warrant for deciding what her actual behavior was and its relevance to shaping the patient’s transferential response.

A similarly respectful spirit is manifested in their discussion of analysts’ failures of understanding that can lead to viewing the patient as “an intrinsically difficult, recalcitrant person.” (p. 3). In contrast, they offer a perspective in which emphasis is on empathically grasping why the world does look to the patient as it does, why the patient’s perspective, however problematic for the patient in leading his or her life, makes sense if one genuinely understands the person’s experience. This is a viewpoint on patients’ experiences that, as they note, can be at odds with certain longstanding traditions in psychoanalytic discourse. But it is at the same time one that has emerged, more or less independently, from a number of different lines of psychoanalytic theory development. The tie the authors understandably emphasize is to Kohut’s (1959) efforts to establish psychoanalysis on an epistemological ground of empathy. But parallels and consonances are also evident between their work and Gill’s (1984) emphasis on understanding what is valid in the patient’s transference response and on transcending the idea of the transference as a “distortion,” and interesting parallels may be seen as well to the work of other writers who have addressed the potential for pathologizing in psychoanalytic formulations and have
emphasized the clinical value of a more respectful and validating perspective on the patient’s experience (e.g., Wachtel, 1993; Weiss & Sampson, 1986; Wile, 1984).

A central contribution of the authors’ approach is their insightful dissection of the false dichotomies that characterize not only psychoanalytic formulations but Western psychological thinking more generally. In addressing, for example, the frequent debates in psychoanalysis about the role of insight versus that of new relational experience in the psychoanalytic process and in the process of cure, they suggest that this debate reflects the chronic tendency in Western culture to fragment the psyche into separate affective and cognitive domains, and they argue that “insight through interpretation, affective bonding through empathic attunement, and the facilitation of psychological integration are indissoluble facets of a unitary developmental process that we call psychoanalysis” (p. 101). To this they add, insightfully and usefully, that,

The therapeutic impact of the analyst’s accurate interpretations lies not only in the insights they convey, but also in the extent to which they demonstrate the analyst’s attunement to the patient’s emotional states and developmental needs. The analyst’s interpretations are not disembodied transmissions of insight about the analytic relationship. They are an inherent, inseparable component of that very bond, and their therapeutic action derives from the intersubjective matrix in which they crystallize. (p. 101, italics in original)

Yet ironically, and perhaps inevitably, the authors at times themselves manifest the very dichotomizing they elsewhere are so perceptive in challenging. Perhaps most significant for the psychoanalytic reader is their insistence that the very definition of psychoanalysis should include a restrictive limitation that dichotomously separates psychoanalysis from all the rest of the social and behavioral science disciplines. Theirs is a framework that acknowledges the legitimacy of asking -- how biological variables influence our subjectivity. If puberty and Prozac are declared to be outside the realm of psychoanalysis, then psychoanalysis itself becomes diminished. It is as if physicists were to declare either a wave view of light and matter or a particle view to be “pure physics” and to declare an interest in the other perspective as perhaps interesting but just not physics. It is in the very effort to hold and address the tension between these seemingly incompatible or disparate frames of reference that the stimulus for new knowledge largely lies. The same, I believe, holds for psychology and psychoanalysis.

Problematic in a different way -- and, interestingly, inconsistent with the valuable and progressive contribution that is their overall point of view -- is the incorporation into their analytic framework of the concepts of developmental deficit and developmental arrest. Oddly, this conceptual tack seems to be one place where they do go outside the introspective-empathic mode. Rather than highlighting why a particular desire or perception might make sense from the point of view of the patient’s experience, the concept of developmental arrest implicitly makes judgments that
essentially dismiss the patient’s inclinations as infantile. In contrast to their overall perspective, which seeks to understand the frame of reference through which the person is making sense and meaning out of what is happening in his life right now (even if that frame of reference may be highly idiosyncratic and reflect conflicts and anxieties important to examine more closely), the developmental arrest perspective attributes the patient’s perception to a limitation, a deficit from childhood. This conceptualization is closer to the invalidating “distortion” view of transference that, like Gill and like the present author, Stolorow et al are generally at pains to critique.

The idea of developmental arrest also rests uneasily with intersubjectivity theory’s overall emphasis on contextualism. As Stolorow, Orange, and Attwood (1998) have put it, intersubjectivity theory “pictures personal experience as fluid, multidimensional, and exquisitely context-sensitive (p. 720).” None of these qualities seems applicable to a depiction of developmental arrest. If personal experience is fluid, it is not “stuck” at a particular arrested developmental level; if it is exquisitely context-sensitive, it is not just mired in the past or repetitively manifesting a fixed “early” structure from the past.

It is important to notice in this regard that the concept of developmental arrest is by no means essential to their point of view. Their other insights and formulations stand quite well without this concept. In part, I suspect, the retention of the developmental arrest concept is an unexamined holdover from the influence of Kohut on the origins of intersubjectivity theory. In part, however, it is likely also maintained by observations that may seem to be consistent with it. When the observer has the opportunity for intense immersion in the other’s experience that is afforded not only by the intersubjective approach but by almost all psychoanalytic practice, people often do seem to perceive and react to the events of their lives in ways that can look more suited to an earlier developmental period than to the “realities” of adulthood. But a still closer look reveals a larger structure to experience; a structure related to the systemic dimension that is another central feature of intersubjectivity theory. From that vantage point, one can see that these seemingly anomalous features, these seemingly “arrested” psychological structures, are indeed, just as intersubjectivity theory posits, “exquisitely context-sensitive.” What one sees is that the actions in the world that are generated by the person’s subjectivity create an intersubjective experience that is unique and idiosyncratic. Far from living in an “average expectable environment,” every person lives in a particular environment, especially with regard to the realm of affect and relations with others. If one follows the subtleties of how people elicit responses from others and how those responses in turn feed back to maintain or modify the subjective structures that initially elicited those responses – and especially if one does that from a vantage point that utilizes the insights both of psychoanalytic and systemic theorists and investigators – one sees over and over a process of repetitive, self-perpetuating, and self-justifying interaction cycles, often in the form of vicious circles but also of a sort that maintains positive or benign experiences as well (Wachtel, 1987, 1993, 1997, 1999). Such a process – deeply contextual, mutual, and intersubjective – seems a far better foundation for an intersubjective understanding of how old patterns persist than does the concept of developmental arrest.

These quibbles notwithstanding, however, what I most wish to convey is my appreciation for the contribution of these authors to a more humane and more sophisticated version of psychoanalytic thought. In the intersubjective experience of reading their words I have engaged in many implicit conversations from which my understanding has grown substantially. I hope that in their reading of this review, a similar process ensues.

References


Paul L. Wachtel, Ph.D. is CUNY Distinguished Professor in the doctoral programs in clinical psychology and social-personality psychology at City College and the CUNY Graduate Center. He is the author, among other books, of *Therapeutic Communication: Knowing What to Say When* (Guilford, 1993); *Psychoanalysis, Behavior Therapy, and the Relational World* (APA Books, 1997); and *Race in the Mind of America: Breaking the Vicious Circle between Blacks and Whites* (Routledge, 1999).
Dr. Susan Kavaler-Adler is the author of three books and 40 articles related to her view of mourning as a developmental process ("developmental mourning") that is fundamental to self integration as well as to psychic change and transformation throughout one's lifetime. Her unique integration of British and American object relations theory can be seen throughout her writing, fully defined as a theoretical perspective related to "developmental mourning" in her first book The Compulsion to Create: Women Writers and Their Demon Lovers (Routledge, 1993, Other-Press, 2000). Dr. Kavaler-Adler's focus on a well-known brilliant women writers in this book and on brilliant women writers and artists in her second book, The Creative Mystic: From Red Shoes Frenzy to Love and Creativity (Routledge, 1996) allows her to explore how the creative process can be the focus of progressive mourning for self integration and reparation or can be the captive of a demon lover complex (an object relations view of pathological mourning and psychic arrest) in those that fail to mourn due to developmental arrest from trauma in the primal stage of self development.

Dr. Kavaler-Adler’s third book, in press with Routledge, goes deeper into the clinical area than these two books, while further elaborating her theoretical perspective, in relation to Freud and the British theorists. This book, Mourning, Spirituality, and Psychic Change: A New Object Relations View of Psychoanalysis, extends the clinical application of Dr. Kavaler-Adler’s theories that can be seen in her first two books with in-depth descriptions of the developmental mourning process in dialectic with transference work in analysis, and with the interactive engagement of the psychoanalyst and analysand. The following interview focuses primarily on the thesis of the first two books, but touches on the third book at the end.

Dr. Summers: What would you say is the primary message of your work?

Dr. Kavaler-Adler: The primary focus of my work is on the use of the psychoanalytic situation to promote a developmental mourning process that allows self integration, self differentiation, separation-individuation and the growth of capacities for both love and creativity to take place. In my first two books I focus on women artists and writers who attempted to use the creative process for psychic development and for psychic reparation and healing. I found that these brilliant and well-known women often failed in their attempt to use the creative process for psychological purposes without undergoing an adequate clinical treatment. Curious to understand why, I used the extensive research I did on the biographies and creative work of these women to describe the repetition of primal trauma as it appears in the work and lives of these women as a demon lover complex. This demon lover complex appears in themes of muse-god figures who continually turn demonic when the woman artist seeks merger with them through their self-expression in creative work. In a creative moment of ecstasy, Emily Bronte yearns to merge with a vague male phenomenon, who in her fantasy is the muse inspiring her creativity and her life as she attempts to live life within her creative work. The female poet cries: “My outer sense is gone. My inner essence feels!” Expecting to be rescued from the pain involved in living within a traumatized body by the deified fantasy muse, she surrenders to an ecstatic state of bliss, only to be rudely and abruptly dropped into the hell of submission to a masculinized other to whom she has offered up all her power, as it exists in a state of manic erotic desire and craving. The poem turns from merger with an inspiring muse to the possession of the male that extinguishes the independent voice of the female poet. The next image of the poem is of a tombstone in a cemetery. Transcendence has failed and possession results, when the woman displaces all her own potential power into the fantasy figure of the male muse-god through projective-identification.

Her compulsion to do so stems back to her own traumatic self-disruption during the toddler years of separation-individuation. The repetition brings loss of voice, and thus of life, for the female poet. The demon lover theme is complete in a continuing cycle that creates the demon lover complex, (as seen throughout the work and life of a multitude of women), when the yearning to merge with an omnipotent fantasy god results in possession and/or abandonment leading to the ultimate denouement of death. This is a death at the hands of the demon lover, who is a projected combination of mother and father part object internalizations, along with the split off aggression and eroticism that cannot yet be tolerated at the level of psychic fantasy, unless expelled onto paper or canvas. The woman’s failure to mourn the early trauma results in this object relations phenomena of a psychically fixed pathological mourning state.

Women artists, just like other women, need a psychoanalytic/object relations treatment to recover from the psychic arrest that can feel like an endless paralysis in creativity and in life, when loving relationships continually fail. Yet, the very artists and writers who are so affected may reject clinical treatment due to certain societal and cultural myths. I deconstruct two of these myths in The Compulsion to Create. The first is that you have to be crazy...
or depressed to profoundly create. The second is that you cannot enter psychotherapeutic treatment because you need to preserve your psychopathology in order to be crazy or depressed to create. In truth, a clinical process that includes the developmental mourning of abandonment depression trauma will be the primary route to an enhanced creativity. Treatment can allow the artist’s creativity to be finally liberated from its compulsive and diminishing repetition, as mourning heals the splits and dissociations due to the trauma and allows the artist to understand her primal dilemma so that she can create a life in the world that can nourish both her and her work.

Dr. Summers: How do you think people use the creative process?

Dr. Kavaler-Adler: How people use the creative process depends on their developmental issues (desires, conflicts, and traumas). For women with early trauma, during the first three years of life, when the self is first being formed, their basic psychic development is disrupted in a critical way. These traumatized souls are driven to create to externalize an internal division within the self that they are unconsciously trying to repair. They often create in a state of manic intensity, which is reflected in their creative process and in the characters in the content of their work. They often attach to the creative process itself as if it’s the early mother.

If these individuals cannot consciously face and mourn their early trauma, they repeat it continuously, both in their life and in their work. Those most traumatized often try to give up their external life altogether and to live within the virtual world of their creative work and creative process (Emily Bronte, Emily Dickinson). On the pages of their work they endlessly live out their hope for love and life and the failure of this hope. Emily Dickinson describes the demon lover parent/god who possessed, abused, and abandoned her in her fantasy as “the metallic god who drilled his welcome in,” and the deity who “lets loose one thunderbolt” that “scalps [her] naked soul.” Like any addiction, such absorption in sadomasochistic fantasy takes over and destroys life. The woman artist seeks an unavailable, idealized man within the fantasy realm of her work in a futile effort to repair the disrupted self.

By contrast, I have found that women artists who have had good enough development in their first three years of life are able to mourn and repair themselves through their own creative work, independent of clinical treatment. At least to a certain extent they can tolerate the grief of mourning in their work, since the aggression related to it is less primitive and disruptive to their symbolic capacities than it is for those traumatized. They can succeed at symbolizing the figures whom they need to separate from, since they are equipped with whole object attachment in their internal worlds. Through their symbolic capacities, they are able to mourn losses that are often at the level of Oedipal disillusionment where separate rather than merged objects are found. Also, they suffer the pain of love that involves differentiated male figures of human rather than god-like or monster-like proportions. Two such women artists are Charlotte Bronte studied in The Compulsion to Create and Suzanne Farrell of the New York City Ballet studied in The Creative Mystique, who had Ballanchine as a masculine muse whom she does not convert to a demon.

Those who do not internalize an early holding environment cannot mourn. For example, Anne Sexton tried, but couldn’t mourn properly. Although she was creative and highly productive, her creativity was not able to contain, symbolize and thus help her mourn her early trauma. Even though she sought therapeutic treatment, the lack of understanding of the borderline personality and of object relations work on the part of one legitimate clinician caused the failure of treatment and caused exacerbating counter-...
transference enactments. In the second treatment, Anne Sexton succeeded at enacting a masochistic submission to a male psychiatrist who enacted the role of the demon lover, heralding the Greek tragedy of her eventual suicidal demise, as she repelled the husband who loved her. Two chapters on Anne Sexton in The Creative Mystique go into careful detail of the failed clinical attempts and the abuse in the clinical situation that replayed the demon lover cycle.

**Dr. Summers:** How do you see mourning as a developmental process?

**Dr. Kavaler-Adler:** Mourning helps the child go through the separation-individuation process and to thus achieve self-integrity. The child needs to let go of the primal parents and life long mourning may be involved, but critical separation-individuation stage mourning is essential. The more pathological the parenting and the more disrupted the early maternal bonding the harder it will be to let go, because then no adequate internalizations will be formed to create an inner blueprint for new and future relationships to be created. If mourning does not take place, development is arrested.

**Dr. Summers:** What do you see as happening when the child gives up his/her dependence on the parent?

**Dr. Kavaler-Adler:** If adequate internalization has taken place, the child develops capacities for many forms of psychic dialectic that are the core of psychic health. In The Creative Mystique I speak of psychic health in terms of a “love-creativity dialectic,” which is a free flowing interchange between connection to one’s internal world for the expression of creative work and the connection to others through the intimacy of interpersonal relations in the external world. This psychic dialectic operates in parallel with dialectics between mind and body, and between personal voice and other directed empathy, as well as other psychic dialectics, as spoken about in the work of Sheldon Bach. When one form of dialectic is arrested by splitting so are the other forms of psychic dialectic. When someone deflects a whole part of themselves into the other through projective-identification, rather than interacting with or being with the present other, this is a sign of failed dialectic due to pathological splitting from early trauma.

However, if there has been enough sustained affect contact between the parent and child during the formative stages of self-development, a dialectic between self and object takes place that becomes internalized. This dialectic takes place internally between the self and the lost other represented in the internal world during the mourning process. If no blueprint for self and other relating has been established the internal dialectic needed for mourning cannot take place. Without the dialectic of mourning, there is no renewal of love for a potential new object, and creativity is arrested as love is arrested. The psychic dialectic is needed for both love and creativity, and the dialectic of mourning is needed for both to be re-born when the shock of object loss threatens to abort the flow of internal process. If there has not been enough relating between parent and child, this developmental process is disrupted, and all the other dialectics of healing and of living are never established.

**Dr. Summers:** And then?

**Dr. Kavaler-Adler:** The early trauma leads to a build-up of more bad than good internal objects, leading to an excess of sadomasochism. Then there is not enough psychic space for the pathological internalized objects, and they cannot be contained. The result is an abandonment depression (Masterson) related trauma. In this situation, the child cannot mourn. She needs therapy to develop the capacity to mourn the early loss of objects. Charlotte Bronte did mourn on her own through the character Lucy Snowe, in her last novel, Villette, which is her most profound psychological novel, despite the more action paced and magical Jane
People can mourn on their own if they have a sufficiently internalized relatedness with their early mother, a mother who can register in the internal world as a good enough figure, becoming a whole object representation rather than a viscerally intrusive and disruptive internal object. When the Bronte sisters’ mother got ill with cancer her younger daughter Emily was two and two and a half, in the critical stages of separation-individuation. When the mother died Emily was three. Her sister Charlotte was already five and had much more sustained nurturance from a healthy mother, and was already moving into the realm of attachment with the Oedipal father. Emily Bronte, unlike her sister, Charlotte, became schizoid, and like Emily Dickinson, who also became schizoid, she secluded herself in her father’s home for life, until dying from illness in her thirties, turning her father’s home into a maternal womb, resisting ever leaving it. Emily Bronte tried to overcome the loss of her mother by idealizing her father and then seeking his fantasy equivalent, a male muse phantom, energized by internal object enactments. Emily’s muse inevitably turned demonic being eroticized by Emily as she sought the body merger of an infant overwhelmed with Oedipal level drive energies. Emily’s muse became her demon lover; just as her did Heathcliff become the demon lover for her alter-ego heroine, Catherine, in Wuthering Heights.

Lacking a sold sense of self, Emily Bronte sought self-agency through creating male characters in her work and then attempting to merge with them. The idealized masculine figure became the target of early cravings for her mother (expressed repeatedly in oral and anal terms). The muse mother/father figure, once eroticized and endowed with split off aggression, becomes the demon lover who lives upon the stage of the creative work, which becomes too easily a replica of the internal world, rather than its evolving transformation as it was for Emily’s older sister, Charlotte. Virginia Woolf, Diane Arbus, Sylvia Plath, Camille Claudel, Anna O., Katherine Mansfield and Edith Sitwell are other examples of those who I have written who also operate in this desperate enactment within their creative work, as did Emily Bronte and Emily Dickinson. However, in the clinical cases at the end of the books I demonstrate how object relations psychoanalytic psychotherapy can heal the very splits created in such personalities. This is true when these personalities are able to mourn and find the meaning of the psychic fantasies attached to their extreme opposite self-states within the holding environment of treatment.

Dr. Summers: All of this raises a question for me: How do you know whether the trauma suffered was Oedipal or pre-Oedipal?

Dr. Kavaler-Adler: This can be determined from their biographies. Emily Bronte lost her mother when she was two and three, but her sister was five when her mother first got ill. Charlotte’s major loss was the disillusionment with her father. Emily’s internal loss led to the longing for an attachment to a male figure and led to her Demon Love Complex. Emily Dickinson has pathological story of her own. Dickinson had a mother who was a schizoid personality to begin with, and then was in a profound pathological mourning state when she lost several close family members just prior to the birth of her daughter, Emily. In each case, one can see the roots of the trauma in the maternal relationship and the dynamic picture.

Dr. Summers: Is there a problem here in your assuming a pre-Oedipal conflict in those women who are unable to resolve their conflicts and assuming an Oedipal conflict in those who can resolve their conflicts? Could there be circularity here?

Dr. Kavaler-Adler: There’s nothing circular about it at all. When I began my studies of women writers and artists I was expecting one thing and I found the other, through a careful review of the biographies and the creative work of the subjects of my study. I was hoping to find the positive capacities of the creative process as a format for the developmental mourning process, and instead I found that in the case of most of the writers and artists whom I studied, who tended to have profound fantasy systems around male fathers or male authority figures, there was evidence of early pre-Oedipal trauma that went hand in hand with arrests in mourning process within creative work and with the compulsive nature of the creativity, in contrast to those with free creative motivation (and love-creativity dialectic) who could mourn and self integrate through their creative work.

The female sculptor, Camille Claudel is a case in point. Her biography demonstrates how a cold and paranoid mother, along with a narcissistic father, who treated her as special due to her artistic talent, resulted in her living out a demon lover complex with the male sculptor Auguste Rodin. In the throes of disappointment with Rodin, from whom Claudel sought the love lacking with her mother and the role of a special child that she had with her father, Claudel smashed her sculptures, became suicidal and became profoundly paranoid about Rodin. After she broke up with Rodin as a lover and turned her story into that of him abandoning her (he did resist marrying her), Claudel viewed Rodin, as a malicious rival who was calculating day and night to steal her work and to impoverish her. In fact, Rodin
attempted to support Camille as an artist, although he also co-opted some of her art. Perhaps Rodin envied Claudel’s talent, which he thought to be greater than his own. Far beyond any reality, Claudel developed a whole paranoid system around Rodin to avoid facing the hate and abandonment she felt in relation to her mother. Yet it was her mother who incarcerated Claudel in a mental hospital and refused to have her released, so that she died there after rotting away for thirty years.

This case demonstrates that Kohut was wrong when he assumed that a father’s attention and idealization could substitute for the failed early mother’s love. Claudel’s search for a father became an addiction and a compulsion to create, as opposed to a free motivation to do so. Her creative process became a captive of her psychodynamics. Her Oedipal issues were clearly overshadowed by the pre-Oedipal ones. Her attempt to mourn through the grief stricken figures that she portrayed in her artwork clearly failed, as she smashed the very sculptures she created in a ritual attack on the male father-god figures, father and Rodin, who had encouraged her to be an artist. Her attacks on the father muse gods through her attacks on her own sculpture express the level of hate that she had to dissociate in relation to her primal mother in order to psychically survive. Yet her attempts at psychic survival were tenuous and she ultimately succumbed to withdrawal from the world and to psychic death, a purgatory of deadness that lasted thirty years before her actual physical death.

Dr. Summers: Is there any difference between such a compulsion and the use of drugs or alcohol?

Dr. Kavaler-Adler: The “compulsion to create” is often accompanied by alcoholism and/or drug addiction, as in the cases of Camille Claudel and Anne Sexton. There is a similarity between addiction to a substance and to a creative process that is unconsciously representing the lost symbiotic mother of infancy, prior to the disruption of maternal bonding. Without an adequate mother of during the separation-individuation period there is no development of psychic dialectic because there is no internalized blue print of self and other in relationship to each other through states of both connection and autonomy. Without this psychic dialectic that becomes love-creativity dialectic and the dialectic between self and other in both the internal and external worlds, compulsion or blocking occurs in creative process and in life process. Such compulsion and/or blocking results in failure in the critical process of developmental change seen in mourning and grief. Only when aggressive states can be contained, modified and symbolized can mourning proceed so that new modes of developmentally advanced connection can proceed. Without such containment, modification and symbolization of aggressive states the internal aggression blocks the flow of thought and feeling that becomes creative process and psychoanalytic process. In other words, the unassimilated aggression, like Wilfred Bion’s beta elements, drives one into manic thrusts of compulsion.

Dr. Summers: And without creativity?

Dr. Kavaler-Adler: An addiction is inevitable.

Dr. Summers: And how does this fit with what you call “the creative mystique”?

Dr. Kavaler-Adler: The “creative mystique” is an addiction to one’s own image as an artist versus just being in the process of creating. For example, Edith Sitwell became manic in order to keep up the mystique of feeling recognized. She was desperate for a basic recognition that she could never get from an absent and disorganized borderline mother and a grossly grandiose narcissistic and schizoid father. She frantically sought this recognition by performing her poetic works, striving to feel wanted by the audience, an audience that she later attacked and devalued. Sitwell was desperate to create an idealized image of her as she performed, and this manic activity warded off the primal object loss of early trauma that was terrified of confronting. Creating her image through her art, seeking to be a “star” as an artist was her mystique. When Sitwell got too old to perform, she withdrew to her bed and compulsively drank a milk-laced brandy. Angry with an audience that couldn’t repair her, she stopped writing poetry, the one thing that had kept her going. Earlier when she had gotten close to her actual pain in her poetry, and had used the word mourning, and seen visions of a wounded and emaciated child self within her, she quickly aborted the process and stopped writing poetry for ten years. When she returned to writing poetry she placed herself above a devalued feminine child self in the role of a prophet, who looked down on the female masochistic self and the demon lover male figure to which it was always attached (like Fairbairn’s sealed-off libidinal and anti-libidinal egos). She used a manic psychic defense to go on compulsively writing, without the expression of the true self.

Dr. Summers: Is there a cultural aspect to this?

Dr. Kavaler-Adler: It started with the romantic poets: Keats, Shelley, Wordsworth, and Blake. These were great poets, but their followers tended to idealize the image of being an artist. This resulted in the cult of suicide and death that followed Sylvia Plath, Anne Sexton, and Diane Arbus, when the image of the artist was extended to the idealization of the artists who committed suicide.

Dr. Summers: Your work focuses on women, but is the process any different for men?

Dr. Kavaler-Adler: No. Van Gogh would be a good example. He was in a state of manic excitement on the day when he shot himself and continued at the same time to paint his last painting.
Dr. Summers: Do you see Van Gogh as dealing with the same issues as the women you’ve studied?

Dr. Kavaler-Adler: Yes. Van Gogh had a frantic need to express something from within, a need that was so intense because of his craving for the mothering he never had. He was searching for a mother’s basic recognition as well as for an authentic self, in the midst of his internal self being sealed off and divided from the world of external relations. The basic issues are the same for men and women artists, but they are dealt with differently. The male artist seeks a muse that is an externalization of a grandiose self, hoping to be inspired by this split off grandiose self. He feels that he receives inspiration and thus power, from his muse, which is often female. The developmentally arrested female artist often seeks a muse that turns against her, possessing her rather than inspiring her. By worshipping a muse god that turns demonic, and which enacts upon her a masculine form of domination that extends to sadism, she creates a masochistic position for herself. In this way, the arrested female artist re-experiences the helplessness of an infant dependent on an inadequate and unavailable mother.

Dr. Summers: How do we understand dynamically the difference between the male and female artist?

Dr. Kavaler-Adler: That’s a good question. For the man the mother is both the pre-Oedipal and Oedipal object. The boy feels a sense of power, and when he loses the mother he continues to seek an inspiration for his power. The little girl switches from the mother as pre-Oedipal object to the father as the Oedipal figure. Through the Oedipal longing, the female may seek a power she cannot have. If the father relationship is insufficient, the girl continues to seek the power that she feels resides in the male. She masculinizes and eroticizes the object of her primal cravings that stem back to her need for her mother.

Dr. Summers: It sounds like there is similarity here with the work of Jessica Benjamin.

Dr. Kavaler-Adler: There is an overlap. Benjamin speaks of the omnipotent angel figure and I speak of the muse/demon. We both touch on the archetypical dimensions of the primal infant yearnings that can become pathological in the developmentally arrested adult. Benjamin speaks of the lack of a symbolic third, and I speak of the lack of symbolism in those for whom separation-individuation has not taken place due to the lack of capacity to mourn. The failure to mourn I speak of involves the lack of the father as a differentiated third figure, as opposed to the father as an alternate mother or extension of mother. Differentiation fails along with the failure of mourning. For Benjamin the female child can be consumed and engulfed by the tie to the mother when the father isn’t there to serve as a differentiated figure for identification, aside from his role as an Oedipal love object. However, in my work I emphasize that the father can never be perceived as differentiated, no matter how differentiated he is as an objective figure, unless developmental mourning has proceeded and allowed separation-individuation to take place. All of this depends on the personality of the primal mother, and her capacity to negotiate the complex interplay of closeness and distance involved in the separation-individuation phases of development.

Dr. Summers: How does the male artist evade mourning?

Dr. Kavaler-Adler: When the parents are inadequate narcissistic compensation may be sought in the male through idealizing the father figure and then identifying with his own contrived image of omnipotence. Simultaneously, he devalues the underdeveloped child and infant self, seen as an inferior feminine self that is split off and projected into women. To defend against his impotent feelings, a boy can split off his feminine side and project it into

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females, so that his muse figures become part object self extensions, who have the air of devalued female cherubs. Thus, the male remains underdeveloped, and without re-owning his split off feminine side the work of mourning can never proceed. Consequently, the self remains in a manic state of narcissistic defense and lack of completion.

**Dr. Summers:** What do you feel the relevance of this is for clinical work?

**Dr. Kavaler-Adler:** What is needed developmentally is mourning and integration. What gets in the way in a pathological mourning state is the Demon Lover Complex, and this is what comes up with patients.

**Dr. Summers:** What is needed to mourn?

**Dr. Kavaler-Adler:** What's needed is to symbolize and process affects related to loss, including aggression as well as grief. When that happens, the patient can internalize a containing internal object that creates a containing sense of self. The patient needs to do this with the therapist. If that occurs the patient replaces mourning with going-on-being, and becomes truly capable of being present with the self and with the internal or external other in the moment. From this stems all love and creativity.

**Dr. Summers:** And you believe that at the Oedipal level the patient can use creativity to mourn?

**Dr. Kavaler-Adler:** Yes. There is convincing evidence of this. Creativity can be used as the mourning process, and the person then can continue to be creative, as mourning also promotes the discovery of creativity within the self. Creativity is gained, not lost, is the person is healthy.

**Dr. Summers:** Can you say something about your new book, *Mourning, Spirituality, and Psychic Change: A New Object Relations View of Psychoanalysis*?

**Dr. Kavaler-Adler:** Mourning has been both implicit as well as explicit in psychoanalytic theory, stemming back to Freud’s *Mourning and Melancholia*. In Klein’s *Mourning and Its Relation to Manic Depressive States*, Klein first speaks of mourning as a critical clinical and developmental process. I have continued from Klein and have shown how Winnicott, Fairbairn, Balint and Bowlby are all dealing with mourning as well.

Winnicott’s ideas on object survival through the continuing presence of the analyst during the primitive rage affect storms of developmentally arrested patients, and survival through the relinquishing of interpretation when it is being experienced as retaliation, are all related to a dialectic with Klein that opens the pathway to grief and mourning, and to the free associative and symbolic processes that are a part of this mourning. Fairbairn’s whole theory of the addiction to a bad object is about a pathological mourning state and thus speaks implicitly to the theory of mourning. Since mourning requires that the subject experience more love than hate for the object, the possession by a primal bad object, related to the original real external object, obviously obviates mourning. Balint speaks explicitly of mourning in speaking of healing the basic fault. Bowlby, a follower and analysand of Klein, speaks of mourning as a fundamental developmental process in which aggression has an accepted role, rather than being seen as defensive as Klein would view it. In my new book I relate to all these theories in my discussion of mourning and psychic change and in my discussion of my own metapsychology. I am in dialogue with these theorists who are in dialogue with each other. However, I also add the element of spirituality to the mourning process, since it appears so vividly in some of my in-depth clinical cases. It has been reported recently that only three out of a thousand articles on psychoanalysis address spirituality. I wrote the case studies in this book some time ago and can now look back at the profound psychological change that emerged as I remained attuned to the spiritual dimensions of the developmental mourning process. This is true whether these dimensions emerged directly in the clinical dialogue and the clinical associations, or they emerged in the art and dreams of the analysands.

**Dr. Summers:** That’s all the time we have to talk.

**Dr. Kavaler-Adler:** Thank you. It’s been a pleasure sharing my work and ideas with you.
BOOKS BY DIVISION 39 AUTHORS - 2001

WRITTEN OR EDITED, ISSUED OR RE-ISSUED DURING 2001 TO EARLY 2002

This list was compiled through a search of the Internet and various other sources and is not presented as comprehensive. If a member wishes to have a book listed that they published during the past year, please let me know. The editor.

The New York Freudian Society: History, Organizational Contributions, Current Programs

Jeffrey H. Golland, PhD

The 1950s were an especially interesting decade for American psychoanalysis. Psychoanalysts had assumed undisputed leadership in American psychiatry, chairing departments at the most prestigious medical centers. Psychiatric residents assumed psychoanalytic training to be a requirement for pursuing a successful career. The American Psychoanalytic Association (APsaA) had effectively established in the public perception that psychoanalysis was a medical specialty. APsaA had also isolated “wayward” theorists such as Karen Horney and Franz Alexander in its quest to define a “standard” theory and practice. These developments (and their negative consequences) were documented by Eissler (1965) in his book on medical orthodoxy, and later by Richards (1999) in his paper on the politics of exclusion.

Neither psychoanalytic theory nor practice were so easily contained or restricted. Alternate theories, however marginalized, and alternate practices, free from medical orthodoxy, found settings in which to flourish. An especially gifted psychologist, David Rapaport, organized an elaboration of metapsychology to incorporate the contributions of Hartmann and his collaborators. He attracted equally gifted students, many of them not physicians, who went on to make theoretical innovations whose importance was recognized even by the APsaA establishment, despite their explicit rejection of the Hartmann-Rapaport paradigm.

Theodore Reik, the defendant in the earliest dispute over “lay” analysis, created in New York City a psychoanalytic society and institute in which several facets of orthodoxy were eschewed, among them the APsaA requirement that training analysts “report” to training committees about their candidate analysands. By the end of the decade of the ‘50s, the openness of Reik’s group, the National Psychological Association for Psychoanalysis (NPAP), appeared to some of its own members to make for diminished standards of theory and practice. As has happened all too frequently in the psychoanalytic world, organizational splits ensued.

In 1959 one new group to emerge was the New York Society of Freudian Psychologists (NYSFP). Founded by a strong-willed social worker, European-trained psychoanalyst Gisela Barenbaum, NYSFP attracted a core group of creative individuals committed to building psychoanalysis within the framework of its founder’s basic theories, but without the strictures of medical orthodoxy. Like similar groups at their founding, personal ties to the leader were strong; many members and candidates were her supervisees or analysands. By the end of the decade of the ‘60s, however, NYSFP had added to its ranks several members trained at NPAP or at the newer NYU postdoctoral program. This cadre provided new leadership, expanded the faculty and supervisory ranks, and created a more formal structure for institute training. Society membership included nine graduates by 1969.

In addition to their organizational skills, the new leadership group brought to psychoanalytic training at NYSFP theoretical and practical leanings that were both rigorous and flexible. As the developmental psychology of Mahler and the humanizing approaches of Stone and of Loewald were achieving influence within American psychoanalysis, NYSFP faculty incorporated these approaches with its teaching of modern conflict theory, and added to them the object relations orientation of Winnicott, Balint, Fairbairn and Guntrip. This curriculum expansion would come to be called total composite theory by Rangell.

[Having been trained at NYSFP during the late ‘60s and early ‘70s, I was well aware of being exposed to a curriculum richer than that studied by my friends who were in training within APsaA.]

The mid-seventies saw NYSFP change its name (more accurately to reflect its diverse membership) to the New York Freudian Society (NYFS). Its roots remained both strong and clear. By this time a group of child and adolescent psychoanalysts, many of whom had been trained by Anna Freud at the Hampstead Clinic in England, had been welcomed to membership. This group created for the NYFS institute a strong training program in its subdiscipline. Its first candidate was graduated in 1980.

The next major expansion of NYFS was the formation, beginning in the mid-1980s, of its Washington, DC training center, the first geographically-distant institute started in the United States outside of APsaA. Before the successful settlement of the Division 39 lawsuit, APsaA arbitrarily rejected a group of candidates, mostly psychologists, approved by their local training facilities, for advanced training. They took the initiative in collaborating to be trained by faculty who would fly to Washington on alternate Saturdays to provide full NYFS training without advanced standing. This initial Washington group has long since graduated and its members have joined the ranks of faculty and supervising analysts. They are frequent contributors at Division 39 programs and have recently taken over administrative direction of the ongoing Washington Division of NYFS.
Following the Division 39 lawsuit, NYFS became one of the first three (now four) groups to become full component societies within the International Psychoanalytical Association (IPA). The NYFS training program had been designed early on to be consistent with IPA standards and philosophy. At the time of its admission, NYFS had graduated 65 psychoanalysts and had become a major training site. Its current graduates number close to 150. NYFS members have made many significant contributions to psychoanalysis. As scholars, they have authored dozens of books and hundreds of articles as well as being regular presenters at national and international professional meetings. Members serve with distinction on editorial boards of several psychoanalytic journals. As organizational leaders, two NYFS members have been president of Division 39, another has been president of APA's Division 42, and seven NYFS members have held the presidency of Section I. NYFS members have also been active on the Boards of Sections III and IV. One member has served on the Executive Council of IPA. Two members are recipients of the coveted Sigourney Award.

In its most recent decade NYFS has continued to grow, both in membership and in its range of activities. The latest IPA roster had NYFS as the fourth largest component society in the world (following APsaA, the Canadian Psychoanalytic Association, and the Argentine Psychoanalytic Association). Its membership ranges geographically beyond the New York tri-state and Washington, DC metropolitan areas to include France, Germany and Mexico, as well as mid-Connecticut, Colorado, Florida, northern Maryland, Massachusetts, Michigan, Missouri, Pennsylvania, and central and southern Virginia. Its newer programs include a parent/infant/toddler training sequence, continuing education for psychologists and social workers at the New York City Board of Education, and divorce and forensics outreach groups. Recently, NYFS has created a clinical services division and it supports the work of a counselor at a private school in Manhattan. NYFS offers the Plumsock Prizes for psychoanalytic writing by candidates and members who are new to publication. A foundation has been established to promote support for its community programs. A psychotherapy training program is scheduled to admit its first class in 2002. NYFS as a society and its members as individuals have also participated generously in the response to the September 11 tragedy in both New York and Washington, and have made a commitment to continue to assist families of the victims. Now in its 43rd year, NYFS looks forward to continuing as a strong member of a renewed and vibrant psychoanalytic movement in the United States and in the international community.

References

Jeff Golland is a member of the faculty and a supervising and training analyst at the NYFS training institute, and serves on the NYFS Board as Vice President. He is also Visiting Professor of Early Childhood and Childhood Education at Lehman College, City University of New York.
What do these letters stand for, and why should a division member be interested? Bill MacGillivray, the Editor of *Psychologist-Psychoanalyst* asked me to write this essay so our members would know what CAPP and IG are, and what relevance they have for the Division of Psychoanalysis. Also by knowing what these letters stand for, you may better appreciate my reports on CAPP and IG activities. This is not a report on the CAPP or IG meetings but, as noted, a general background essay to help you know where to place such reports in your minds when you read them.

CAPP stands for the Committee For The Advancement Of Professional Practice. IG stands for the Integration Work Group, which is a sub-group of CAPP and reports directly to it. CAPP and IG are part of the Practice Directorate. APA has four Directorates: Education, Practice, Science and Public Interest. Funding for the Practice Directorate is provided by the special assessment that APA practitioners send in when they pay their annual dues. Thus, each of us in the Division supports the Practice Directorate.

Our Division sends an observer (currently me) to the CAPP meetings. There are four two-day meetings per year, which are held in Washington, DC. The IG group meets before the CAPP meetings. I represent the Division at the IG meetings. Once or twice a year, the CAPP and IG meetings are held in conjunction with other APA Board and Committee Meetings. These combined meetings are called the Consolidated Meetings. During the Consolidated Meetings, CAPP and IG meet as usual but there is a plenary session where all who are attending Board and Committee meetings that weekend have a joint session. There are also several open meetings where topics of general interest are discussed and anyone attending the Board and Committee meetings may attend. At the Consolidated Meetings, there is also the opportunity to meet informally at the breakfast and lunch buffet and share information and concerns regarding APA governance, activities and other psychological matters.

The Council of Representatives elects members of CAPP and these committee members represent a broad perspective on professional practice. The mission statement of CAPP is:

> “There shall be a Committee for the Advancement of Professional Practice whose responsibility it shall be to (a) be the administrative agent of the Board of Directors exercising general governance supervision over the relevant affairs of the Practice Directorate, (b) recommend to Council through the Board of Directors procedures for the enhancement of human welfare for the professional practice of psychology, (c) identify projects important to the enhancement of human welfare through the professional practice of psychology and, (d) recommend to the Board of Directors the need for funding such projects.

CAPP is a 501(C)(3) Internal Revenue Service entity and thus its political advocacy is limited. Therefore in January of 2001, the Practice Directorate and CAPP formed a 501(C)(6) Internal Revenue Service entity called the APA Practice Organization Committee for the Advancement of Professional Practice. The mission statement for the Practice Organization is:

> “The mission of the APA Practice Organization is to promote the mutual professional interest of practicing psychologists in all settings through a wide range of activities focusing on policymakers, legislators, the legal system, purchasers and consumers of services, and the overall healthcare marketplace.”

The priorities of the Practice Organization are: 1.) Maintaining and pursuing a strong advocacy agenda, 2.) Generating additional resources for practitioners and the profession, 3.) Re-branding psychology as a major helping profession, 4.) Expanding the applications of psychology, 5.) Building a professional network of key alliances and connections, and 6.) Integrating the practice community.

The Practice Organization, because it is a 501(C)(6) entity, can be more politically active and can enter into various business arrangements and efforts to generate revenue (including political contributions from members) so that more unrestricted lobbying and political advocacy can occur. It is important to note that the CAPP and its Practice Organization define professional Practice very broadly. That is, it includes clinical practice but also such areas like rehabilitation psychology, health psychology, etc. Thus, it advocates for practice broadly defined and not specifically for one modality or clinical activity.
As the Division observer, I attend the CAPP meetings and can speak on topics being discussed but I do not vote, only elected members of CAPP vote. I see my role as primarily observing and, as appropriate, advancing a psychoanalytic perspective into the CAPP discussions and activities. I also see my role as an ambassador to other components of the Practice community (and to APA governance in general) to educate them about contemporary psychoanalysis, Division activities, and to develop strategic linkages and relationships with others in the practice community.

CAPP may develop activities that it carries out such as entering carefully selected lawsuits against managed care (and the Practice Directorate has been very successful in this endeavor) or may send recommendations as proposals to other boards and committees of APA. The CAPP also receives information about issues relevant to the Practice Community and is asked to provide input to the originating committee or board. For example, the Taskforce on Revising the Ethics Code asked for CAPP input. Thus, again, it is important for the Division to have an opportunity to provide input into these many activities of APA and our observer to CAPP is one way for the Division to be alert to what is going on at APA and to provide input from our perspective.

I report to the Division Board and membership on issues discussed and acted upon at CAPP. Reports also appear in APA Monitor and the Practitioner Update. All Division members get both publications. My reports appear in the Psychologist-Psychoanalyst.

The Practice Directorate has committees on: Government Relations, Legal and Regulatory Affairs, Marketing, Public Relations/Communications, State Advocacy, Professional Development, Policy and Advocacy in the Schools, Professional Issues and College of Professional Psychology.

The Integration Work Group (IG) is a smaller subcommittee of CAPP and it has representatives from clinical divisions and some state associations. Its chief function is to bring to CAPP issues or concerns that these representatives want CAPP to address. The IG also functions to develop important communication channels so that various constituencies can be aware of common problems such as membership recruitment and retention and assist each other in dealing with such problems.

I believe it is important that Division members be as active in as many APA Boards and Committees as possible. It provides us with an opportunity for our voices to be heard and an opportunity to play a role in what APA does so that we can ensure that APA activities are compatible with our psychologist/psychoanalytic perspective.

NEW MEMBERS
SEPTEMBER - DECEMBER 2001

James W. Anderson, PhD
Jessica Arenella
H. Robert Baird, MS
John Bergeron, MA
Robert Besner, PsyD
Patricia Billotti, PhD
Benjamin Bloch
Catherine Classen, PhD
Crystal DeLoach, PhD
Michael Emnis, MA
Sheila Erlich, PhD
Susan Etkind, MA
Jeffrey Fine-Thomas, MA
David J. Frankel, PhD
Richard Gibb, DMH
Mitra Gilbert
Ricardo Gonsalves, EdD
Diane Gottfried, MA
Efrat Hadar, MA
Catherine Harrington, BA
Nick Johnson, MA
Edwin Kahn, PhD
Mark Kiel, MA
Peter A. Klein, PhD
Ana Carina Koch-Weser, BA
Michael J. Koski, PhD
Laura A. La Piana, PsyD
Jody Leader, PhD
Laura B. Mason, PhD
Elizabeth Moran
Clare Mundell, PhD
Lisa Orbe, MA
Robert Osman, MA
Jan M. Premich, PhD
Olga Pugachevsky, PhD
Pamela Raizman, PhD
Mark Reaves, PhD
Geneva Reynaga, MA
Linda Robinson, MA, CSW
Tammy Saltzman
Jennifer Sarti
Saundra Segan, PhD
Jessica Selvin, MA
Lisa Sokoloff, MSW
Robert E. Strazicich, PsyD
Sandra Taub, PsyD
Martha Temple, PsyD
Jeffrey L. Trop, MD
Erica Wandner, PhD
Doug Wayland-Smith, PhD
Section I, in collaboration with the San Antonio Society for Psychoanalytic Studies (SASPS), organized what in hindsight turned out to be one of the first conferences in the country that dealt with the aftermath of the September 11th attack. The clinical material presented and the three discussions that followed, exerted a profound effects on audience and participants. The event took place at the Coates Center, Trinity University in San Antonio, Texas. SASPS members Drs. Tim Zeddies, Wayne Ehrisman and Fernando Esparza were actively involved in the planning of the encounter, which was attended by over sixty mental health practitioners from San Antonio and Austin.

Dr. K. William Fried presented with vivid details clinical material of a patient who had witnessed the murder of a family member. The patient had come to treatment suffering from the sequelae of trauma, in addition to feeling deep remorse and survival guilt. The title of Dr. Fried’s presentation, The Unbearable Thickness of Blood, highlighted how family bonds often coalesce with violence. Dr. Fried alluded to the risk undertaken by his patient in seeking help from outside the family. The vicissitudes of the case made it clear how

“[Alongside this literal blood-letting, however, is the blood that symbolizes membership in this family...This is the blood that has become viscous by a continuing narrowing of the family’s frame of reference, suspicions of any outsiders to whom members become attached and powerful resistance to new ideas or practices, lest adulteration lead to thinning..”

A most ironic twist of pace was precipitated by Dr. Fried’s final comments. After reading the manuscript he had prepared over the summer, he faced the audience and announced that he had to share recent developments of the case, which due to time constraints, were not included in the manuscript. Dr. Fried recounted how his patient, an emergency medical technician, dramatically survived - one more time - another bloody trauma. Involved in the rescue operations of the World Center attack, the patient escaped the collapse of one of the towers while witnessing the tragic death of over a dozen of his co-workers.

The discussants, Dr. Gediman from New York City, and Drs. Ingmundsen and Speicher from San Antonio, unaware of the latest development of the case, were called to respond to the new material as it was unfolding in front of their eyes, becoming actual witnesses to Dr. Fried’s horrifying tale. The discussants and the audience reactions appeared to enact the patient’s own experience of re-traumatization. In this vein, the discussants thoughtfulness and sensitiveness seemed to have facilitated the beginning of a process of mourning and reparation for which the audience was most appreciative.

The three discussants complemented each other, covering diverse and complex aspects of trauma, development, and its derivatives. Dr. Gediman offered a most eloquent overview of Freudian theory of trauma, stressing the need to embrace aspects of both topographical and structural theory. “Our major focus now in treating trauma” - she explained - “is not on discharge of excess stimulation but in processing the individualized meaning that a trauma has for a given person.” Dr. Gediman addressed how transference interpretation intersects with a discussion of trauma. She asked the question: “How does a psychoanalyst go to the front lines of the trauma in New York and offer what is uniquely psychoanalytic on the front lines of the emergency crisis center?” Discussing technical considerations, she reminded therapists of the need to listen closely to resistances, i.e., shifts in affects or interruption of the thinking flow, adding that free floating attention may not necessarily work with victims of trauma. According to Dr. Gediman, the analyst’s task is to contain powerful affects and impulses, concluding that

“[Like the patient, we all lost brothers and sisters and were subject to violent and sudden shocks of seeing people jumping to their bloody deaths before the horrifying collapse of the towers...our countertransference, our shared and individual subjectivities...will help sometimes unbearable thickness of blood become bearable in the times to come.”

Dr. Ingmundsen emphasized the importance of culture and its effects on trauma. He reminded us of the influence of family dynamics and sibling constellations in connection to trauma. With a poetic tone, he alluded to the Egyptian myth of Osiris and its relevance to the understanding of the fragmentation of body and psyche so prevalent in trauma. The Egyptian myth expands on the fragmentation of the body of Osiris, and how Isis tried to put it back together. Collecting the part-objects was regarded by Dr. Ingmundsen as an analogy to the therapist in working with trauma victims.

Dr. Spicher’s response to Dr. Fried’s paper weaved together the reactions to the trauma of September 11 and to the particulars of the case. She elaborated on trauma
and the analytic process, emphasizing the role of neutrality and the processing of traumatic experiences. Moreover, she expanded on countertransference aspects, vividly sharing her own reactions to Dr. Fried’s case. Dr. Spicher warned therapists on the danger of our countertransference, adding that the failure to process traumatic events such as the September 11th attack may foster vindictiveness and xenophobia in the countertransference.

Workshops followed the case presentation and discussions. The workshop co-led by a Section I Board member and a San Antonio Society member were: Civilian Victims of War Trauma with Drs. Helen Albanese and Isaac Tylim; Childhood Trauma with Drs Debra Morrow and Mary Beth Cresci; Trauma and Sexuality with Drs. Lisa Chatillon and Harriet Basseches; and Addictions with Drs. Ursula Sander and Martin Schulman.

Summary reports by workshop leaders oscillated between personal accounts of trauma during World War II, the plea of Vietnam Veterans, the effects of terrorism in urban settings such as Oklahoma and New York City, the observed decline of psychosomatic illness during periods of war, the use or abuse of drugs, and the difficulties in sorting out normative as opposed to pathological guilt. Following the reports, the need to maintain an ongoing dialogue and to share experiences related to September 11 created an unusual feeling of solidarity and support among all participants.

Section IV - Local Chapters

Andrea Corn, PsyD

Section IV is launching an Educational Initiative program with the intent to create a “speaker’s bureau” to assist psychoanalytic education and practice building within the geographically dispersed thirty local chapters throughout North America. Presently, Section IV is gathering names of interested presenters in the division who would be willing to travel to a local chapter and present his or her psychoanalytic ideas to psychoanalytic thinkers and practitioners in other locales. Section IV is pleased to announce that forty-five division members have expressed an interest in participating.

At the August Senate Board Meeting, the local chapter representatives agreed that transportation, housing, and expenses would be provided by the participating local chapter along with an honorarium commensurate with the needs/resources of the chapter. This project is at the beginning phase so all we request now is for those who are interested to submit the following information name/address, areas of interest, and willingness to contribute to this project. Additional parameters will be discussed and formalized as this project proceeds.

Section IV hopes the Educational Initiative will foster greater intersection collaboration and collegial network.

Section IX - Psychoanalysts for Social Responsibility

Neil Altman, PhD

Catching up on some old news: At the Santa Fe spring meeting Section co-sponsored (with the Multicultural Committee of Division 39) a showing of Ricardo Ainslie’s film Crossover: A Study of Desegregation. Dolores Morris and I were discussants. The film documents the desegregation process in one town in Texas, through interviews of people who lived through it. The experience of watching and discussing the film was an emotional and educational experience for all of us. Ricardo’s work is a model for all of us of one way to address social issues as psychoanalysts.

A number of Section IX members are involved in the Children’s Psychotherapy Project/New York. As you may remember, the Children’s Psychotherapy Project began in San Francisco under the leadership of Toni Heinemann, and has now expanded to New York under the leadership of Elizabeth Kandall. The project’s goal is to offer psychotherapy to foster children “for as long as it takes.” In New York, 13 foster children and adolescents are currently being seen pro bono by 13 therapists. Five consultation groups are running to offer free consultations to the therapists. Anyone interested in participating in this project should call Elizabeth at 212-255-8895.

Section IX is offering a cash prize for a paper or other project (clinical, preventative, etc.) that addresses the interface of psychoanalysis and social issues. The prize will be awarded at the Section IX social reception at each year’s Annual Meeting. If you want us to know about your project, call Neil Altman at 212-595-0821 or email at neilaltman@hotmail.com, or Rachael Peltz at 510-841-3201, or rapeltz@earthlink.net.

My term as president of Section IX ends with 2001. I feel very privileged to have been part of the founding and early years of the Section, and to have been able to work in various ways with many of you. Rachael Peltz will be taking over as President on January 1. I am sure we will see Section IX develop in all sorts of exciting new ways under Rachael’s leadership. I will continue on the Board as Past President.
The Appalachian Psychoanalytic Society (APS) highlighted its fall programming by presenting its third Hans H. Strupp Award for Psychoanalytic Research, Scholarship, and Teaching to Bertram P. Karon, PhD, professor of psychology at Michigan State University, at the annual convention of the Tennessee Psychological Association (TPA) in Nashville, Tennessee, on October 26, 2001. With his usual passion for matters psychoanalytic, Dr. Karon spoke for more than four hours about the psychoanalytic treatment of psychosis and severe psychopathology. Complementing Dr. Karon’s talk was a presentation by APS member John S. Auerbach, PhD, associate professor of psychiatry at East Tennessee State University, on experiences of self in schizophrenia and borderline personality disorder. As in previous years at the TPA convention, the APS talks were well attended and well received, with the large turnout suggesting once again that psychoanalytic ideas remain relevant to working clinicians, even those who are not versed in the psychoanalytic tradition, even in an age of managed care and manualized treatments.

Also as in previous years, the APS continues to have an active program of scientific meetings and continuing education programs, most of the continuing education efforts being presented by APS members. The Spring 2001 scientific program brought Calvin A. Colarusso, MD, of the San Diego Psychoanalytic Institute to Knoxville, Tennessee, on March 31 to present a full-day workshop on separation-individuation in adulthood. Dr. Colarusso described how separation-individuation processes continue throughout the life cycle. The Fall 2001 scientific program brought Frank Summers, PD, associate professor of psychiatry and the behavioral sciences at Northwestern University Medical School, to Knoxville on November 3 to present a full-day workshop on his object relations model of psychoanalytic therapy. And the Spring 2002 scientific program, scheduled for April 6, will bring Polly Young-Eisendrath to the area to speak about ambivalence in the mother-child relationship.

Meanwhile, the annual continuing education series began with a January 20 presentation by APS member Paul Lerner, PhD, on the relationship, from a psychoanalytic perspective, between psychological assessment and the treatment process. Other continuing education offerings in 2001 have included APS member Peter Young, PhD, on the convergence on neuropsychology and psychoanalysis (March 17), Susan Gantt, PhD, and APS member Carol Walton, PhD, on System-Centered ® group psychotherapy (April 21), Antonio Virsida, PhD, on chemical dependence and the concrete attitude (May 19), APS member James Gorney, PhD, on resistance in psychoanalysis and psychotherapy (September 25 and October 6), Linda Rankin, PhD, on ethics and mental health care (October 20), and APS member Joan Harrigan, PhD, on spiritual issues in the psychoanalytic hour (December 8).

In 2002, the series will resume with a January 5 presentation by APS member William Hogan, MD, on psychoanalytically oriented psychopharmacology and will continue with APS member Vance Sherwood, PhD, on treatment of adolescents (February 16) and J. Lavelle Ingram, PhD, on cross-cultural issues in psychoanalytic treatment (March 16). In Spring 2002, the continuing education series will see return visits from Sidney Blatt, PhD, on depression, Antonio Virsida, PhD, on chemical dependence, and Bertram Karon, PhD, on psychosis.

Finally, the APS Scholars Symposium in February 2001, in Knoxville, featured a presentation by Allen Dunn, PhD, professor of English at the University of Tennessee, of his research on the disavowed narratives of women murderers. Complementing Dr. Dunn’s contributions was a talk by APS member Ronda Redden Reitz, PhD, presenting material from her clinical work with men who batter their partners. In January 2002, the Scholars Symposium will feature Dr. Gorney, with Beverly Gibbons, PhD, and Mary Papke, PhD, as discussants. Thus, the Scholars Symposium continues its tradition of giving voice to APS members and other local scholars who wish to present their psychoanalytic ideas to their peers.
AUSTIN SOCIETY FOR PSYCHOANALYTIC PSYCHOLOGY

A SPP continues to play an important role in maintaining the presence of psychoanalytic psychology in Central Texas. A yearly program of activities, starting in September through June, provides different settings to explore psychoanalytic thought. The yearly program consists of monthly meetings opened to all members, a Spring Conference and a Fall Case Seminar traditionally conducted by invited speakers of national standing, and courses in psychoanalytic theory and technique taught by members of the society. Informal reading groups are often offered by some of our members to provide a forum for the discussion of papers presented at the Division 39 Annual Meeting of other topics of interest. The yearly program is organized around a theme traditionally chosen by the president-elect of the previous year. Members of the society have an opportunity to prepare individual or joint presentations exploring the theme of the year. The monthly meetings are open to all society members. Licensed mental health professionals in the community are also welcome. Terry Parson Smith, PhD the president for the 2000-2001 organized the monthly program. The limits of Psychoanalysis was the theme for the year. The monthly presentations showed rich and diverse approaches to this theme: Psychoanalysis and Metaphor/Psicanalisi E Metafora, by Gemma Ainslie, PhD; When Psychoanalysis Becomes A Cult: Clinical And Theoretical Abuse, by Virginia Eubanks, MD; A Womb With A View: Infant-mother Psychotherapy, by Deanna Engber, MDiv, LPC/OTR; Extending the Limits of Psychoanalysis Treatment and Diagnosis With Psychological Testing, by Stephen Finn, PhD, Dale Rudin, PhD, Terry Parsons Smith, PhD, Mary Tonsager, PhD and Judith Zamorsky, PhD; A Song Of Cure: From A Hum And A Whistle To Three-part Harmony, by Donald W. Giller, PhD; Psychoanalysis by Telephone, by Martin Manosevitz, PhD, ABPP; Psychoanalysis and Psychotherapy; Distinct Entities Or A Continuum? A Discussion of Theoretical Considerations and Clinical Practice, by Deborah Shelton, MD; and The Limits of Psychoanalysis: Factors Within the Psychotherapist, by Mary Pharis, PhD, ABPP. Allan Schore, PhD explored the interactions between psychoanalysis and neurobiology in our Fall Seminar. His presentation provided an in-depth look at the effect of early trauma and the development of the right brain and his view of projective identification as intrapsychic mechanisms of right brain communication. In coordination with Dr. Schore’s visit, Mary Pharis, PhD and Elaine Lanford, PhD presented a course discussing Dr. Schore’s work and Gemma Ainslie, PhD provided an opportunity to take an in-depth look at projective identification from a psychoanalytic perspective. Ernest Wolf PhD graciously accepted our invitation to conduct our Spring Case-Conference. Dr. Wolf discussed psychoanalysis from the vantage point of self psychology in formal presentations as well as in a discussion of in-depth clinical materials presented by participants to the conference. In coordination with Dr. Wolf’s visit, Richard Campbell, PhD offered a course in self psychology. We are also grateful to Alan Davis, MD who responded to the interest of many of our members to have an opportunity to attend a course in adolescent psychology from the point of view of psychoanalytic theory. Our monthly meetings and courses are well attended and we are continuing to attract young members from all mental health disciplines. Our current goals include developing a web site, establishing better connections with other chapters and providing our members and the community with a psychoanalytic perspective in general and particularly at this time of national crises.

CHICAGO OPEN CHAPTER FOR THE STUDY OF PSYCHOANALYSIS

This year has been a very active one for the Chicago Open Chapter for the Study of Psychoanalysis. Founded in 1985, its mission is to provide a forum for the discussion of various trends in psychoanalysis, and to promote the application of psychoanalytical theory to a wide variety of areas (including, but not limited to, anthropology, history, literature, the arts, and religion). The Open Chapter strives to provide a democratic and egalitarian atmosphere for the exchange of ideas. Hence, although the organization sponsors presentations by nationally, regionally, and/or locally recognized psychoanalysts, it does not view psychoanalysis as the sole domain of mental health professionals. As its name implies, the Open Chapter is truly “open,” in that it encourages the application of psychoanalytical enquiry to the work being done by other disciplines. The Open Chapter also has been a clearing-house for those offering study groups in various arenas in psychoanalysis (clinical, applied, theoretical).

The Open Chapter sponsored two very well received symposia by two highly regarded psychoanalytical scholars and practitioners: Frank Summers, PhD; and Peter Shabad, PhD. Dr Summers presented on The Therapeutic Action of Psychoanalysis: An Object-Relations Concept. Dr Summers’s foci included the roles of interpretation and the psychotherapeutic relationship as they pertain to psychoanalytical object-relations models of psychotherapeutic action. He also emphasized how therapeutic impasses in which understanding has been achieved, but the hoped-for
results have not occurred, are resolved in the context of object-relations paradigms. Dr Summers is the author of (amongst other works) the recently published Transcending the Self: An Object Relations Model of Psychoanalytic Psychology.

Dr Shabad’s presentation was entitled, Shame and the Burden of Loneliness: The Problem of Human Freedom. Dr Shabad explored how ruptures and disillusionments in the give-and-take with one’s parents lead to a burdened sense of omnipotence and mental responsibility for their well-being. In adulthood, the consequent inadequacy and shame of perfectionistic thinking then transforms aloneness into the experience of loneliness. This sense of shame and loneliness compromises one’s ability to act freely, as now, through the idealising transference, one seeks to surrender the omnipotent burden of mental responsibility for significant others to a powerful other; or, give over one’s decision-making to the crowd. Dr Shabad is the author of the just-published Despair and the Return of Hope: Echoes of Mourning in Psychotherapy.

In the ecumenical spirit of fostering trans-organizational dialogue and co-operation; and inter-disciplinary discourse, the Open Chapter has also worked collaboratively with The Chicago Circle of the Ecole Freudienne du Quebec. Here the foci have included workshops, study groups, lectures, and symposia on the unique contributions of Jacques Lacan to the theory and practice of psychoanalysis. There has been a special interest within The Chicago Circle and the Open Chapter on the understanding and treatment of psychosis and primitive mental states.

KANSAS CITY ASSOCIATION FOR PSYCHOANALYTIC PSYCHOLOGY

The Kansas City Association of Psychoanalytic Psychologists (KCAPP), since its inception in 1999, actively supports mental health professionals and all persons interested in psychoanalysis to become involved in study groups, seminars, and continued individual training to deepen understandings about psychoanalytic work.

Under the dynamic leadership of our founding president, Dr. Marilyn N. Metzl, PhD, the initial year of KCAPP was rich and fruitful, featuring events and presentations including the following: Psychoanalysis in Everyday Life, presented by Kathryn Zerbe, MD; Ancient Images, Modern Questions, presented by Robert Cohen, PhD, curator of ancient art at the Nelson-Atkins Museum; Self Psychology Strikes Back, presented by Frank Lachmann, PhD; The Creative Genius of Nijinski, presented by Leonard Crowfoot, ballet artist; and A State of Self and its Implications for Self-Disclosure in Psychoanalytic Technique, by Walter Ricci, MD.

In March 2001, KCAPP brought to the Kansas City community Dr. Karen Shore, PhD, the founder and initial president of the National Coalition of the Mental Health Consumers and Professionals, Inc., a grassroots organization designed to protect mental health care from the ravages of managed care and the essential patient rights including the right to privacy. Dr. Shore’s presentation was entitled Immodesty, Destructives, and the Threats to Psychotherapy: Pernicious Effects of Managed Care, Research, and our Training Programs.

Ryan Allison, MA, a Fourth year candidate in the New England Institute for Psychoanalytic Studies, on September 7, 2001, offered a seminar on Psychoanalysis and Literature, examining fads in psychoanalytic literary criticism, focusing on the subject of irony.

A unique one-day writing workshop will be conducted by Martin Schulman, PhD, on December 1, 2001. Dr. Schulman is Editor of The Psychoanalytic Review, President-elect of Section 1 (Psychologist-Psychoanalyst Practitioners), the Chair and Founder of the Council of Editors of Psychoanalytic Journals, and is a former editor of Psychoanalytic Books, having edited or co-edited eight books. This workshop is designed to improve one’s writing skills for acceptance in various psychoanalytic journals, book chapters, and book publications.

The KCAPP Newsletter has provided an effective means of communicating with and educating members, recruiting new members and publicizing articles written by guest speakers invited to the Kansas City area. The most recent newsletter featured the leading-edge work of Allan N. Schore, PhD, author of the 1994 book entitled Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development (Mahwah, NJ: Erlbaum). Dr. Schore presents his research on affect regulation in Kansas City in October 2001.

Another educational effort, under the auspices of Section IV, is to form a volunteer speakers bureau composed of persons willing to go to other cities and give lectures on psychoanalytic theory and practice and other topics of special interests. Speakers are presently being recruited.

Plans for future programming include opportunities to analyze connections between literature and psychoanalysis. Play performances having psychoanalytic content will be attended and reviewed. Dinner and discussion sessions following these performances will provide a time to analyze play content with the directors and with fellow members.

The KCAPP membership appreciates the effective efforts of our outgoing president, Dr. Marilyn N. Metzl, who has been elected as President of Section IV (Local Chapters). Dr. Metzl will chair the Section IV programs at the Annual Meeting in New York, April 10-14, 2002.
In recent years, MAPP has tried to meet several related challenges: to provide a uniquely useful role in the changing Boston-area psychoanalytic community; to maintain and expand membership; and to offer stimulating programs and services. Under the energetic and creative leadership of past-president Jack Foehl, PhD and current president Gerard Donnellan, PhD, we have made impressive advances toward these goals.

MAPP historically has provided a sense of community and wide range of superb educational offerings to analytically-inclined practitioners in the Boston area not formally affiliated with a specific analytic institute. As the volume and accessibility of educational programs in Boston has increased, MAPP has been challenged to maintain its unique relevance to the local analytic community. Toward this end, the MAPP executive committee has undertaken a number of initiatives: (1) we have made special efforts to recruit graduate students and provide programs especially geared to their interests; (2) we have published a member directory cross-referenced for practitioner location and specialty, which has served as an invaluable networking and referral resource for members; (3) we have mounted our own website, mappsych.org, featuring an on-line member directory and updated calendar of programs; (4) we have held a series of outreach events to recruit new volunteers for our membership and other committees; and (5) we have tried to sponsor educational programs covering a broader range of analytically-relevant topics than might be offered by other local organizations. We also publish a spring and fall newsletter, MAPP News, which summarizes past MAPP events, publicizes upcoming programs, and publishes other features of interest such as book and film reviews.

A sampling of stimulating MAPP programs over the past year includes a workshop by Janice Haaken, PhD on the cultural context of multiple personality disorder; a panel discussion among Contardo Calligaris, PhD, Jim Frosch, MD and Jack Foehl, Ph.D on Lacanian versus other approaches to analytic treatment; a workshop by Dawn Balcazar, PhD on the multiple meanings of self-injury; and a workshop by Joan Sarnat and Mary Frawley O’Dea on a relational model of supervision. In 2002, some planned MAPP programs include a community discussion on the impact of the recent terrorist attacks, a workshop by Gerry Donnellan, PhD on applications of theatrical methods to analytic work, and a workshop by John Schott on financial issues in treatment.

For further information about MAPP, readers are welcome to visit our website at mappsych.org; contact Gerry Donnellan, Ph.D, MAPP President, at 781-446-8520 or pepdog@rcn.com; or contact Elizabeth Bernstein, PhD, MAPP News editor and Section IV liaison, at 617-776-7257 or Eberns1010@aol.com.

Four years ago, Marilyn Jacobs, after giving a paper at the San Diego Self Psychology Study Group, said we had a great group and should become a local chapter of the Division of Psychoanalysis. Thus the San Diego Society for Psychoanalytic Psychology was born. Since then, our 95 members have continued to meet five times a year to hear papers and participate in discussions. We alternate between outside speakers, and our local members.

In contrast to the active involvement of our members at the local level, there is little involvement with the national organization. This could be because many of our members are not psychologists, and those who are have not had formal psychoanalytic training. Nevertheless, the San Diego Society for Psychoanalytic Psychology is still the only place where San Diego therapists can learn about contemporary psychoanalytic thinking, and our numbers continue to grow.

Presentations from the last two years include: The Mind-Brain Relationship, by Regina Pally, MD; The Experience of Personal Annihilation, by George Atwood, PhD; Imagistic Alliances and the Enhancement of the Self, by Jan Berlin, PhD; Outside the Box: The Impact of Contemporary Psychoanalytic Thinking on Technique, by Sanford Shapiro, MD; Transforming Aggression, by Frank Lachmann, PhD; Freud on the Couch, by Lou Breger, PhD; You’re No Good: Devaluing in Couple Relationships, by Sheila A. Sharpe, PhD; and Long Term Treatment of an Addictive Personality, by Peter Seymour, MD.
This has been a demanding year, requiring a reassessment of how we can provide outreach to the larger community around us. Shortly after the 9/11 WTC disaster, SEFAPP made contact with the American Red Cross, and we were able to offer the services of our mental health professionals for crisis intervention. We appreciate our members who have been able to participate.

Our annual conference, cosponsored with Florida International University in March, 2001, also expanded our consciousness, and raised important questions concerning both the impact of race and ethnicity in the clinical interchange, and the role of language and bilingualism in the clinical process. The topic was Psychoanalytic Perspectives on Race and Ethnic Diversity: Change and Strain. We welcomed Neil Altman, PhD, Kimerlyn Leary, PhD, and Rose Marie Perez Foster, PhD who asked us to address aspects of cultural difference between analyst and patient, to be aware of patients’ and analysts’ racial and ethnic history, and the gaps in understanding resulting from a psychotherapy conducted in a patient’s second language.

We were also fortunate to have James Fosshage, PhD, in January 2001, who presented a paper, The Organizing Functions of Dreams: Theory and Clinical Implications. This was a presentation of his particular model in which he posits that dream mentation, like waking mentation, develops, maintains, and restores psychological organization and regulates affect. He focused on an analytic case, and using rich dream material, he illustrated the shifting priorities of relational dynamics. Michael Guy Thompson, PhD in June 2001, presented The Mysteries of Termination and the Psychoanalytic treatment of Experience. The film 1919 explored the effects of Freud’s analytic technique via the recollections of the Wolf Man and a young homosexual woman whom Freud also treated. The goal of therapy and the enigmatic nature of the psychoanalytic treatment experience were explored. Our last speaker for the year, Ruth Jean Eisenbud, PhD, also presented on dreams. Entitled The Dream: “A Letter to the Self,” she used the metaphor of the dreamer as artist-in-residence: the purpose of the artist/dreamer is to deliver a picture to the dreamer regarding the self. The contexts of the psychotherapeutic relationship, the state of treatment, the current life and aspiration of the dreamer are all involved.

Our more informal Symposium Brunches were also as diverse as they were educational: Debra Bader, LCSW, in April, 2001, presented Anorexia and Bulimia: Signs that Suggest a Mystery; Marylou Lionells, PhD, May, 2001, spoke on Harry Stack Sullivan: His Relevance to Postmodern Psychoanalysis; Lenore Foehrenbach, MS, Sept. 3, 2001, presented Psychotherapy & Female Reproduction: Influences of Infertility, Technology, Medication. And of course there was our participation with SouthEast Florida Foundation for Psychoanalysis in our 8th Annual “Freud Amongst the Arts” Fundraiser in our quest to promote the availability of affordable quality mental health services in Southeast Florida. It was held June 9th, 2001, and was gratifyingly successful. It was held at The Florida Stage and included the performance of The Pavilion.

The year ahead is full of promise, as Scott Winfield, LCSW, becomes our new President. We welcome him, confident that, in his hands, SEFAPP will continue our mission to promote “...excellence through quality continuing education for all mental health professionals, professional development, and the scholarly exchange of ideas.”
The Vermont Association for Psychoanalytic Studies (VAPS) hosted its annual scientific meeting on November 10th in a spectacular natural setting in the new conference center at the Trapp Family Lodge of Stowe, Vermont. Against a picturesque background of snow falling over the orchard and on the mountains, Leston Havens, MD spoke to us about doing the work of psychoanalytic therapy. The theme for the day was The Spontaneous Moment: Moving Beyond Explanation in Analytic Therapy and Dr. Havens’ keynote address reviewed the various concepts of “therapeutic work” that have evolved over the decades: from interpretation, to empathy, to relationship and negotiation. He raised provocative questions about the authority of the analyst or therapist and asked each of us to think about our own blend of being professional and personal in the therapeutic relationship. Responding to him were Robert Emmons, MD who spoke about the therapeutic action of working through projective identification, especially using Dr. Havens’ method of “counter projection,” and Polly Young-Eisendrath, PhD who spoke about the function of self (the experience of being an individual subject) in relation to authenticity and spontaneity within and outside psychotherapy. After watching a twenty minute video of Dr. Havens interviewing a patient, we broke into small groups to discuss the ideas from the morning and the methods demonstrated in the clinical interview. The day closed with a plenary discussion and an address from our president, Melvin Miller, PhD. All in all, it was a very successful day for our local chapter.

On February 10, 2002, we will host our annual business meeting in Montpelier, Vermont, and offer an afternoon seminar with some visiting French Lacanian analysts on Saturday, February 17th. Their topic will be the tracing of intergenerational family traumas. On Saturday, May 11, 2002, we will convene for another afternoon seminar with Mary Gail Frawley-O’Dea, PhD on the supervisory relationship.

Our membership has expanded to 77 and is growing. We are a mix professionally of psychologists, psychiatrists, social workers and mental health counselors. In our upcoming scientific meetings we will host Jessica Benjamin, PhD in 2002, and Glen Gabbard, MD in 2003. Among our wish list for new developments is to offer occasional evenings of Psychoanalysis at the Movies for the general public.

The chapter decided to award a student prize to encourage graduate students submissions relevant to psychoanalytic themes. The award was to commemorate Jonathan Bloom-Feshbach, an outstanding teacher and leader in the Washington, D.C. area, whose untimely death was great loss to those who knew and studied with him. Dr. Bloom-Feshbach was dedicated to the dissemination of analytically oriented theory and research and their application in practice and in the training of psychotherapists. Announcements were mailed to disseminate information about the award in the Washington, D.C. area to directors of clinical programs and psychology departments. A panel reviewed the submissions. The 2001 Award was presented at the WPSP’s first fall program meeting. It was given to Stephanie E. Meyer, MA, a fellow at the Clinical Neuroendocrinology section of NIMH, for her paper A Developmental Psychopathology Approach to the Study of Bipolar Illness, with two other submissions receiving Honorable Mention.

Our annual Fall Workshop speaker was Steven H. Cooper, PhD. His talk on Hope and Other Perversions: The Therapeutic Dismantling of Perverse Forms Of Hope, was well attended.

Vermont Association for Psychoanalytic Studies

Polly Young-Eisendrath, PhD

Washington Professionals for the Study of Psychoanalysis

Roslyn Hirsch, PhD

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www.divpsa.org
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:

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We are pleased to announce a new task force, which will focus the clinical experience and research expertise of our Division members who have worked in the area of health psychology, or who are currently interested in doing so. Norline Johnson, the current President of APA, has identified health psychology as the primary initiative of the central organization. There is so much that psychologists have to offer patients suffering from chronic or acute pain and disability, addressing anxiety, depression, effects on intimacy and competency, etc.

However, too often psychoanalysts are marginalized or even excluded from initiatives relevant to health issues. Cognitive behavioral psychologists have commandeered attention because their clinical and research efforts often lack the complexity of our own approaches. However, psychoanalysts implicitly explore cognition and coping—the purview of cognitive-behaviorists—as only one aspect of a multi-faceted conscious and unconscious coping with physical illness and pain.

We would like to gather the people interested in the area of health psychology at the New York 2002 meeting and talk about how we can support each other’s work, possibly collaborate on projects, and further our thinking and contribution in the area of health psychology. We will announce the time and place of our conversation hour before the meeting, but welcome any preliminary thoughts about the task force’s focus and efforts.

The Journal of the American Academy of Psychoanalysis invites submission of papers on the topic of patient suicide. This special issue of the journal focuses on the effect of patient suicide on clinicians, training programs, and organizational dynamics. Papers addressing themes of professional crises arising from patient suicide, organizational responses to suicide, the effect of a patient’s suicide on the therapist’s work with other suicidal patients, or the effect of suicide on the training process or training program are welcome. This special issue will be restricted to the actuality of suicide and its impact on the clinical system. Papers concerned primarily with the effect on family and community, papers exploring the threat of suicide or the evaluation of the suicidal patient are not within the main focus of this concern - except insofar as prior experience with a suicidal patient might modify clinical work.

Papers should be approximately 15-30 pages double-spaced; brief vignettes will also be accepted for review. The submission deadline is May 1, 2002. Authors interested in preparing a paper are invited to contact the Guest Editor, Jane G. Tillman, PhD to discuss their possible submission. You may contact Dr. Tillman at Austin Riggs Center, 25 Main Street, Stockbridge, MA 01262, Phone: 413-298-5511 x213, E-mail: jane.tillman@austenriggs.net
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