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FROM THE PRESIDENT: Diagnosis and Its Discontents

Nancy McWilliams PhD

In my previous column, I advocated cooperative ventures between Division 39 and other psychoanalytic organizations. One such effort, an endeavor that has attracted both enthusiasm and controversy, is the development, spearheaded by the child psychiatrist Stanley Greenspan, of the Psychodynamic Diagnostic Manual (published June, 2006). Supported by the Division 39 Board of Directors and influenced by many of our members (Sidney Blatt, Abby Herzig, Marvin Hurvich, Bertram Karon, Herbert Schlesinger, Jonathan Shedler, Howard Shevrin, George Stricker, Joel Weinberger, Drew Westen), the PDM was a massive, daunting undertaking. Here I comment on its evolution and mention some of its assets and limitations.

Origins of the PDM

In what he was initially calling “an effort to devise a more clinically useful classification system,” Greenspan enlisted our support as well as that of the International Psychoanalytical Association, the American Psychoanalytic Association, the National Membership Committee on Psychoanalysis in Clinical Social Work, and the American Academy of Psychoanalysis and Dynamic Psychiatry. I became involved when Jaine Darwin appointed me to a committee charged with representing a psychoanalytic understanding of personality patterns and disorders.

Shepherding the undertaking along with the patience of a saint and the perseverance of the possessed, Greenspan got the job done in a mere two years. His resolve was the product of his seeing one too many high-quality psychiatric hospitals put out of business by the ubiquitous lie that there is no empirical evidence supporting psychoanalytically oriented treatments. His capacity to elicit cooperation from diverse members of a fractious discipline attests both to his leadership skills and to the depth of the dismay with which analytic clinicians view the contemporary mental health scene. The project was a labor of love pervaded by rescue fantasies toward psychoanalysis itself.

Greenspan set up task forces to address (1) adult personality structure and pathology, (2) adult symptom syndromes, (3) assessment of specific capacities implicated in mental health and illness, (4) childhood and adolescent syndromes, and (4) outcome research on psychotherapy. In addition, he solicited original papers from noted psychoanalytic scholars on the conceptual and empirical foundations for a more inferential, contextual, dimensional, holistic, biopsychosocial way of representing human psychological suffering than contemporary taxonomies permitted.

Limitations of the DSM for Practitioners

Whatever our differences, all the contributors to the PDM tended to connect the horror stories of the past quarter-century (denial of care, overprescription of favored medications, demoralization of patients when their problems fail to disappear after the six sessions they are told should be adequate) not only to the insurance industry, Big Pharma, biological psychiatrists and anti-analytic psychologists, but also to the putatively atheoretical direction of the DSM since its revision in 1980 (the shift from DSM-II to DSM-III). Reliance on descriptive psychiatry as it is embodied in the DSM and ICD systems has allowed arguments that consistently favor chemical intervention and short, symptom-focused therapies over more complex and open-ended psychodynamic, family systems, and humanistic treatments.

Our gripes with the DSM included its reification of symptom syndromes as separate “disorder” categories, split
off from conceptualization of the whole human being; its
deficient consideration of individual subjective experience;
its inclusion of only some personality types (and those
only in their most pathological versions); its reliance on
conceptualizing via externally observable traits rather
than inferred intrapsychic conflicts, developmental arrests,
dissociated self-states, and problematic cognitions, affects,
and defenses; and its developmentally unsophisticated list of
the psychological problems of children and infants. We noted
that unless one defines mental health as simply the absence
of symptoms, the DSM and ICD systems have no concept of
positive mental functioning. Consequently, they implicitly
discourage clinicians from attending to overall capabilities
such as affect tolerance and regulation, ego strength, self-
esteem maintenance, defensive maturity and flexibility, self
and object constancy, ability to mentalize, moral consistency,
capacity for intimacy, and similar endowments that analytic
therapists have long considered central to overall mental
well-being.

The DSM is a compilation of disorder categories
defined by externally observable symptoms. Even if we
accept medical metaphors for what Szasz memorably
called “problems in living,” we should note that no serious
physician would equate the amelioration of symptoms with
the healing of underlying illness or the building of healthier
structure. Yet this equation has become standard in mental
health circles, largely because of the hegemony of the DSM.
Those of us who educate therapists at the graduate level find
that our students have been uncritically taught its categories
as definitional of psychopathology, with little attention to
the intrapsychic and intersubjective contexts that those of
us of a certain age take for granted. (I find this phenomenon
particularly striking in psychology, where skepticism about
the medical and disease models implicit in descriptive
psychiatry used to pervade our textbooks.)

Freud made a critical hermeneutic corrective to
the descriptive psychiatry he inherited. By refusing, for
example, to join the prevailing dismissive attitude toward
people with hysterical and posttraumatic symptoms—by
assuming that symptoms have meaning and are not just
accidents or biological quirks or lapses in self-discipline—he
nudged psychiatric evaluation from a taxonomic enterprise
to an inferential art. The effort with the DSM, since its third
edition, to eliminate inferences about meaning, function, and
psychic causation seemed to the PDM contributors a great
leap backward, comparable to internists deciding to eschew
a concept like “diabetes” and replace it with diagnoses of
comorbid eye problems, foot problems, and chronic thirst.

**Structure of the PDM**

Although the determinedly nonanalytic DSM-III and
its followers have made some kinds of research easier
and have given practitioners of disparate orientations a
common language for psychological maladies, they have
largely impoverished clinicians trying to understand
their clients. Construing our proposed classification as a
badly needed complement to existing systems, the PDM
task forces developed sections on (1) adults, (2) children
and adolescents, and (3) infants, followed by (4) a hefty
collection of articles by conceptually integrative practitioners
(e.g., Greenspan, Wallerstein) and cutting-edge researchers
(e.g., Blatt, Fonagy, Shevrin).

In the adult and child/adolescent sections, we
presented (a) personality differences (in terms of both
level of organization and type), (b) a profile of mental
functioning, and (c) the subjective experience of each DSM
“disorder” in terms of its cognitive, affective, somatic, and
interpersonal aspects. Finally, noting that the formulation
of individual dynamics is a dying art, we included extended
conceptualizations of three clients. In the adult section,
they had similar symptoms but significantly differing
psychologies and therapeutic needs.

The infancy/early childhood section is the baby
of Greenspan and his close collaborators. It is specific,
sensitive, and useful for therapists—a welcome and scholarly
challenge to the current disposition to lump problematic
kids together in broad categories (ADD, bipolar disorder),
ignoring the nuances of differing capabilities and implicitly
discouraging interventions tailored to the needs of particular
children and families.

The articles in the conceptual and research
foundations section were solicited with a view to their value
for teaching students of psychotherapy, but in addition,
they have the political aim of demonstrating that there is an
extensive empirical basis for psychoanalytic inference and
treatment orientation.

To keep the cost as low as possible, with students
in mind, Greenspan opted for self-publishing the final draft,
which is available at www.pdm1.org for $32.00. The down
side of this decision was that the PDM lacked the copy
editing and marketing services of a publishing house. Robert
Wallerstein and I therefore did the copyediting; publicity for
the PDM will have to depend on word-of-mouth advertising.

**Future Revisions**

The manual is a work in progress, our best first effort.
We hope it will be followed, pending sufficient feedback
from the professional community, by improved versions.
Division 39 members interested in participating in
revisions are welcome to volunteer. Greenspan is setting
up a Web site to which criticisms and comments can
be sent; in the meantime, they can go directly to him
(stanleygreenspanmd@comcast.net) or me (nancymcw@
aol.com). Daniel Plotkin at UCLA Medical Center has
already advised us of a major flaw: in this avowedly developmental document, we include infancy, childhood, adolescence, and adulthood. Where are the elderly? In view of the average age of those of us on the steering committee, one can only conclude that a massive amount of denial was at work. The idea of including a section on elderly patients never occurred to us!

The creators of the PDM do not expect it to triumph in the mental health marketplace. We have no illusions that insurance companies and pharmaceutical corporations will flock to embrace a dimensional, contextual, subjectively attuned, inferential diagnostic formulation in preference to the discrete categories they have every reason to prefer. Nevertheless, we consider it a worthy enterprise to have made explicit many psychoanalytic ways of construing individual differences and psychological pain that, despite the ever-increasing empirical support for many psychodynamic concepts, have virtually disappeared from the training of most mental health professionals.

This is as much of a description of the PDM effort as this space permits. Wallerstein is currently supervising the preparation of a more comprehensive set of articles intended for publication in the American Psychologist. I am hopeful that the PDM has called into question some of the reifications of the DSM and opened for students of psychotherapy a wider window on the many dimensions of human mental suffering.

**Shortcomings of the PDM**

There are grave limitations in any effort to systematize and assign labels to the infinitely variable manifestations and meanings of human psychological experience. In the effort to expose and compensate for the reifications of the DSM, the contributors to the PDM have argued for concepts that can perhaps be just as destructively reified. It is arguable that the very paradigm of empirical science in which the PDM locates itself has problematic unintended consequences.

Irwin Hoffman, in a plenary address to the American Psychoanalytic Association, has, among other concerns, questioned the premise of the whole project and worried publicly about the implications of our presuming to define mental health. At the Toronto meetings, he, Ann d’Ercole, and Gary Walls critiqued the PDM for, among other things, buying into a social construction that should provoke critical analysis rather than uncritical participation in the same illusions that gave us other flawed taxonomies (see the synopsis of that panel in this issue on page 32).

I welcome this conversation and invite more contributions to it. Psychoanalytic discourse and practice occupies an interesting space between science and art, philosophical sophistication and commonsense pragmatism, theory and metaphor, positivism and phenomenology. Freud may have positioned psychoanalysis solidly within an Enlightenment vision of ultimate scientific rationality, but the therapeutic sensibility he inaugurated, which is so essentially a meaning-making activity, does resist being represented fully by any classification system, however comprehensive and however empirically supported.

**Next Presidential Column**

In my fall column, I hope to address the interrogations issue over which so many Division members are now agonizing. Once I know the fate of the proposed, Division-supported moratorium on psychologists’ involvement in interrogations, which will be decided at the San Francisco APA convention, I expect the moral context to be clearer, and I look forward to trying to grapple with it here.

---

**Guidelines for Submitting Material**

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.

**Advertising**

Psychologist-Psychoanalyst accepts advertising from professional groups, educational and training programs, publishers, etc. Ad copy must be in camera-ready form and correct size. Rates and size requirements are: $400 full page 7.5” x 9”; $250 half page 7.5” x 4.5”; $150 quarter page 3” x 4.5”. Checks should be made payable to Division 39 and mailed along with camera-ready copy.

**Deadlines**

Deadline for all submissions is October 1, January 1, April 1 or July 1. Issues generally appear 5-6 weeks after deadline date.

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**Copy Editor**

ANGELYN BALE, PhD
DIVISION OF PSYCHOANALYSIS (39)
28th ANNUAL SPRING MEETING

April 9–13, 2008
The Waldorf Astoria, New York, NY

Were we able to prevail upon Freud to address us, he might smile at our deliberations about repression, disavowal and dissociation. He might wryly remind us that as early as 1893 he had already described the “blindness of the seeing eye” as an experience in which “one knows and does not know a thing at the same time”.

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

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

FOR EACH SUBMISSION:

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

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| Discussion Hour* | 50 minutes |
| Poster Session** | 2 hours    |
|                  | 150 words  |

NOTES:

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

Send all submissions to: Division 39 Spring Meeting

c/o Natalie P. Shear Associates, 1730 M Street, NW, Suite 801, Washington, DC 20036.

DEADLINE FOR SUBMISSION: POSTMARKED BY SEPTEMBER 7, 2007
LETTERS TO THE EDITOR

I am writing to respond to the recent open letters published in Psychoanalytic Psychology by Drs. Altman, Davies, and Hoffman. I feel it important to clarify my position because Dr. Hoffman mentions me by name as one of the panel participants at the Division 39 New York meeting in April 2005. As a member of the executive board of the Canadian Psychological Association’s Section on Psychoanalysis and Psychoanalytic Psychology, I was invited to give a paper along with Dr. Mills. I presented a now published work on the role of agency in the relational and interpersonal traditions of psychoanalysis.

My talk was not a focus of discussion following the presentations, but I experienced first-hand the nature of the commentary. I found it unsettling and not appropriate to an academic setting. I thank Drs. Davies and Hoffman for clarification of their views in their open letters because I had difficulty following what was said at the time.

Of much greater concern to me, however, is the way in which this interchange, direct and indirect, published and unpublished, has developed over the past two years. Psychoanalysis, besieged as it is from myriad economic, political, and organizational forces can ill afford a breakdown of discourse amongst its own members. As the fractious history of psychoanalytic politics suggests, the “plea for constructive dialogue” needs to be heeded by all. I sincerely hope that this set of unfortunate events can be put behind us and we can get on with the task at hand, namely articulating the importance of psychoanalysis as a valuable clinical and theoretical discipline.

Roger Frie, PhD, PsyD
William Alanson White Institute

We are writing to announce the good news that Psychological Issues has a new publisher (Rowman & Littlefield). Arthur T. Pomponio is the Editorial Director. We are committed to continuing and re-vitalizing the tradition of excellent monographs and books that have appeared over the years since George Klein, Robert Holt and their outstanding editorial board founded the monograph series in 1958, with International Universities Press as the publisher. There have been many notable publications in this series. In fact, the list of authors reads like a “Who’s Who” of prominent contributors to the field. The roster includes, in alphabetical order, Robert Emde, Erik Erikson, Merton Gill, Stanley Greenspan, Adolph Grunbaum, Heinz Hartmann, Fritz Heider, Robert Holt, Phil Holzman, Lawrence Kubie, Michael Polanyi, David Rapaport, Benjamin Rubinstein, Robert White, and Peter Wolff.

Although Psychological Issues was a paperback monograph series for many years, in more recent times it has been published in separate, hardbound volumes. We are now able to accept manuscripts that would be suitable for either monograph or book length publication. The title “Psychological Issues” is apt for although most of the series has been devoted to psychoanalytic topics, the interests of the editors and the editorial board include topics that are not directly psychoanalytic in nature but can inform psychoanalytic thinking. Examples of excellent monographs in this category include the ones by Fritz Heider and Michael Polanyi. We are open to a wide range of first-rate contributions of a theoretical, clinical, or research nature.

There are two main criteria for accepting a manuscript for publication. First, in the judgment of the editor, in consultation with the editorial board and outside reviewers, the manuscript reflects excellent scholarship on a topic of significant interest. Second, the publisher has to believe that the book or monograph will have sufficient sales to make it worthwhile from an economic standpoint.

We invite you to contact us if you have a manuscript that you think would be suitable for publication in the series. We would also appreciate suggestions as to others who you think should be contacted for possible manuscripts. Please address any correspondence to David Wolitzky, PhD, Editor, Psychological Issues, Department of Psychology, New York University, 715 Broadway, Suite 204, New York, NY 10003.

David Wolitzky, PhD
Morris Eagle, PhD

At the Spring Meeting in Toronto this past April, the presenters for Section III’s Panel were Marsha Levy-Warren and Eileen A. Kohutis. Finding a discussant for the papers was an important task—one that we were able to complete when Rita Frankiel agreed to take on this responsibility. We were thrilled that Rita was willing to be part of our panel. Prior to her accepting to be the moderator on the panel, Rita and I spoke of my interest about the loss of a mother and in those conversations I found her to be warm, generous, and giving. The breadth of her knowledge was vast and comprehensive.

In the discussion of the papers in the panel, Rita’s comments about both Marsha’s and my paper revealed her sensitivity and insight about our topics; and this, in turn, generated an enthusiastic response from the audience. Working on this panel was truly a delight.

On behalf of the members and the Board of Section III, I would like to extend my deepest sympathy to her husband, Roy Schafer, and to their family. She will be greatly missed.

Eileen A. Kohutis, PhD
President, Section III
PSYCHOANALYTIC RESEARCH: PROGRESS AND PROCESS
DEVELOPMENTAL AFFECTIVE NEUROSCIENCE AND CLINICAL PRACTICE

ALLEAN N. SChORE, Phd

Over a number of years members of my study groups and I have used this column to offer contributions to psychoanalytic research, especially as it relates to clinical practice. I have suggested that an integration of psychoanalytic information with observational studies and experimental data from the disciplines that border our field, especially neuroscience, can offer a deeper understanding of both the function and structure of the human unconscious. Psychoanalytic research informed by interdisciplinary knowledge can be not only experimental but theoretical, capable therefore of acting as a fertile source to both pragmatic clinical applications and to the generation of testable hypotheses. In this column I use a perspective from neuropsychoanalysis and affective neuroscience in order to offer a model of clinical expertise.

CLINICAL EXPERTISE: INTRODUCTION—THE PRIMACY OF AFFECT

There is currently a palpable sense that psychoanalysis is undergoing a significant transformation, indeed a paradigm shift. A powerful engine for the increased energy and growth in the field is the ongoing dialogue it is having with neighboring disciplines, especially the developmental sciences and neuroscience. This mutually enriching communication is centered on common interests in the critical role of relational-emotional contact between humans, the impact of these processes on brain systems that regulate bodily-based survival functions, and the primacy of affect. In a recent editorial of the journal Motivation and Emotion, Richard Ryan asserts,

After three decades of the dominance of cognitive approaches, motivational and emotional processes have roared back into the limelight. Both researchers and practitioners have come to appreciate the limits of exclusively cognitive approaches for understanding the initiation and regulation of human behavior . . . More practically, cognitive interventions that do not address motivation and emotion are increasingly proving to be short-lived in their efficacy, and limited in the problems to which they can be applied. (2007, p. 1)

Although Freud argued that the work of psychotherapy is always concerned with affect, until recently psychoanalytic conceptualizations of the change process have been dominated by models of cognition, too frequently focused only on verbal, conscious cognition. During this period of cognitive dominance, clinical applications of advances in theory mainly involved an attempt to construct more efficient interpretations, in order to more effectively make unconscious content conscious to the patient. This emphasis on verbal content and insight as the major change mechanism thereby focused on improving the analytic processing of the patient’s (and therapist’s) left hemisphere. In contrast to the prevailing privileged status of verbal, conscious cognition, in my first book I suggested that affects are at the psychobiological core of the therapist’s empathic emotional communications, that the regulation of conscious and unconscious feelings is placed in the center of the clinical stage, and that right brain emotional processes are essential to development, psychopathology, and psychotherapy (Schore, 1994).

At this point in time all forms of psychotherapy are emphasizing the centrality of affect. Yet in contrast to other clinical approaches, psychoanalysis, the science of unconscious processes, places not just conscious but unconscious affect at the core of the therapeutic mechanism. If in the recent past psychology as a whole trivialized the concept of the unconscious, current neuroscience now is focusing on the critical role of affective processes that lie beneath levels of conscious awareness, an area of intense interest to Division 39.

Neurobiological studies are now reporting that only the right and not left hemisphere responds to preattentive negative emotional stimuli (Kimura, 2004), and are describing a “right hemispheric dominance in processing of unconscious negative emotion” (Sato & Aoki, 2006) and a “cortical response to subjectively unconscious danger” (Carretic, 2005). Indeed, even cognitive science is now asserting that “approaches to emotion require a theory of unconscious subjectivity to handle the case of unconscious emotion” (Neisser, 2006, p. 1). These data clearly imply that a patient’s inability to consciousness experience an ongoing state of unconscious danger and to regulate unconscious negative affect is a primary target of treatment.

An organizing principle of regulation theory is that attachment communications are implicit, affective and nonverbal, and that unconscious affect regulation plays a critical psychobiological role within mother–infant and patient–therapist dyads (Schore, 1994, 2003). A young infant functions in a fundamentally unconscious way, and unconscious processes in an older child or adult can be traced back to the primitive functioning of the infant. This neuropsychoanalytic perspective argues that
both optimal development and effective psychotherapy promote an expansion of the complexity of the right brain implicit self, the psychobiological substrate of the human unconscious. This right lateralized system is dominant for the regulation of affect and bodily states, stress, empathy, pain, intersubjectivity, self-awareness, intuition, creativity, and humanness. As compared with classic cognitive and behavioral approaches, psychodynamic treatment is conceptualized to act as a growth-facilitating environment for not left brain conscious emotion regulation but right brain unconscious affect regulation.

Over the course of my writings I have integrated data from a number of sciences with the rich history of psychoanalytic clinical observations to suggest that the right hemisphere, “the locus of emotional brain,” represents the early developing unconscious system described by Freud. This model emphasizes not left hemisphere conscious verbal content, but right hemisphere nonconscious affective process, not mental states of mind but psychobiological states of mind–body. Recent studies of the early developing right brain demonstrate the unique capacities of right–lateralized cortical–subcortical systems in the processing and regulation of affects at all points of the lifespan and in all intimate contexts, including the therapeutic alliance.

This organizing principle of affective dynamics has direct implications for the treatment of all forms of psychopathology, especially early forming personality disorders. These more severely disturbed patients lack a reflective function, and are refractory to insight–driven cognitive interventions. The effective treatment of patients whose subjectivity is dominated by chronic dysregulated unconscious affects requires much more than clinical techniques that focus on “content analysis” and accurate interpretations in order to change self cognitions.

As Alvarez (2006) describes this shift in treatment approach, “Schore points out that at the more severe levels of psychopathology, it is not a question of making the unconscious conscious: rather it is a question of restructuring the unconscious itself” (p. 171).

There is now extensive evidence to show that unconscious processing of emotional stimuli is specifically associated with activation of the right hemispheric implicit self (Schore, 2005). Decety and Chaminade’s (2003) overview of the adaptive functions of this hemisphere also describe essential elements of the psychotherapy change process:

Mental states that are in essence private to the self may be shared between individuals . . . self-awareness, empathy, identification with others, and more generally intersubjective processes, are largely dependent upon . . . right hemisphere resources, which are the first to develop. (p. 591)

The current paradigm shift into the nonconscious affective-relational functions of the right brain has direct bearing upon the underlying mechanisms of the change process as it is expressed in the intersubjective field. This perspective highlights the clinician’s role as a co-participant in the creation of the therapeutic alliance, and as a regulator of the patient’s dysregulated affective states. A just published study in the American Journal of Psychiatry reports that an affective treatment focus is critical to therapeutic effectiveness, and that “the more therapists facilitate the affective experience/expression of patients in psychodynamic therapy, the more patients exhibit positive changes” (Diener et al., 2007, p. 939). As a result of their analysis of a large body of psychotherapy process-outcome research they conclude, “research indicates that contemporary psychodynamic therapies place greater emphasis on encouraging experience and expression of feelings compared with cognitive behavior therapies” (2007, p. 936).

With this paradigm shift from cognition to affect and from left to right brain functions, the important question of what makes an effective therapist must now be reformulated. What types of therapist expertise allow for effective reception and expression of unconscious nonverbal affective communications? Why are certain therapists more capable of co-creating a therapeutic alliance with a broader array of different types of patients? Which therapeutic skills are required for clinical efficacy, especially in working with the deficits in affective processing that routinely accompanies the attachment pathologies of early onset severe personality disorders? How do we define clinical expertise that promotes this expansion of the right brain human unconscious?

In upcoming sections, I will discuss the implications of the paradigm shift for models of clinical expertise. I will provide recent interdisciplinary data which indicates that the therapist’s right (and not left) brain generates the essential components of this expertise. These right brain functions of the skilled therapist act on implicit levels: clinical sensitivity, defined as the ability to receive and express nonverbal affective communications; clinical empathy and the therapist’s right brain activity within the intersubjective field; clinical intuition, and the therapist’s capacity for interactive affect regulation. All technique sits atop the therapist’s ability to access the implicit realm. A developmental neuropsychoanalytic perspective suggests that the art and science of psychotherapy are directly linked to the functioning of the clinician’s right brain, which deepens and expands with clinical experience.
CLINICAL EXPERTISE: SENSITIVITY - THERAPIST’S ABILITY TO RECEIVE AND EXPRESS RIGHT BRAIN NONVERBAL AFFECTIVE COMMUNICATIONS

It is now well established that the therapist’s ability to form an alliance is possibly the most crucial determinant of her effectiveness. According to Safran and Muran (2000), “after approximately a half century of psychotherapy research, one of the most consistent findings is that the quality of the therapeutic alliance is the most robust predictor of treatment success” (p. 1). In this current period of increased emphasis on “evidence-based practice,” Karver et al. (2006) performed a meta-analysis of therapeutic relationship variables and asserted:

The empirically supported treatment movement has largely ignored more universal aspects of the therapeutic process that may be of even greater importance to treatment outcomes. [C]ommon process factors reportedly account for 30% of the variance in adult treatment outcomes, above and beyond the 15% of variance accounted for by specific techniques. Furthermore, empirical research suggests that one common process factor, the therapeutic alliance, is among the most robust predictors of treatment outcomes for both adult and young clients. (pp. 50-51)

This research is mirrored in current relational and attachment models in psychoanalysis. It has also been incorporated into a recent APA Presidential Task Force on Evidence-Based Practice (2006), which concludes that “psychological practice is, at root, an interpersonal relationship between psychologist and patient” (p. 277). They note an essential task of the clinical expert is to monitor the therapeutic alliance:

Central to clinical expertise is interpersonal skill, which is manifested in forming a therapeutic relationship, encoding and decoding verbal and nonverbal responses, creating realistic but positive expectations, and responding empathically to the patient’s explicit and implicit experiences and concerns. (p. 277, my italics)

In line with this description, I have demonstrated that implicit attachment communications are expressed within the therapeutic alliance, and that they are expressed in ultra-rapid transactions of nonverbal facial expressions, gestures, and prosody between the patient’s and therapist’s right brains (Schore, 2005). Furthermore, with intimations of failed manualized treatment attempts, the APA Task Force reports that “Research suggests that sensitivity and flexibility in the administration of therapeutic interventions produces better outcomes than rigid application of . . . principles” (p. 278, my italics).

The concept of sensitivity is, of course, also important in the developmental attachment literature, where Ainsworth (1978) referred to the importance of the mother’s “sensitive responsiveness to infant signals and communications.” According to Van den Boom (1997) the sensitive caregiver packages her social interactive behavior in such a way in the interaction flow that it promotes rather than interrupts the exchange. These authors then expanded the concept, stating, “It would be more fruitful to think of sensitivity not as a parenting dimension that exists apart from other dimensions, but rather, as permeating all interactive behavior” (p. 593). This surely includes the sensitive clinician’s interactive behavior within the attachment bond co-created within therapeutic alliance.

In more recent attachment research Schachner, Shaver, and Mikulincer (2005) propose that sensitivity to a relationship partner’s nonverbal behavior directly influences the quality of interpersonal interactions and relationships, including all forms of attachment relationships. These authors point out that “adult attachment researchers have not paid much attention to patterns of nonverbal behavior and sensitivity” (pp. 147-147, my italics). Indeed, the findings of Roter et al. (2005) on the central role of the expression of emotion through nonverbal behavior in the physician-patient relationship applies directly to the therapist-patient relationship: “High-context communication depends on sensitivity to nonverbal behaviors and environmental cues to decipher meaning, while low-context exchanges are more verbally explicit, with little reliance on the unstated or nuanced” (p. S28).

In writings on “the art of psychotherapy” Bugental (1987) asserts,

The primary instrument brought to the support of the client’s therapeutic efforts is the therapist’s trained, practiced, and disciplined sensitivity. In many ways, this sensitivity is akin to a musical instrument which must be carefully prepared, maintained, tuned, and protected. With experience it can make possible the detection of nuances and feelings that would quite elude any attempt at explicit documentation, the drawing of inferences which are intimately in harmony with the client’s subverbal experiencing, and the phrasing of interventions in terms exquisitely fitted to the client’s needs, both in the moment and long-term. (p. 222)

The dictionary definition of sensitivity is “susceptible to the attitudes, feelings, or circumstances of others; registering
very slight differences or changes of emotion “ (American Heritage Dictionary, my italics). Bugental’s (1987, p. 267) proposal that the therapist’s sensitivity allows her to “learn to experience finer and finer distinctions or nuances” and to “pick up faint hints of emotions” reflects Reik’s (1948, p. 141) earlier suggestion that clinical skill requires that the clinician is ready to “trust tiny stimuli and register tiny impressions” that may be “hardly noticeable.” From a neuropsychoanalytic perspective, I have described operations of the therapist’s right brain by which “the sensitive clinician’s oscillating attentiveness is focused on barely perceptible cues that signal a change in state, and on nonverbal behaviors and shifts in affects” (Schore, 2005, p. 845).

Neuropsychological studies of emotionally toned stimuli presented too rapidly for conscious identification indicate “greater sensitivity in the right than left hemisphere” (Snodgrass & Harring, 2004-2005, p. 318). Describing the unique operations of the right hemisphere in “preconscious processing” these authors note,

Evidence from a variety of sources indicates that certain aspects of stimuli can be processed preattentively, and that conscious awareness is not necessary for a stimulus to influence behavior. Moreover, in some situations stimuli presented below awareness are more influential than information that is presented at an individual’s level of awareness. One such factor that seems to have a reliable pre-attentive influence is the attitudinal or emotional quality of the stimulus. (p. 318)

Congruent with my model of a common neurobiological mechanism underlaying maternal and clinical sensitivity to right brain-to-right brain implicit nonverbal communications of facial expressions, prosody and gesture, Jacobs (2005) details the problem of focusing exclusively on verbal exchanges, while neglecting “nonverbal behavior in the therapeutic process”:

Conveyed through posture, gesture, and movement, in facial expressions, in the tone, syntax, and rhythm of speech, and in the pauses and silence . . . these unconscious communications anticipated both subsequent conscious recognition in patient and (therapist) of the affects and fantasies to which they referred and the later verbalization of this material (p. 181). . . . They operated . . . as an early signal system for affects that were approaching, but had not yet reached consciousness. (p. 182)

Just as the left brain communicates its conscious states to other left brains via linguistic behaviors, so the right brain communicates its unconscious states to other right brains that are tuned to receive its communications. Clinical sensitivity thus relates to the depth and breadth of the therapist’s capacity to psychobiologically attune to an array of conscious and especially unconscious affective states. This sensitivity to not only unconscious verbal content but unconscious psychobiological process directly relates to Freud’s assertion that the clinician must “turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient . . . so the doctor’s unconscious is able . . . to reconstruct [the patient’s] unconscious” (1912, p. 115).

**Clinical Expertise: Empathy and Therapist’s Right Brain Activity Within the Intersubjective Field**

Recall the APA Task (2006) assertion that the clinical expert is capable of “responding empathically to the patient’s explicit and implicit experiences and concerns.” Stimulated by the groundbreaking explorations of Kohut, a large body of observations within psychoanalysis now definitively indicates the central role of empathy in the change process. I refer the reader to my discussions of the critical role of psychobiological-affective (in contrast to purely cognitive) empathy in my books (Schore, 1994, 2003). Meares (2005) concludes that the therapist’s capacity for empathy is the principal agent of beneficial change in the patient. In summarizing the field, Watt (2005) now asserts that empathy has been long hypothesized as a critical, and possibly the most critical, outcome variable from the therapist’s side.

This well-established clinical principle is supported in current studies demonstrating that perceived clinician empathy is associated with decreased psychological problems and increased health-related behaviors (Cape, 2001), whereas an absence of perceived empathy is one of the best indicators of poor psychotherapy outcome (Mohr, 1995). Interestingly, clinical empathy is now being studied not only in psychoanalysis, clinical psychology, and psychiatry but also in internal medicine, where studies demonstrate the importance of nonverbal emotional transactions in the patient-physician relationship (Larson, 2005).

In line with the above-mentioned emphasis on psychobiological affective states, research is focusing on the physiological correlates of perceived therapist empathy and social-emotional process during psychotherapy (Marcé et al., 2007). Adler (2002) links the therapist’s affect attunement, defined as the regulation of physiology, and clinical empathy. Citing neurobiological studies of attachment (including my own work), he argues that the clinician’s use of the empathic process directly affects the patient’s psychobiology.

Because people in a caring, (i.e., empathic)
relationship convey emotional experiences to each other, they also convey physiological experiences to each other, and this sociophysiolgic linkage is relevant to understanding the direct physiologic consequences of caring in the doctor–patient relationship. (Adler, 2002, p. 182)

Even more specifically, Adler provides evidence to show that individuals in an empathic relationship co-regulate each other’s autonomic nervous system activity. In this manner, empathic sociophysiolgic connections within the therapeutic relationship reduce the patient’s stress-induced affective arousal.

Neuroscience is also contributing to a deeper understanding of affective empathy. In line with the accepted clinical principle that “the most striking evidence of successful empathy is the occurrence in our bodies of sensations that the patient has described in his or hers” (Havens, 1979, p.42), current models of somatic countertransference hold that the therapist decodes nonconscious communications of the patient’s right-lateralized unconscious mind by actual felt (somatic) emotional reactions, by a form of empathic responding (Schore, 2003). Indeed a growing body of neurobiological research reveals that the right hemisphere is dominant for affective empathy (Schore, 1994; Leslie, Johnson-Frey, & Grafton, 2004; Shamay-Tsoory et al., 2005).

Recall that not only empathy but also intersubjectivity is dependent upon right hemisphere function (Decety & Chaminade, 2003). In light of the ongoing relational emphasis in psychoanalysis, there is an intense interest in the essential neuropsychoanalytic processes that occur at the interface of two subjectivities. (Ginot, 2007). In my own work I have argued that the empathic therapist resonates with the patient’s spontaneous implicit nonverbal expressions of engagement and disengagement within the co-constructed intersubjective field. More than explicit left brain-to-left brain verbal communications, implicit right brain-to-right brain intersubjective transactions lie at the psychobiological core of the intersubjective field.

Bugental (1987) describes the clinical expertise involved in such explorations of the “depths of the patient’s subjectivity”:

Concentrating work in this area distinguishes therapists more deeply engaged with their patients, just as it challenges them with the most difficult and personally confronting issues . . . much of this realm is implicit rather than explicit (p. ix) . . . This focus calls for continual attention to the patient’s inner experiencing, and it recognizes that the prime instrument needed for that attention is the therapist’s own subjectivity. (p. 3)

In a similar conception, Whitehead (2005) notes, “every time we make therapeutic contact with our patients we are engaging profound processes that tap into essential life forces in our selves and in those we work with . . . Emotions are deepened in intensity and sustained in time when they are intersubjectively shared. This occurs at moments of deep contact.” (p. 624, my italics)

During heightened affective moments these right brain intersubjective dialogues between the relational unconscious of both the patient and therapist (like the attachment communications of the infant and mother) are examples of “primary process communication” (Dorpat, 2001). According to Dorpat, “The primary process system analyzes, regulates, and communicates an individual’s relations with the environment” (p. 449). Furthermore,

[A]ffective and object-relational information is transmitted predominantly by primary process communication. Nonverbal communication includes body movements (kinesics), posture, gesture, facial expression, voice inflection, and the sequence, rhythm, and pitch of the spoken words. (Dorpat, 2001, p. 451)
Interestingly, in addition to psychoanalytic authors who have implicated the right brain in primary process functions (see Schore, 1994), neuroscience researchers now contend that “the right hemisphere operates in a more free-associative, primary process manner, typically observed in states such as dreaming or reverie” (Grabner et al., 2007, p. 228).

The capacity of the empathic clinician’s right brain primary process system to make not surface but deep contact of mind and body within the intersubjective field is critical to the depth of the change process activated in the therapeutic growth-facilitating environment.

**Clinical Expertise: Right Brain Source of Clinical Intuition**

Developmental psychoanalysis and neuropsychoanalysis can also make important contributions to our understanding of the sources and mechanism of clinical intuition. With allusions to the right brain, Orlinsky and Howard (1986, p. 343) contend that the “non-verbal, prerational stream of expression that binds the infant to its parent continues throughout life to be a primary medium of intuitively felt affective—relational communication between persons.” There are thus direct commonalities between spontaneous interactions of an intuitive psychobiologically attuned primary caregiver and an intuitive therapist’s sensitive responsiveness to the patient’s unconscious nonverbal affective bodily-based intersubjective communications.

In the cognitive sciences current models of intuition now include the concept of “embodied cognition.” Allman et al. (2005, p. 370) assert, “We experience the intuitive process at a visceral level. Intuitive decision-making enables us to react quickly in situations that involve a high degree of uncertainty which commonly involve social interactions.” In the cognitive neuroscience literature Volz and von Cramon (2006) conclude that intuition is related to the unconscious, and is “often reliably accurate.” It is derived from stored nonverbal representations, such as “images, feelings, physical sensations, metaphors” (note the similarity to primary process cognition). Intuition is expressed in not language but “embodied” in a “gut feeling” or in an initial guess that subsequently biases our thought and inquiry. “The gist information is realized on the basis of the observer’s implicit knowledge rather than being consciously extracted on the basis of the observer’s explicit knowledge” (p. 2084).

Indeed, the definition of intuition, “the ability to understand or know something immediately, without conscious reasoning” (Oxford English Dictionary), clearly implies right and not left brain processing. In the clinical literature it is now thought that

There is a crucial difference between attending to patient reports of subjective experience and actually coming into immediate intersubjective communication . . . [This means] being open to intuitive sensing of what is happening in the patient back of his words and, often, back of his conscious awareness. (Bugental, 1987, p. 11)

Marcus (1997, p. 238) observes, “The analyst, by means of reverie and intuition, listens with the right brain to the analysand’s right brain.” Supporting this proposal, research indicates that the right lateralized frontal-insula and anterior cingulate relay a fast intuitive assessment of complex social situations in order to allow the rapid adjustment of behavior in quickly changing social situations (Allman et al., 2005).

In his last work Bowlby (1991, p. 16) speculated, “Clearly the best therapy is done the by therapist who is naturally intuitive and also guided by the appropriate theory.” This theory should include neuropsychoanalytic understandings of the therapist’s right brain, which are describing the underlying unconscious psychobiological mechanisms of clinical intuition itself.

**Clinical Expertise: Therapist’s Right Brain Affect Regulation Essential to the Change Process**

Throughout my writings I have provided a large body of clinical data and experimental evidence to show that implicit interactive affect regulation, the psychoneurobiological mechanism of attachment, is a central organizing principle of development at all points of lifespan, including the change process of therapy. The relevance of developmental attachment studies to psychotherapeutic process lies in the commonality of implicit intersubjective implicit right brain-to right brain affect communicating and regulating mechanisms in the caregiver–infant relationship and therapist–patient relationship. A good deal of this work has focused on the commonality of the unconscious affect dysregulating mechanisms in the stressed insecure infant and the symptomatic patient. In this contribution I have concentrated on common right brain mechanisms in the growth-facilitating environment created by the secure mother and the expert clinician. These neuropsychoanalytic data are now being incorporated into clinical models (e.g., Siegel, 1999; Cozolino, 2002; Ragan, 2006; Wilkinson, 2006; Ginot, 2007).

At the psychobiological core of the therapeutic alliance is the attachment bond of emotional communication and affect regulation. The therapeutic alliance is now defined as the regulation of the collaborative relationship between patient and analyst. In this intersubjective right brain-to-right brain relationship, the psychobiologically attuned clinician’s implicit regulation of
a variety of negative and positive affective states allows the patient, at a nonconscious level, to experience an increasing level of trust and safety. Clinician’s vary in this regulatory capacity, just as mother’s do. A recent study of the NICHD Early Child Care Research Network (2004, p. 4) reports, “Some caregivers may be better able to help their young children learn to use and manage potent affects, whereas others may be less skilled.”

This same principle applies to variations in affect regulatory skills amongst clinicians (of whatever form of psychotherapy). This skill is most highly cultivated in clinical experts, whose effectiveness in the short term effectively reduces a patient’s traumatic affective symptomatology, or in the long term efficiently alters the developmental trajectory of an early forming personality disorder associated with a history of attachment trauma. Such clinical expertise is directly related to the therapist’s right brain adaptive capacity to implicitly process and regulate the patient’s dysregulated negative affect states. Recall that the APA definition of clinical expertise refers to an ability to form a therapeutic relationship, to encode and decode nonverbal responses, and to respond empathically to the patient’s implicit experiences and concerns (APA Presidential Task Force on Evidence-Based Practice, 2006). It is well known that patients with borderline personality disorder (essentially a disorder of affect regulation) have the most difficulty engaging in a therapeutic alliance, and that more experienced therapists are better able to develop alliances with such patients.

A fundamental tenet of current clinical psychoanalytic models, especially with more disturbed patients is that in moments of “deep contact” the therapist’s unconscious will (and should) have a significant impact on the patient’s. At moments of deep contact within the intersubjective field, the resonance between the patient’s relational unconscious and the clinician’s relational unconscious produces an amplification of arousal and affect, and so unconscious affects are deepened in intensity and sustained in time. The increase in intensity (energetic arousal) thus allows bodily-based affects beneath levels of awareness to emerge into consciousness of both members of an intimate dyad. This right brain-to-right brain intersubjective psychobiological context thus generates heightened affective moments, (i.e., “moments of meeting”). A direct corollary of this neuropsychoanalytic model is the complexity of the patient’s right brain unconscious can only go as far as the therapist’s unconscious. This joint exploration takes them out of the left and deeper into the right-lateralized cortical and subcortical realm of the biological substrate of the unconscious.

According to Van Lancker and Cummings (1999, p. 96), “Simply stated, the left hemisphere specializes in analyzing sequences, while the right hemisphere gives evidence of superiority in processing patterns.” This brings up the question, beneath the patient’s verbal sequences, what kinds of right brain patterns is the sensitive clinician implicitly attending to and regulating? Maroda (2005) notes Freud posited that transference represents an established pattern of relating and emotional responding that is cued by something in the present. Neuropsychoanalytic models describe nonverbal emotional transference–countertransference transactions between the right brain implicit self of the patient and therapist. Recall, “adult attachment researchers have not paid much attention to patterns of nonverbal behavior and sensitivity” (Schachner et al., 2005). In my first book I concluded, “The core of the self lies in patterns of affect regulation that integrate a sense of self across state transitions, thereby allowing for a continuity of inner experience” (Schore, 1994, p. 33). The therapist’s preconscious tracking of right brain patterns thus represents a self monitoring of psychotherapy “process” (versus left brain verbal “content”).

A dictionary definition of regulation describes its psychological function: “the action or process of regulating a thing or person; the state of being regulated” (The New Shorter Oxford). Interactive regulation consists of two separate processes: affect synchrony that establishes and maintains positive affective states, and interactive repair that minimizes negative affective states and allows recovery from affective ruptures of the attachment bond. Clinician’s vary in not only an implicit capacity for negative and positive affect tolerance, but also in the ability to implicitly regulate negative and positive affect states. Bennett et al. (2006): observe, “Because clients are vulnerable to iatrogenic deterioration and intolerant of therapeutic errors, therapist skill is likely to be a major factor. Irrespective of therapy type, competence in the task of resolving alliance threats and ruptures is a key to helping these clients towards a successful therapeutic outcome” (p. 396).

In a similar vein Stark (1999) notes, “The therapist’s handling of the feelings the patient projects requires considerable effort, skill, and strain on the therapist’s part, because the feelings with which the patient struggles are highly charged, painful areas of human experience that are probably as conflictual for the therapist as they are for the patient.” (p. 276). This clinical skill of “handling” the patient’s feelings involves the therapist’s capacity to autoregulate these painful affects. Like the securely attached mother, the empathic psychobiologically attuned clinician’s regulation of the patient’s affective- arousal states is critical to transforming the patient’s insecure nonconscious internal working model that encodes strategies of affect regulation.
At the beginning of this column I proposed that the current paradigm shift into the nonconscious affective-relational functions of the right brain has important implications for models of the psychotherapy change process. Regulation theory clearly suggests that especially in cases of early forming severe psychopathologies, the therapist’s role is much more than interpreting either relational distortions of the transference, or unintegrated affective-laden attachment experiences that occur in incoherent moments of the patient’s narrative. We need to go beyond objectively observing the disorganization of left brain language capacities by dysregulating right brain states and feeding this back to the patient in insight-oriented interpretations. Rather, we can directly engage and therefore regulate the patient’s inefficient right brain processes with our own right brains.

Clinical sensitivity, empathy, intuition, and affect regulation are all manifestations of the therapist’s emotional intelligence, the adaptive capacity by which emotions are perceived, understood and used to guide effective human behaviors. This function, which is distinct from cognitive intelligence, is mediated by the processing of the ventromedial prefrontal cortex, somatosensory cortex, amygdala and insular cortex, especially on the right side (Bar-On et al., 2003). According to these authors, emotional intelligence, equated with empathy, “emotional awareness,” and “psychological mindedness,” is expressed in the ability to “function interpersonally,” to “control emotions,” and to “cope flexibly with the immediate situation, make decisions and solve problems of a personal and interpersonal nature.”

Within the therapeutic alliance the most difficult clinical decisions occur in the spontaneous moment-to-moment unconscious transactions in the co-created intersubjective field. During stressful heightened affective moments of enactments, the emotionally intelligent expert clinician can more sensitively detect even subtle transferralistic communications from the patient, empathically resonate with an array of affective states (“take the transference”), flexibly cope with countertransferralistic emotional stress, facilitate interactive repair of ruptures of the alliance, and interactively regulate an array of the patient’s affective self states. The fact that the right brain functions of the skilled therapist act on implicit levels clearly suggests that individual differences in clinical expertise are expressed at not just conscious but primarily preconscious–unconscious levels. It is these aspects of the therapist’s personality, more so than the ability to generate accurate interpretations that facilitate change in the patient’s unconscious.

Neuroscience is now reporting, “[t]he left hemisphere is known to dominate in intraconceptual analysis of verbal stimuli, while the right hemisphere is involved in the processes underlying more complex symbolic and metaphorical associations between stimuli.” (Razumnikova & Bryzgalova, 2006, p. 650). Indeed, it is thought that right brain thinking “is the highest human mental function, responsible for creativity and integration of past, present, and future experience” (Rotenberg, 2004, p. 864). From the perspective of affective neuroscience Panksepp (2003, p. 11) warns that “Progress toward an understanding of affective processes may be slow and theoretically lopsided . . . if selectively pursued by individuals enriched in left hemisphere skills but impoverished in those of the right.” The experience and knowledge we gain from working with patients over the course of our careers increases our clinical effectiveness. This expertise is more than left hemispheric technical skill—rather it fundamentally involves more complex learning of a number of nonconscious functions of our right brain, which is dominant for a sense of “humanness” (Mendez & Lim, 2004).

In closing, I’d like to announce an upcoming conference “Affect Regulation: Development, Trauma, and Treatment of the Brain-Mind-Body” to be held November 3-4 in New York. The presenters include Philip Bromberg, Joe Lichtenberg, Beatrice Beebe, Pat Ogden, Ed Tronick and myself. For further information go to PsyBC.com.

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PSYCHOANALYTIC RESEARCH: PROGRESS AND PROCESS II
"I FEEL STUPID AND CONTAGIOUS": QUANTITATIVELY BASED METHODS OF ASSESSING SUPERVISEE COMPETENCE IN CLINICAL SUPERVISION

Geoff Goodman, PhD

My 24-year-old second-year clinical psychology doctoral student looked worried. She was treating her first case, a 17-year-old boy who had been living in a therapeutic group home for four years. Her patient called therapy “a waste of my life.” She wanted to reach her patient, to help him talk about his disappointment in her, his caregivers, and himself, but she felt incompetent in her efforts to help him to recognize the value of what she was offering him. Together, we eventually figured out that this patient was making the doctoral student identify with a hopeless, dying part of himself that had discouraged previous therapists and caregivers from caring about him. In effect, this patient was getting my doctoral student to feel what a part of him insidiously experienced all the time: “I feel stupid and contagious.”

This pattern of interaction took time to unfold in the therapy and to identify in clinical supervision. We needed to rely on my doctoral student’s description of her countertransference feelings with this patient in our clinical supervision to uncover what was going on in the therapy and formulate a strategy of intervention. This student was involved in her own therapy and, fortunately, had access to these feelings of incompetence and hopelessness. Over time, she developed a barely perceptible understanding that perhaps the patient was inducing these feelings in her, and that, because of her own fledgling status as a clinician, she was providing fertile ground for this induction process known to psychoanalytic clinicians as “projective identification” (Goodman, 2005). But what would have happened with a less articulate doctoral student whose unconscious anxieties, resentments, guilt, and conflicts were less accessible to her? What would have happened had she not been in her own therapy, like so many doctoral students?

Quantitatively based methods can be used in clinical supervision to assess the competence of our supervisees. Transference and countertransference phenomena can be enormously helpful tools in empathizing with our patients and providing them with transforming insights (Tansey & Burke, 1989), but when these phenomena remain undetected and elusive, they become instruments of enactment and, ultimately, futility. Quantitatively based methods can be used to identify transference–countertransference paradigms in our supervisees’ psychotherapy sessions that could limit the effectiveness of their clinical work. Identifying these paradigms in clinical supervision can especially help fledgling clinicians find intervention strategies that facilitate rather than hinder psychotherapy progress.

Different models of clinical supervision exist in the literature. How would quantitatively based methods of assessing supervisee competence in clinical supervision fit into this existing literature? One model (Gonsalvez, Oades, & Freestone, 2002) suggests that supervisors and supervisees together select appropriate objectives for both the clinical supervision and therapy, appropriate assessment of supervisee competence, and appropriate evaluation of supervision efficacy. Because supervisors and supervisees can have different objectives, a discussion between both parties needs to occur to arrive at a concordance. Quantitatively based methods of assessing competence in clinical supervision could facilitate the application of this so-called “objectives approach” to clinical supervision. These methods could provide an objective assessment of 1) the extent of the supervisee’s knowledge base of the theoretical orientation to be used, 2) the appropriateness of the supervisee’s typical interventions given the patient’s presentation, and 3) the supervisee’s improvements over time—in regard to growth of knowledge as well as increased specificity of interventions in response to the patient’s verbal and nonverbal behaviors. As the American Psychological Association (APA, 2002a, 2002b) increasingly advocates that Clinical Psychology Doctoral Programs systematically assess students’ competencies across a variety of domains, there will be an increased demand for quantitatively based methods of assessment.

A second model of clinical supervision (Milne, 2006) suggests a systematic analogy between psychotherapy and supervision such that the therapeutic relationship could be used as a template for supervision. The common thread is an emphasis on problem solving within the context of a working alliance. A supervision experience during my postdoctoral fellowship illustrates a limitation of this model. My psychoanalytically trained supervisor spoke only in reference to my process notes and freely interpreted my unconscious dynamics. At times, I felt the supervision would be better conducted on the couch. I did not find that experience helpful, either professionally or personally. This personal example underscores how a model of clinical supervision based on a model of
psychotherapy can be taken to an extreme. Quantitatively based methods of assessing supervisee competence can be used in such situations by identifying specific interaction patterns between the supervisee and the patient that might also be going on in the relationship between the supervisor and supervisee, commonly known as “parallel process.” Using quantitatively based methods to identify this process objectively could help diminish the potential for defensiveness of both supervisee and supervisor because they would be completing an instrument used to characterize these interaction patterns (see below). In my personal example, using such an instrument might have identified an interaction pattern between my patient and me simultaneously operating in the supervision.

Several literature reviews on supervision have been conducted (Ellis, Ladany, Krengel, & Schult, 1996; Ladany & Muse-Burke, 2001; Russell, Crimmings, & Lent, 1984; Tsui, 1997; Watkins, 1997). These reviews underscore the serious methodological weaknesses that characterize these studies as well as the paucity of knowledge gained from them. These weaknesses are particularly concerning as the emergence of empirically supported treatments (ESTs) elevates the importance of clinical supervision in establishing therapist competence and adherence to specific treatment manuals. A major aim of randomized controlled trials (RCTs) is to establish an empirical basis for treatment efficacy. Clinical supervision is critically important to RCTs because it is one of the main mechanisms used to ascertain that all patients enrolled in these treatment studies are receiving exactly the same intervention as prescribed in the treatment manual. While the generalizability of such studies has been sharply questioned (Westen, Novotny, & Thompson-Brenner, 2004), RCTs continue to be the mainstay of psychotherapy research. The validity of RCTs largely depends on the quality control of therapist interventions, which in turn largely depends on the quality of clinical supervision administered to the therapist–participants.

Clear guidelines that articulate the particulars of the clinical supervision conducted with the therapist–participants are critical because the hallmark of rigorous research is replicability. To my knowledge, only one study in the literature (Fehrenbach & Coffman, 2001) discusses issues related to the clinical supervision of therapists. Therapists in this study participated in two National Institute of Mental Health-funded clinical trials of couples therapy and depression. No researcher who has conducted an RCT has yet developed a manual that standardizes the delivery of clinical supervision to therapists who participate in RCTs, or even an instrument to assess the competence of the supervision. Contrary to the spirit of manualized treatment packages, RCT therapist–participants have been shown to deliver more eclectic amalgams of theoretical orientations than the manuals stipulate (Ablon & Jones, 1998). Quantitatively based methods of assessing competence in clinical supervision could rectify this methodological weakness by offering standardized feedback to therapist–participants seeking to follow a particular theoretical orientation in their treatment delivery.

**Four Areas of Supervisee Competence in Clinical Supervision**

I would like to propose four areas of supervisee competence that quantitatively based methods could be used to address in clinical supervision. The first is adherence to theoretical orientation. In this domain, clinical supervisors could use a gold standard of clinical practice (as agreed upon by a group of experts) to determine whether a supervisee is able to carry out a particular theoretical orientation with high fidelity to the overarching principles of that orientation. In addition, supervisors could determine the extent to which a supervisee is able to carry out this theoretical orientation without alloying other orientations during treatment delivery. Thus, fidelity to the overarching principles of that orientation without alloying other orientations would be the hallmark of treatment adherence.

Second, clinical supervision should attend to the therapist’s specific interventions—whether they indirectly or directly serve the therapeutic goals agreed upon by the therapist and patient (McWilliams, 1999). Do the therapist’s interventions flow out of the patient’s clinical material, serve the therapeutic goals, and reflect the theoretical orientation being used?

Third, clinical supervision should include concordant observations between supervisor and supervisee about the patient’s verbal and nonverbal behavior. A wide discrepancy between the clinical supervisor’s and the supervisee’s perceptions of the same clinical material indicates a possible countertransference reaction that would need to be identified and, ultimately, used in the service of the therapeutic goals.

Fourth, clinical supervision should attend to the interactional matrix co-constructed by both therapist and patient to determine which transference–countertransference paradigms might be operating in the treatment. Jones (2000) referred to these paradigms as “interaction structures,” a construct that conceptually overlaps with Luborsky’s (Luborsky & Crits-Christoph, 1998) “core conflictual relationship theme.” The term “interaction structures” implies that the therapist’s countertransference reactions also significantly contribute to the dyad’s pattern of engagement. Josephs and his
colleagues (Josephs, Anderson, Bernard, Fatzer, & Streich, 2004; Josephs & Fatzer, 2006) have used longitudinal research to demonstrate some ways in which therapist interventions influence these patterns. Ideally, clinical supervision would focus on all four of these areas of supervisee competence. Quantitatively based methods provide the means with which to assess these four areas of supervisee competence, identify specific needs for improvement, and, ultimately, improve the quality of the therapist’s interventions and, in turn, the patient’s outcomes.

The Psychotherapy Process Q-Set (PQS) and Child Psychotherapy Process Q-Set (CPQ)

The PQS (Jones, 2000) and CPQ (Schneider, 2004; Schneider & Jones, 2004) are two powerful and easy-to-use instruments that help clinicians and researchers quantify auditory or auditory/visual observations of the psychotherapy process. Supervisors, therapists, and researchers can begin to use these instruments to assess processes of therapeutic change in adult and child psychotherapy. The PQS and CPQ each consist of 100 items and use an entire audiotaped or videotaped psychotherapy session as their unit of analysis.

Q-sort methodology has existed since the 1930s as an alternative to Likert-type scales. In Likert-type scales, items are assigned a score along a continuum (e.g., 1 to 5). The score assigned to each item is independent of the scores assigned to all the other items. For example, if item #1 is assigned a score of 3, item #2 could also be assigned a score of 3. Q-sort methodology, however, requires the rater to assign a specified number of items a particular score (Block, 1978). All items are therefore ranked in comparison with each other rather than rated independently of each other, as is the case with Likert-type scaling (see Block, 1978, for additional information regarding Q-sort methodology and procedures). Raters of the PQS and CPQ assign scores of 1 to 9 to all 100 items. A score of 1 indicates that the item is most uncharacteristic of the session being rated. A score of 9 indicates that the item is most characteristic of the session being rated. A score of 5 indicates that the item is neither characteristic nor uncharacteristic of the session. A specified number of items is assigned to each score. All 100 Q-sort items are sorted into nine piles ranging from most uncharacteristic to most characteristic of the psychotherapy session being rated. This forced-choice (ipsative) distribution is illustrated below:

<table>
<thead>
<tr>
<th>Item Scores:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most uncharacteristic</td>
<td>Most characteristic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Items Assigned:</td>
<td>5</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>18</td>
<td>16</td>
<td>12</td>
<td>8</td>
<td>5</td>
</tr>
</tbody>
</table>

A Q-sort takes about 45 minutes to complete. The prearranged number of items assigned to each score forms a normal distribution that facilitates statistical analysis.

The PQS (Jones, 2000) and CPQ (Schneider, 2004; Schneider & Jones, 2004) Q-sort items were carefully constructed to capture descriptively three elements of psychotherapy process: 1) the patient’s attitude and behavior or experience, 2) the therapist’s actions and attitudes, and 3) the therapist–patient interaction, or the climate or atmosphere of the encounter (Jones, 2000; Schneider & Jones, 2004). Approximately one-third of the items for both instruments were designed to assess each of these three elements. For example, item 64 of the CPQ assesses the child’s behavior: “Child draws therapist into play.” If this item is highly characteristic of the psychotherapy session being rated, relative to the other 99 Q-sort items, it would be placed in one of the highest piles (8 or 9). Item 100 of the PQS assesses the therapist’s interventions: “Therapist draws connections between the therapeutic relationship and other relationships.” If this item is highly uncharacteristic of the psychotherapy session being rated, relative to the other 99 Q-sort items, it would be placed in one of the lowest piles (1 or 2). Item 11 of the PQS assesses the therapist–patient interaction: “Sexual feelings and experiences are discussed.” Again, this item is placed along the continuum from 1 to 9, relative to the other 99 Q-sort items (for a complete list of the PQS and CPQ Q-sort items, see Jones, 2000, and Schneider & Jones, 2004).

The resulting PQS and CPQ distributions of adult and child psychotherapy sessions have a variety of uses. A factor analysis of the 100 Q-sort items can be conducted with a minimum of 100 sessions. The resulting factors depict psychotherapy process related to a particular patient or group of patients with a particular psychiatric diagnosis (Jones & Pulos, 1993; Josephs & Fatzer, 2006). These process factors can then be used to predict both symptom outcome measures such as the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1983) and structural outcome measures such as the Social Cognition and Object Relations Scale (SCORS; Westen, 1993). With the PQS and CPQ, the empirical question of most interest shifts from “which psychotherapy works?” to “how does it work?”

The PQS has also been used to construct ideal prototypes of adult psychotherapy sessions from several theoretical orientations. Celeste Schneider and I have received funding from the International Psychoanalytical Association to construct prototypical Q-sort distributions for the CPQ. In constructing the PQS prototypes, two groups of experts widely recognized for their expertise in psychodynamic psychotherapy (N = 11) and cognitive–behavioral therapy (N = 10) were asked to sort the PQS...
Q-sort items according to the process that occurs within a
prototypical psychotherapy session conducted from their
theoretical orientation (Ablon & Jones, 1998). These Q-sort
distributions were then composited within each theoretical
orientation to form two prototypical Q-sort distributions
that reflect the ideal psychotherapy process from a
psychodynamic orientation and a cognitive-behavioral
orientation. Correlations between the Q-sort distribution
of each psychotherapy session and the prototypical Q-sort
distribution comprised of the experts reflect the extent to
which a particular session adheres to the ideal principles
of a particular theoretical orientation. These adherence
correlations can then be treated as scores used to predict
outcome measures.

**Assessing the Four Areas of Supervisee Competence in
Clinical Supervision Using the PQS and CPQ**

I would like to demonstrate how clinical supervisors can
use quantitative methods—namely, the PQS and CPQ—to
assess the four areas of supervisee competence in clinical
supervision described earlier. This year, I began using the
PQS and CPQ in my own clinical supervision with three
clinical psychology doctoral students. All three students
have attested to these instruments’ value not only for
learning the psychodynamic orientation I am teaching
them but also for improving their observations of their
patients’ verbal and nonverbal behaviors, their interaction
patterns with their patients, and their own interventions.

My supervisees and I have been able to identify specific
transference–countertransference paradigms by examining
the Q-sort distributions of their sessions. Awareness of
these paradigms produces positive changes in supervisees’
interventions, and, in turn, increased awareness in the
patient.

At the beginning of the fall semester, I was
assigned three second-year doctoral students from our
clinical psychology doctoral program. These supervisees
are carrying individual outpatient psychotherapy cases
in their first externship. None of these students had ever
conducted individual psychotherapy. One student (student
A) was assigned a 16-year-old adolescent girl, another
(student B) a 7-year-old girl. The third student (student C)
was not assigned a patient because our program’s clinic
did not have enough patients in the fall semester to assign
to all students. I asked student A to sort the PQS, which is
used for adults and late adolescents, and student B to sort
the CPQ, which is used for children and early adolescents.
I also asked student C to sort the CPQ. First, I gave each
student instructions on Q-sorting; then I told each one to
sort the items according to the process occurring within
a prototypical psychotherapy session conducted from a
psychodynamic orientation, as they currently understood
this orientation. I also sorted both the PQS and CPQ. After
collecting the students’ Q-sort distributions, I correlated
their prototypical Q-sorts with both my own as well as
the composite prototypical Q-sort composed of the
psychodynamic experts (obtained from Stuart Ablon; see
Table 1).

Table 1 indicates that the correlations between the
three students’ prototypical Q-sorts and my own varied
widely. While the correlations between Student A and
Student C and me were similar (.50 and .49, respectively),
the correlation between Student B and me was much
higher (.73). Student B’s exceptional standing as a
student, as well as her strong interest in psychodynamic
theory, could account for her high correlation with me. In
supervision with each student, I reviewed all the Q-sort
items in which the student and I experienced discrepancies
larger than 3. For example, student A placed PQS item
45 (“Therapist adopts supportive stance”) in pile 8, while
the psychodynamic experts and I placed this item in pile
2 (a discrepancy of 8 – 2 = 6). Student A had assumed
that psychodynamic therapy was characterized by a
high degree of therapist supportiveness (approval and
encouragement). We discussed the theoretical reasons for
this discrepancy, including the idea that a patient could
interpret the therapist’s supportiveness as a subtle form of
evaluation that could stifle disclosure of negative material. I
used this review process to teach each student the essential
elements of psychodynamic psychotherapy process and to
help them to consider how they might further the goals of
psychodynamic treatment. At the beginning of the spring
semester and again at the end of their externship (August),
I will ask all three students to complete prototypical Q-
sorts. We will use these Q-sorts to determine whether their

**Table 1**

<table>
<thead>
<tr>
<th>PPPQS</th>
<th>SPPS</th>
<th>SCPQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPPQS</td>
<td>54&lt;sup&gt;a&lt;/sup&gt;</td>
<td>50&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>APQS</td>
<td>50&lt;sup&gt;b&lt;/sup&gt;</td>
<td>50&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>BCPO</td>
<td>73&lt;sup&gt;a&lt;/sup&gt;</td>
<td>49&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>CCPQ</td>
<td>49&lt;sup&gt;b&lt;/sup&gt;</td>
<td>49&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Note: PPPQS = Psychodynamic Prototype—PQS.
SPQS = Supervisor PQS
SCPQ = Supervisor CPQ
APQS = Student A PQS
BCPO = Student B CPQ
CCPO = Student C CPQ.

<sup>a</sup>All correlations are significant at p < .001.
<sup>b</sup>A psychodynamic prototypical Q-sort for the CPQ is under
construction.
basic understanding of psychodynamic psychotherapy process has improved. Student C, who has not been supervised, will serve as a control. I am expecting student A’s and student B’s correlations with me to improve, while student C’s correlation with me should remain the same. If this hypothesis holds, then we can attribute the learning curve of student A and student B to clinical supervision and the use of the PQS. This example, drawn from my own supervision experiences, underscores one way that clinical supervisors can assess the degree of a supervisee’s competence in their knowledge about a particular theoretical orientation using the PQS and CPQ.

I have also been using the PQS and CPQ in weekly clinical supervision with these students. Each student completes a Q-sort immediately following a session and then e-mails me the distribution prior to our supervision appointment. Clinical supervisors could also ask the student to provide them with an audiotape or videotape of each session, which the supervisor could then Q-sort. Then the supervisor could correlate the student’s Q-sort with his or her own and review item discrepancies within supervision.

Because of time constraints, I simply review with the student during supervision the 10 items he or she places in the extreme piles—1 and 9. Because of their placement at the extremes, these 10 items essentially characterize the psychotherapy process of a session. Because it is impossible for a supervisor to review with the student the entire audiotape or videotape of a session, I often ask the student to play back portions of the session of particular interest or difficulty. Later, I review with them the 10 extreme Q-sort item placements, which give me an overall sense of the process across the entire session.

Using quantitatively based methods in this way during clinical supervision has proved enormously helpful to the student and, I imagine, the patient. For example, student A placed PQS item 3 (“Therapist’s remarks are aimed at facilitating patient speech”) in pile 9, item 7 (“Patient is anxious or tense [vs. calm and relaxed]”) in pile 1, and item 15 (“Patient does not initiate topics; is passive”) in pile 1. This particular constellation of item placements told me that the patient was feeling calm and relaxed and was spontaneously pursuing topics; however, the therapist was feeling compelled to encourage the patient with responses such as “mm-hmm,” “sure,” and “right.” In our discussion of these items, the student confirmed that these encouraging responses helped her allay her fear that the patient would stop talking and fall silent. Of course, one would hope that an attentive supervisor would catch these issues when listening to or watching a session, but the PQS and CPQ use the therapist’s own observations to identify the salient characteristics and alert the supervisor to technical errors, transference–countertransference paradigms, and the like. These instruments could also harness audi-taped and videotaped observations to disconfirm the student’s item placements, which might reflect a countertransference that could be distorting the student’s perceptual capacity. Objective measures of psychotherapy process such as the PQS and CPQ can be used to test the subjective impressions offered by the student.

In another example, student A played an audiotape in which the patient was discussing fears of elevators, flying, heights, needles, and roller coasters. The student placed item 7 (“Patient is anxious or tense [vs. calm and relaxed]”) in pile 1. I pointed out to the student that the session’s content—a litany of situationally based anxieties—stood in stark contrast to the patient’s presentation in session as markedly calm and relaxed. Student A was then able to discuss this discrepancy with the patient—to facilitate the patient’s ability to reflect on these seemingly compartmentalized mental states. In this way, the PQS and CPQ can also be used to lay the groundwork for confrontations and interpretations.

**Directions for Future Research**

For her dissertation, one of my students will be using her CPQ psychotherapy session Q-sorts to examine the effects of countertransference on psychodynamic child psychotherapy process. She will be completing the Countertransference Questionnaire (CTQ; Betan, Heim, Conklin, & Westen, 2005), while two independent raters will be Q-sorting her videotaped psychotherapy sessions. We are hypothesizing that the discrepancies between her Q-sort distributions of her sessions and those of the independent raters will be positively correlated with her countertransference reactions as measured by the CTQ after each session. These discrepancies will also be used to predict changes in psychotherapy process throughout the entire year of treatment. The PQS and CPQ are extremely versatile, quantitatively based methods that can be used to assess supervisee competence in clinical supervision. I hope that someone will construct a Clinical Supervision Process Q-Sort (CSPQ) in which supervisor–supervisee interactions can be systematically observed, assessed, and used to predict changes in psychotherapy process and patient outcome. The effectiveness of clinical supervision on students’ psychotherapy interventions and on their patients’ improvements is an area of research in need of attention. Using the methods proposed here, doctoral students (and their clinical supervisors) can begin to feel a little less stupid and contagious and a little more competent and hopeful about the impact of their interventions on therapeutic change.
Psychoanalytic Research

References


"Scary and scary smart, serious and seriously funny. Machiavelli move over, there’s a new kid in town.”

-DANIEL GILBERT, Harvard College Professor of Psychology, Harvard University, and author of Stumbling on Happiness

“Someone had to say it... And Drew Westen, a clinical psychologist and political strategist from Emory University, has stepped up to the plate in The Political Brain to give a scathing, sobering diagnosis of what ails a political party whose beliefs are in line with the majority of Americans on almost every issue and yet fails to translate that alignment into sustainable electoral success. Armed with numerous studies on how the brain operates in that crucial interplay between emotion and reason that energizes voters, Westen has succeeded in penning a manifesto on behalf of bringing the passionate back into the narrative—and actions—of the Democratic Party.”

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“Westen’s analyses and suggestions speak precisely to Democrats’ greatest tactical failures of the last quarter-century, and they do so without descending to the level of ‘Mission Accomplished’ banners and the ‘death tax.’”


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I. Conceptual Grounding: The Influence Taboo
A central feature of the psychoanalytic tradition has been concern that under the influence of the transference, the patient will too readily submit to the analyst’s authority so that whatever changes emerge in the process will reflect sheer compliance with the analyst’s values and desires. Discussion of this issue has always been encumbered by the notion of “suggestion” which in psychoanalysis means quite the opposite of what it means in everyday, common usage. A “suggestion” in that everyday sense is just that; something for a person to consider, something one could take or leave. But “suggestion” in psychoanalysis is linked to hypnotic suggestion, which is largely controlling of the patient’s experience and behavior. The transference, moreover, is understood to have inherited the power of suggestion as it functioned in hypnosis and the psychoanalytic process could be viewed as a kind of “slow motion” hypnotic procedure, which is how Macalpine (1950) characterized it. It’s no wonder that analysts became virtually phobic about being sources of influence in their interactions with their patients beyond promoting, as in Freud, their analysands’ efforts to find, and come to grips with, truths about themselves and their worlds. With the conflation of “influence” and hypnotic suggestion, the options that are possible get organized dichotomously. The patient is either effectively coerced or left on his or her own.

Now put the influence taboo associated with the power of “suggestion” together with the incest taboo and it’s a lock that the analyst would stay relatively detached. Despite these revolutionary changes, in Stephen Mitchell’s terms, in our sense of “what the patient needs,” we are still haunted by the specter of the “slippery slope” associated with incestuous wishes. I’m reminded of something in my own history. I decided I was an atheist by around the age of 16, no small feat for a junior at the Yeshivah of Flatbush High School in Brooklyn, New York. But five years later I was still avoiding un-kosher food like the plague, and twenty years later I was still praying on takeoffs and landings. I mean why take a chance?

This paper is about taking chances, about taking risks in the analytic process. Psychoanalysts as a rule are much more frightened of the consequences of sins of commission than they are of sins of omission, a difference that is not proportional, I believe, to any difference in the actual dangers each kind of sin poses.

My thesis is that the analyst has the power to inspire change in the patient through active imaginative involvement and the exercise of influence that often goes beyond interpretation although it certainly may include it. To leave the patient “space” for choosing his or her own course, in life and in the session itself, is not necessarily described accurately merely as respect for the patient as an autonomous agent. It may also be tantamount to a kind of abandonment of the patient so that he or she has to fend for himself or herself against the attacks of various kinds of internalized bad objects, hostile introjects, in effect, that can have profound effects on the patient’s sense of self (Fairbairn, 1958).

II. Battling Introjects
With regard to such introjects, a common way of working begins and ends with interpretation and understanding as the route to therapeutic action. That is not to say that contemporary approaches do not encourage other kinds of participation as well, but I’m talking specifically about the structure of interpretive work as such. For example, we help people see the relativity of their own self-defeating ways to certain experiences in childhood over which they had no control. Not only does the patient’s rational ego provide the realization that his/her symptomatic, self-defeating reaction is uncalled for, but, (notwithstanding possible struggles with various forms of reenactment) in the long run the implication becomes clear that the analyst thinks so too. The whole inquiry is undertaken in the spirit of critiquing the symptomatic adaptation and its historical underpinnings. All that goes without saying, doesn’t it?

Increasingly over the years I’ve felt that the answer to that question, more often than not, is “no.” Those introjects are extremely powerful. They established themselves in the patient’s mental life very early and now
the patient has them in his or her bones, at the core of his or her being. Rationality and implicit support can be very valuable, but they are often not enough to overcome the influence of destructive introjects. I believe what is needed often is an opposing powerful voice, actual words, words spoken with passion and conviction, that the patient can hear and remember and that can do battle with the destructive voices of the past.

I’m talking about sitting forward though, not sitting back in that stereotypic, stylized posture of psychoanalytic hyper-unperturbed calm. And I’m talking about speaking from the heart, with feeling. I’m talking about letting it come over you as you speak even if it’s not fully “there” when you begin. There’s a good chance that in many cases it will come, because the psychoanalytic arrangement lends itself to that kind of empathic identification with another person’s struggle to be a person in the face of devastating hardship, the hardship of particular unnecessary traumas superimposed on the inevitable, necessary traumas of the human condition. I think Bion’s call for “passion” in the analyst is closely related because it entails opening up to, rather than defending against, thinking that is infused with painful emotion (see Billow, 2000). The psychoanalytic arrangement is a setup conducive to that happening. And we are often wasting the special opportunities it affords. Yes, wasting them!

And why? Why, in fact, do we so favor implicit over explicit forms of affirmation, indeed, implicit over explicit expressions of love? What is so in the way if not the fear of assuming full responsibility to do our utmost to foster another person’s development, masked as that fear may be by pervasive still deeply institutionalized residues of scientific neutrality. Are we afraid we might fail? There are no guarantees and surely the odds are often against us. Those introjects are formidable, sometimes so powerful they invade the patient’s character so that his or her more lovable side has difficulty emerging in such a way that our own empathic potentials can be activated at all.

We do have to worry when we attack hostile introjects, not only about the patient’s attachment to them but also about the patient’s possible identification with them. We have a substantial body of relational literature now about how to work through and out of enactments that might entail a good deal of negative transference and countertransference. But imagine that, with a lot of hard work, we have arrived there at the more loving transference-countertransference situation. Let’s face it, even with those patients at that point, or even with the patients who, to begin with, elicit love in the countertransference in a way that seems relatively straightforward and uncomplicated, we tend to be quite constrained in what we say and do in keeping with those feelings.

We have not only the introjects to overcome and the patient’s attachment to them and to the secondary gains derived from those attachments, but also what I’ve called the “dark side” of the analytic frame (Hoffman, 1998), all the things that contribute to our own bad–object potentials. The latter include the harsh reality of our self interest: money for relationship, money for love; the asymmetry of the arrangement that the patient knows affords us special narcissistic protections and advantages. There’s a lens through which the whole enterprise could readily be seen as exploitative. The patient has to forgive all that in order to take the best that we have to offer. We are at the patient’s mercy in that respect and at some level we know it. One could say it takes a huge act of generosity on our patients’ parts to allow themselves to improve their quality of life under our highly compromised care, to give us the satisfaction of providing the “new childhood” that Racker (1968) says we should offer (see Hoffman, 2000).

So what I am saying we are called upon to do is, in fact, to risk it, to put ourselves on the line in that respect and let ourselves be vulnerable to that degree. We cannot hide anymore. The cat is out of the bag. We cannot admit that our influence is inevitable and ubiquitous and not take full responsibility for choosing what that influence should be and how we should exercise it. Minimizing it is not a viable option, not even by continually trying to analyze it (Gill and Hoffman, 1982; Hoffman and Gill, 1988). Acts of omission when Rome is burning can have dire consequences especially when they go on relentlessly for years and years, even for decades. I’ve seen many casualties of those kinds of analyses and those stories are heartbreaking, absolutely heartbreaking. And no one will ever be sued for that. No one!

III. REALLY TALKING: THE CLIMATE AND EPISTEMOLOGY OF PSYCHOANALYTIC CONVERSATION
One way of describing this subtle yet major shift in the climate I am trying to encourage is to say it moves from a form of interaction that is stylized to one that is more authentic, more emotionally immediate and, in a sense, more natural. The interaction doesn’t reek of therapeutic purposes at every moment. In fact, there are more times, more interludes, when the conversation sounds like one that might occur in ordinary social life. I’m taking my cue from Lipton (1977) who takes his cue from Freud in using the word “conversation” to describe the verbal interaction of the participants.

In connection with the issue of stylized versus authentic engagement, I always think of a paper by Schafer published originally in 1974 and reprinted in 1992 in his book Retelling a Life. It’s called “Talking to Patients.” What Schafer suggests in that essay is that we might consider actually talking to our patients because...
what is prevalent instead, he says, is something he calls “impersonal diction,” a manner of speaking that is devoid of all natural, personal spontaneity. “Impersonal diction” in response to “free association” is what I am calling stylized interaction. Alternatively one could think of it as profoundly dissociated in a manner that is thoroughly institutionalized.

The approach I am advocating entails an underlying epistemology, a relational, critical constructivist attitude rather than a one-person, objectivist perspective. Starting with the assumption that experience is ambiguous, the analyst knows that it is always open to interpretation and that any particular interpretation cannot be the whole story. He or she also knows that interpretations, no less than other kinds of action, shape or create the course of the participants’ experience. In other words, there is no single reality that is just sitting there waiting to be discovered.

Consequently, there is no sharp split in this respect between exploration and other kinds of participation on the part of the analyst. The upshot is that on the one hand, interpretive activity is subject to more concern than it might be traditionally regarding the dangers of influence and compliance. Conversely, other kinds of participation are regarded with less suspicion as compared to interpretation because they are not split off as the unfortunate repositories of the analyst’s subjective involvement viewed as an avoidable contaminant. Personal, not fully transparent influence is inevitable in both exploratory—interpretive and nonexploratory—noninterpretive activity. So what is required is a balance of, on the one hand, effort to make that influence as wise, responsive, and creative as possible, and on the other hand, continual critical reflection on one’s choices and openness to other possibilities that those choices may inhibit or exclude. That balance is called for equally in connection with interpretation and other kinds of participation (Hoffman, 1998).

The critical constructivist epistemology is not some abstract philosophical point of view divorced from the nitty gritty of clinical experience. On the contrary, it’s a perspective that fosters certain ways of being and relating and that discourages others.

Mitchell (1993) spoke of the “revolution in what the patient needs” as distinct from the “revolution in what the analyst knows.” My own view is that they should be integrated because I think what the patient needs, the generic new, good object is one that has this kind of open-minded constructivist attitude toward his or her own experience as well as the patient’s. The result encourages an interaction, a dialogue, in which self-expression and responsiveness form a dialectic, one that is worth aspiring to in many contexts, including those that entail an asymmetrical distribution of power, like that of parent and child, teacher and student, and analyst and patient. In those contexts (and many others), the asymmetry has the potential to be drawn upon to empower the one in the ostensibly subordinate position, as autonomy, self-expression, and the wish to influence are alloyed with responsiveness to, and respect for, the other, and vice versa.

IV. THERAPEUTIC PASSION IN THE COUNTERTRANSFERENCE: MODES OF EXPRESSION IN PRACTICE

Must we be “above” caring whether our work benefits the patient in any way? I think under the guise of selflessly leaving patients “free” to decide their course without any influence emerging from us or from our patients’ consciousness of the interdependence of their well-being and our own, we deny our own vulnerability, we cultivate the illusion that all the power in the analytic situation resides with us, we exaggerate our dominance in the analytic relationship, we deprive the patient not only of opportunities to work out problems associated with the need for love but also with the those associated with the capacity for being sources of love and concern for others. There is an interference with the analyst’s owning of therapeutic ambition and passion in the countertransference that is very simple and straightforward but also potentially embarrassing to consider.

What I have in mind, again, is the analyst’s
ambivalence about the kind of responsibility that the role challenges him or her to embrace. Many of us have many patients under our care and it’s not easy for us to bear the burden of being, as Racker (1968) put it, “prepared to accept fully our new paternity, to admit fully affection for our new children, and to struggle for a new and better childhood” (p. 33). That’s not a small responsibility if we were talking about just one or two people, not to mention scores, possibly, of such quasi-“dependents.” In addition to the special pressures of the role, there’s the simple gravitation toward passivity, toward the easier path.

And let’s face it, our theories of technique are just packed with concepts that can mask and rationalize sheer laziness. The emphasis on just listening, on not interfering, on avoidance of suggestion, on being the blank screen for the transference, on promoting regression through optimal frustration, on allowing the patient to have the lead, on recognition of the patient’s resistance to account for slowness or lack of movement, all these concepts can very easily serve as covers for failure to make the requisite intellectual and emotional effort to understand and formulate what might be going on, not to mention failures of imagination bearing upon more adventurous action. Slochower (2003) has written compellingly about the propensity that we all have toward certain kinds of seemingly small, as she says, “delinquencies.” I think a subtle and pervasive delinquency in our field can be summarized first, as avoidance, in Racker’s terms, of “the hard work the analyst must do to understand and interpret” (Racker p. 31) and second, as backing away from what Buechler (2002) identifies as the “brave act of facing our responsibility” through our highly personal participation, “to grasp the courage to inspire” (p. 277).

I think such “passion” is multifaceted and any particular example of it will have one or another of its possible expressions in the foreground. Among the important possibilities to look for I would include:

1) Working hard on understanding via thought, exploration, and interpretation. I think it’s good to have ideas that are thought-provoking for the patient and that are potentially useful in concrete ways. Sometimes it’s helpful to try to conceptualize and fully explain what one means. The conventional psychoanalytic premium that is placed on evocative brevity is replaced, at least sometimes, by attempts at clarity with elaborations and qualifications that may take time to spell out. Also, along with openness and willingness to change one’s mind, sometimes, some persistence and some efforts to persuade given counterpoints that the patient may advance could be helpful. It’s all part of “really talking.”

2) Explicit affirmation through statements that are recognizing and appreciative of the patient’s good qualities, strengths, talents, and ways of being. I’m talking about stopping to say, explicitly, all those things that one might think “go without saying.” One of the tendencies that I think we have to overcome to do this is our habit of seeing the patient’s creative contributions to the process itself primarily as the “dependent variable,” as responsive to something good about the analytic setting, or to something more specifically good about what we did. In addition, “free association” is a great example of a concept that strips the patient of responsible agency and therefore of any blame or credit for his or her contributions (Hoffman, 2006). Here the determinants of the patient’s contributions are unconscious forces complementing the analyst’s therapeutic “interventions.” Why is it that analysts have ideas while patients have mere “associations”?

3) As I’ve already discussed, doing battle explicitly with “bad objects,” internal and external, through the analyst’s expression of feelings and attitudes that emerge spontaneously in the context of patients’ generously giving of themselves, allowing us to know them. Such feeling and such attitudes provide, potentially, a different kind of “presence” in the patient’s life, maybe it’s not too much to say a loving presence, one that can combat long-standing destructive influences on the patient’s sense of self; and

4) Promoting and supporting specific projects collaboratively identified and endorsed. We have so much fear of superficiality and of behavioral influence and compliance we can’t say “maybe it would be a good idea if you did such and such,” and respond, perhaps, to the patient saying, “Well, maybe, but I think such and such would be more realistic for me right now” with “I see, OK, let’s make that the goal. But you know I’d like to ask how that went. Will you feel that’s too oppressively micro-managing you like your dad?” So much is mistakenly and reflexively blocked before it could possibly get off the ground by the question: “But is that really psychoanalytic?”

People are sometimes getting beaten by internalized attitudes that invaded them in critical periods. Now we’re outside those highly impressionable periods and we don’t have that advantage. So it’s war; and the heavy artillery is on the other side. It’s not the transference battlefield as Freud described it: almost the analyst against the other half. I like to say to people “It’s more like the analyst and a healthy half (or less) of the patient who becomes the embodiment of resistance. It’s more like the analyst and a healthy half (or less) of the patient against the other half. I like to say to people “It’s one and a half against a half, so one and a half should win.”

V. A Concluding “Suggestion”

I will leave you with just this “suggestion,” in its common, everyday sense of course (although maybe I wish I had all of you under a hypnotic spell). The general point is precisely that we cannot standardize modes of expression
of “passion in the countertransference.” The only thing that I am arguing might be generalizeable, is that the analytic situation lends itself to a high probability that our experience within our analytic role will include intense, responsive, passionate feelings, if we open ourselves to them, as we hear the details of patients’ suffering, their historical origins, and the often impressive, even heroic strivings of the patient, despite the obstacles, to survive, to live, and even to grow. The challenge for each of us is to find our own way, expressive of our own personalities including sometimes untapped potentials within us, to express that passionate response in a manner that is usable by each patient in his or her unique way. I am saying that the analytic process holds the promise, not only for a special degree and quality of understanding, but also for a special degree and quality of love and reciprocal inspiration. It’s a promise that I feel we have the responsibility, “calling upon all [our] available mental forces,” to try our damndest to fulfill.

References
Exploring the Lives of Vietnam Vets: The Conjunction of Psychoanalysis and Documentary Film

Presenter: Ricardo Ainslie, PhD
*Vietnam: Sketches From a Film About Private and Collective Memory*

Discussants: Robert Sklar, PhD
Donna Bassin, PhD
*The Things They Carry: Veterans Working Through the Grief of War*

Chair: Neil Altman, PhD

This panel focused on excerpts of Ricardo Ainslie’s film in progress, *Coming Home from Vietnam*, and two discussions. Dr. Ainslie discussed the intersection of film and psychoanalysis from the vantage of the methodology he uses in his documentary film projects. He illustrated his talk with clips from *Coming Home from Vietnam*. He drew material for his interviews and other footage from the February 2007 Tet Offensive Reunion in Abiline, Texas. A central character in this footage is a woman whose brother was killed in Vietnam when his helicopter was shot down. Her struggles to understand and to mourn remain powerfully poignant, nearly 40 years after his death. Ainslie discussed the application of a psychoanalytic sensibility to this kind of work, noting the parallels between his interview with this woman and what might take place within a clinical hour. However, a blend of ethnographic and psychoanalytic methods also inform his approach more generally, engaging an event like the Tet Offensive Reunion as a collection of psychological processes that reflect underlying tensions, anxieties, and conflicts.

Robert Sklar responded to Ainslie’s presentation of his documentary film in progress not only as a cultural historian and historian of cinema, but as a person for whom active opposition to the Vietnam War became the decisive public event of his life. He pointed out how especially painful and tragic it was to see in Ainslie’s film the deep extent to which veterans feel they were insulted and attacked by the anti-war movement: this treatment was a prelude to their being ignored and disrespected in the decades since. He wondered, Was this in fact the case, or is it a political myth that these veterans have clung to? Sklar believed that his anti-war milieu sought to bridge a gap for veterans through respectful contact and communication (although one audience member spoke of protesters reviling veterans as they returned to Oakland, California, from war).

Sklar referenced a film that had appeared on U.S. public television stations in mid April 2007, a week before the Division 39 meeting. The film, *Operation Homecoming: Writing the Wartime Experience*, was part of a series called America at a Crossroads, with major funding by the Boeing Company and U.S. government agencies. This work featured dramatized writings by Iraq war veterans, along with “talking head” comments from “great American writers” who had served in Vietnam and during World War II. He cited a viewpoint spoken in the film by novelist and Vietnam veteran Tim O’Brien: “I think there’s a false notion that we ought to recover from everything. Divorce, Broken homes, Wars. Get on. We all need to heal. And I don’t believe in it. I believe the opposite—that there are some things you shouldn’t heal from, that aren’t healable. And if they are healable, you oughtn’t do it anyway. There’s something to be said for remembering—and not healing.”

Donna Bassin engaged with Robert Sklar’s citation of Tim O’Brien and spoke about a healthy resistance to mourn war-related loss. To the degree that mourning is seen as “moving on,” or “getting over it,” some combat veterans have suggested to her that holding grief may be seen as rebellious as well as a useful way to activate and direct political action. For these individuals loss may in part be managed by attempting to end the circumstances that led to the loss in the first place. She briefly spoke of her own documentary in progress, which follows two generations of veterans who have taken the military oath of “leave no soldier behind” from the battlefield, extended its literal meaning, and applied it to social activism in their post-war lives. Veterans have banded together to advocate for their own care and others who have become traumatized through catastrophic loss. By allowing the mourning after war to work through them, they have harnessed these powerful emotions and painful lessons into a redemptive moral consciousness and humanitarian action. Their way of mourning rejects bitterness and violence and allows grief to become instructive rather than hidden or revengeful.

She appreciated Ainslie’s project for its raw and close-to-the-bone portrayal of a group of veteran’s yearly communal ritual of remembrance. Here, as in her observations, the importance of engaged memory seems to be a significant factor in the refusal to have the war in Vietnam become mere history, remote and abstract. Bassin agreed with Ainslie’s observation of the parallels between documentary filmmaking and clinical work and emphasized the importance of taking our clinical skills out of the consultation room to the community at large.
The Candidate Outreach Committee of Sections I and V was formed to provide candidates in analytic training with programming and networking opportunities within Division 39, thereby encouraging them to join and participate in the Division and Sections I and V. To further this end, the Candidate Outreach Committee offered a roundtable discussion with candidates and administrators of analytic training programs moderated by Dr. Mary Beth Cresci, a co-chair of the Candidate Outreach Committee.

Dr. Lewis Aron, director of the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis described how the proliferation of different theoretical perspectives has generated interest in the field. At the same time, this proliferation requires that training programs introduce candidates to a greater range of theories and help them evaluate the significance and merit of each. Psychoanalytic education today should be comparative, integrative, and more personalized to the candidate than ever before. Psychoanalytic education continues to be the only model of psychotherapy that trains clinicians to listen deeply to patients and to sustain the intensity of their own emotional responses over the long term.

Dr. David Appelbaum, who recently completed training at the William Alanson White Institute, gave his perspective discussing how the experience of analytic training was a life-changing experience that went far beyond a professional identity. He acknowledged that the financial rewards may not be as great as they might once have been. Nevertheless, he felt that analytic training has enabled him to develop a varied and interesting private practice.

Dr. Andrea Corn, a senior candidate at the Southeast Florida Institute for Psychoanalysis and Psychotherapy, presented a paper that addressed a specific transference experience that occurred to the candidate during her Institute training. Not until years later, long after the educational curriculum had been fulfilled, supervision was near completion, and many unconscious conflicts had been worked through in her personal analysis, was a new and important insight realized. The candidate described her inhibition and difficulty expressing independent thoughts caused by a childhood fear of being humiliated, or at worst, destroyed by criticism. Beginning in childhood the words of others, and especially her mother’s, were idealized while her own were devalued. Consequently, a transference reaction constricted her ability to fully participate in the Institute’s tripartite educational experience. The particular transference example was illuminated as a springboard to raise a specific issue regarding analytic training. The question posed was whether faculty members should empathically and privately address a candidate’s transference if it affects the didactic interchange of learning. Gratitude was also expressed for undergoing this transformative process. This candidate felt that the real value in the Institute training occurred not at the end point of completing specified requirements, but learning to appreciate and accept who she was throughout this intensive self-discovery process. The paper ended with two ideas to support the future of postdoctoral analytic training.

Dr. Abby Herzig, a candidate at the NYU Psychoanalytic Institute at the NYU Medical Center, is the editor-elect of the new online journal, *The Candidate*. She shared what candidates have been writing in the journal and the themes that keep coming up in the submissions. She emphasized that *The Candidate* has become a forum for candidates—past and present—to have a true and uncensored voice.

Thomas Bartlett, a former candidate at the Psychoanalytic Center of Philadelphia presented a hypothetical case of a candidate who wants the institute’s approval to take on an analytic case. He suggested that the political hurdles of getting the senior analysts to pass on the candidate’s readiness displays some of the limitations in our learning model. He encouraged all of us to consider how we can inspire new candidates to enter the field.

Dr. Mary Beth M. Cresci, Director of the Postgraduate Programs in Psychoanalysis and Psychotherapy at the Derner Institute of Adelphi

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In The Ordinary Moments: Rethinking Ritual and Reverie From the Relational Perspective

**Presenters:** Stephen Cooper, PhD  
*Rethinking Elements of Privacy and Reverie*  
Jody Messler Davies, PhD  
*The Rituals of Psychoanalysis, or A Ritual by Any Other Name: Rethinking the Ritual/Spontaneity Dichotomy*  
**Discussant:** Malcolm Owen Slavin, PhD  
**Moderator:** Estelle Shane, PhD

The purpose of this panel was to address the question, “How are ‘ordinary moments’ in psychoanalysis thought about from a Relational perspective?” The panel then deliberately deviated from what is ordinarily thought of as the territory of the Relational sensibility, enactment and self-disclosure, entering the terrain of the commonplace in psychoanalytic work.

In his paper, Cooper declared that because the Relational analyst is notably interested in moments of impasse or stalemate, and because he or she is likely to highly value spontaneity and mutual discovery in the clinical situation, the Relationalist is thought to prize privacy and quieter moments in his work far less than the Ego psychologist or the Freudian. In contrast to this perception, Cooper reveals a very different picture of himself at work within such everyday interactions, illustrating his own use of privacy and reverie with his patient, Bennett, with whom he also, in their interactions, exemplifies his concept of “ethical imagination” as well as his approach to analyst-disclosure and good enough impingement, portraying his original re-conceptualization of ritual and reverie from the Relational perspective. Thus, distinguishing between “wanting” privacy and “needing” privacy, and between “analytic” disclosure and “self” disclosure, Cooper clarifies the meaning and value of these concepts. He also demonstrates a new understanding of reverie and its clinical significance. He names the process whereby the analyst retreats through reverie from the immediacy of the moment to a private place within himself in order to explore his own thoughts and feelings as they are evoked in the clinical exchange, the use of Ethical Imagination. However, Cooper’s thoughts and feelings emerging in reverie ultimately find their way back into intersubjective engagement with the patient, through analytic disclosure, in contrast to remaining a private experience of the analyst. Cooper ended his presentation with a compelling assertion about the inherent value of privacy and reverie in the clinical situation, arguing for the inclusion of both reverie and privacy in Relational thinking. He stated, “Privacy provides an intrinsically porous container for reverie, access to associational linkages, and the opportunity to think about points of transference-countertransference entanglements in ways that . . . [are] sometimes take for granted, and . . . have been, perhaps, less emphasized in relational theory.”

Davies asserted that while a Relational sensibility had always opposed attempts to codify basic tenets, she would nevertheless scrutinize some prime assumptions of Relational thought, examining ritual aspects of psychoanalysis within a relational perspective. Davies first described two fundamental shifts in theoretical perspective central to the paradigm shift to a Relational turn: first, the epistemological move to a constructivist model; and second, the different understanding of the nature of mind. Next, Davies presented three basic assumptions of relational thought: mind as structured but fluid; meaning as ambiguous and always subjective; and the interpersonal encounter as inevitably unique, intersubjective, and defined and managed by the ongoing interplay of mutual projections and recognitions. In the context of these basic assumptions of Relational thought, she argued, meaningful interventions with patients must change as well. Davies noted definitively that the traditional interpretation, designed to make the unconscious conscious, can no longer fit with basic tenets of Relational thinking.

To address problems for the Relational clinician inherent in this basic alteration in theory, Davies distinguished among different potential forms of analytic intervention that all depart from traditional interpretation and are more consistent with the current emphasis on the significance of the unique analytic relationship, the multiple self-other configurations that define transference/countertransference processes, and the centrality of enactments that make unconscious experience available for reflection and symbolization. Noting that all intentional forms of intervention, verbal or nonverbal, can be categorized as either evocative, symbolic, or generative, Davies explained, expanded on, and illustrated each of these three interventive forms with what she described as two very ordinary clinical case examples in which the essentially relational nature of the work is unfolded, and where both enactment and self-disclosure are notably absent, in favor of a more patient-centered, or empathic, mode of listening and responding to her patients.

Malcolm Slavin began his discussion with a brief historical perspective on the relational proclivity to break
free of the more routine realm of reflection and choice that represents the great majority of ongoing clinical work. He then described both Cooper and Davies as broadening the scope of the relational paradigm—Cooper attempting “to introduce and legitimate a clearly private, internal dimension . . . into our vision of the process by which the analyst . . . [makes use] of his otherness as a part of a repeated pattern of enactment,” and Davies appearing “to imply that change . . . can take place outside cherished assumptions about the centrality of enactment . . . .”

Slavin perceived in Cooper’s work with Bennett a sense that the analyst needs to use the relationship with this patient “to reach down into that place where his deepest complementary identity lies . . . [that is] where his version of the patient’s problem lies . . . what Steve needs to do is to somehow find the part of him that needs to be cured by curing Bennett . . .”—a difficult and painful process that requires “an immense amount of internal opening up, internally feeling for and finding much that is less than welcome in ourselves, to genuinely feel his way into Bennett’s experience.” Then Cooper must use his otherness to reveal to Bennett the world that Bennett creates and recreates continuously, but this is the “relational message that [Cooper] can listen to, but can’t follow, [being] too empathic a clinician” to expose Bennett to another hurtful rejection, rendering Cooper’s otherness “too real . . . to be usable.” Cooper must “find a place he can go to to know better his own feelings . . . in the form of reverie he calls his ethical imagination.” Here he is able to work out for himself who he is, and how he can be with Bennett, a process that takes time but that requires remaining private.

Slavin concluded that Cooper is asking us to move the relational narrative into a place where none of the major analytic narratives sufficiently go. While Relational narratives of impasses recognize that the analyst must make use of otherness in the process of mutual recognition, they don’t, as Cooper does, illuminate this inner, private, subjective turn of ethical imagination and its return to the patient as a process of mutual recognition.

Turning to Davies, Slavin declared that in her exchanges with her patients, Davies is shifting into a framework where “she brings something akin to a self psychological sensibility.” When, for example, from her own position of interacting Other, she observes in her patient, Kate, some possibility of hidden, displaced anger at her for leaving on vacation, Davies’ own Otherness is not relevant to Davies. What is relevant is her capacity to feel Kate’s experience of disconnection and longing for connection, and to verbally recognize this. Further, Slavin viewed Davies’ putting this idea into words, contrary to Davies’ own assertion, as an interpretation, “a symbolic act, a framing of meanings.” Slavin argued that “interpretation, from a constructivist viewpoint, [one that recognizes] multiple subjective constructions of reality, means . . . offering meanings about the other’s experience in one or another . . . frame, [and that Davies’] . . . warmly recognizing comment and question to Kate lay in the meaning frame of the selfobject transference.” Slavin agreed with Davies that it was, at the same time, an “evocative intervention,” and also likely to be “generative.” Slavin wants to “break the hold on the traditional notion of interpretation as “something that . . . unveils hidden, maybe projected motives,” noting that interpretation comes in many forms and is most of what we analysts do.

Turning to another of Davies’ patients, Bella, Slavin noted that Davies described Bella’s development of self structure through the use of both her dog and Davies as selfobjects—Davies “left her own customary relational meaning frame to dwell in Bella’s subjective world.” While Slavin acknowledged that Davies is speaking of only moments of Bella’s treatment, nevertheless Davies (paraphrasing Slavin) is moving into an alternate meaning frame in which interpretation and enactment are just as central but have different meanings. There are other analytic traditions—those that are broadly self psychological—that emphasize a process of change not necessarily entailing a major experience of enacted conflict within the treatment. These alternate models may miss a lot along with what they gain. We don’t need to abandon aspects of the relational mode.

Slavin concluded that through these presentations, the Relational narrative has moved away from a ritualized use of the analyst’s otherness into primary realms of unformulated experience and across paradigm boundaries into alternate meaning frames.

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University, noted that the proliferation of institutes and fewer numbers of applicants have created an atmosphere that is potentially damaging to the field. There are many temptations to lower requirements or admit candidates who are not well qualified. Having credentialing bodies like the Accreditation Council for Psychoanalytic Education may help to provide a set of standards for free-standing psychoanalytic institutes.

The panel concluded with an audience discussion of their experiences of analytic training and concerns about psychoanalytic education today.
The New Psychodynamic Diagnostic Manual: How Old is the Wine? How New are the Bottles?

Presenters: Ann D’Ercole, PhD

Is the PDM the Right Tool for the Job? And, What’s the Nature of ‘the Job’?

Gary Walls, PhD

Diagnosis, Epistemology and Politics:
The PDM Paradigm

Irwin Hoffman, PhD

From Diagnostic ‘Doublethink’ to the Development of Creative Sensibility in the Psychoanalytic Process

Chair: Lewis Aron, Chair.

Lew Aron chaired this panel presenting critical appraisals of the PDM, the new psychoanalytic diagnostic manual that was produced as a complement to the more behavioral DSM-IV.

Ann D’Ercole began the panel discussion by pointing out that all scientific work is political, because it affects social policy. In evaluating a tool such as the PDM, one needs to ask the following questions: 1) who is doing the work; 2) how is the work organized; 3) what is considered necessary; 4) who cares about it; 5) what are the sources of support; 6) who are the consumers; and 7) how is it used or marketed.

The PDM is sponsored by the most powerful organizations within psychoanalysis, including Division 39, the International and American Psychoanalytic Associations, the National Membership Committee on Psychoanalysis and Social Work, and others. It was carried out by a 35-member task force chaired by Stanley Greenspan, the principal organizer of the work. These organizations strive for consensus. Thus, it is positioned to become the standard for psychoanalytic practice.

The manual is divided into three parts: Adult mental health disorders, Child and Adolescent disorders, and a set of conceptual, research and historical papers that provide the scholarly foundations for the PDM. While the DSM claims to be atheoretical, the PDM is explicitly rooted in psychoanalytic theory. The PDM has been criticized, however, for its lack of research substantiating its reliability and its inclusion of some categories lacking in empirical support.

Further, the medical model it represents is adaptationist in a Darwinian sense, and can limit understanding in clinical situations. It tends to cast psychoanalysis as a medical procedure alleviating symptoms rather than as a meaning-making activity. The use of diagnostic systems can lead to unintended consequences, such as the oppression that occurred when the DSM pathologized “homosexuality” in the fifties and sixties. The PDM does not make this particular error, but it does, for example, contain a category for “gender identity disorder” that may be problematic.

The PDM operates as a marketing strategy for organized psychoanalysis. This can function to pressure therapists to conform to conventional standards of social behavior; for example, to behave in a manner acceptable to employers, an effect that is the antithesis of what psychoanalysis strives to be. The PDM tends to create an illusion of certainty about the clinical situation and a false sense of consensus about how to view and to treat human problems. D’Ercole concludes that the effort to standardize psychoanalysis in order to better sell it is a misguided goal.

The next panelist was Gary Walls. His first criticism of the PDM was that its title is misleading. Calling it the “psychodynamic” diagnostic manual suggests that it represents a consensus-based version of psychoanalytic theory. In Walls’ view, this is radically false. He suggested that a more suitable and accurate title would be “The Ego Psychology Diagnostic Manual.” Ego psychology is only one of several prominent paradigms within psychoanalysis, and there are enormous substantive differences among them in terms of their fundamental premises about human nature, their conceptualizations of human distress, ontology, epistemology, research methodology, and the basic unit of study for psychoanalysis. Ego psychology is very different from contemporary relational theories of psychoanalysis on many points that have profound implications for a diagnostic system. For example, ego psychology takes the individual mind as the basic unit of study and tends to be biologistic, emphasizing the mind as a direct manifestation of brain functioning, a focus that is repeatedly stressed throughout the PDM. The PDM operates strongly against the hard-won theoretical and clinical pluralism that exists in contemporary psychoanalysis, and that has followed decades of the stifling orthodoxy of an ego psychology so dominant that it threatened the intellectual integrity of psychoanalysis as a scholarly discipline.

Of course, the political agenda of the PDM (namely, to be accepted as a standard psychoanalytic nosology complementary to the DSM) would be less persuasive to its psychiatric and insurance company audience if it were to acknowledge the pluralistic epistemological status of theories within the psychoanalytic field. The appearance of being scientific required the PDM to represent psychoanalysis as a unified body of knowledge.
There is no doubt that the many references in the PDM to neuroscientific research make the PDM appear to be a rigorously derived scientific classificatory system. This appearance borrows heavily from the esteem that neurology claims because it is a laboratory based physical and experimental science. What is lost on many readers, most of whom are not conversant with neuroscience research, is that there is nothing at all rigorous in the loosely constructed and highly speculative claims that are used in the PDM to rationalize its diagnostic conceptualizations. Throughout the PDM, neuroscientific arguments are presented as empirically derived strong inferences, when a closer look reveals them to be speculations often based on distortions of neurological findings as well as exploitations of the verbal ambiguity that often exists between the language of neuroscience and the language of psychology.

Since the ebbing of the dominance of ego psychology, psychoanalysis has grown from a singular individualistic, intrapsychic theory to include a pluralistic array of relational theories that conceive human emotional suffering and mental disorder in terms of meaningful language, interpersonal relationships, and cultural, historical, political and economic context. Contrary to the aims of the PDM, Walls argues that we need to develop ways of conceptualizing and categorizing human distress that are consistent with our contemporary and pluralistic relational models. Because we are irrevocably practicing in a pluralistic, multicultural world, the PDM cannot adequately map our future.

In his paper, Hoffman argues that the PDM perpetuates many of the pitfalls of the DSM, including the medical model itself, which is now made out to be “psychoanalysis friendly.” In spite of this, the PDM retains most of the technocratic assumptions and positivist epistemology of traditional psychiatric diagnosis. Hoffman notes the contemptuous tone of many of the advocates of the PDM toward clinicians who embrace the pluralism that characterizes contemporary clinical psychoanalysis.

Hoffman cites Drew Westen as an example of a psychoanalytic researcher (one who is a member of the Task Force and author of two of the eight research articles included in part 3 of the PDM) who literally equates physical diseases such as leukemia with the psychological problems that psychotherapists treat, calling them “cancers of the soul.” Hoffman goes on to discuss Westen’s dismissal of contemporary pluralist epistemology:

[Westen] wonders how many of us contending with illness in a child would want the physician “who we believe lacks the expertise of a specialist who understands the pathophysiology of the disorder and knows the latest techniques for treating it?”

Westen continues by asking sarcastically, “how many of us would be content to have our child treated by a physician who says that he resonates with particular theories of leukemia and that, although he has not read much of the empirical literature on it since medical school, he believes cells can be understood from a multiplicity of angles, none of which constitutes the whole truth?” He then asserts that “The situation is, in fact, no different for our [analytic] patients, who come to us seeking help for cancers of the soul. It is easy to be postmodern with someone else’s misery.” (Emphasis added by Hoffman).

The air of certainty in the tone of the PDM, and the contemptuous dismissal by its advocates of any who dissent from its scientific paradigm lead Hoffman to worry that the PDM may be a part of an emerging Orwellian social reality. While many may see the PDM as purely strategic, and take its scientism with a grain of salt, there is true danger in endorsing any such project as defining psychoanalytic practice. When critical thinking and dissent are treated with derision and contempt, alternative views may insidiously disappear, and the manual begins to function as a technology of thought control as in Orwell’s 1984. As an example, Hoffman points to the numerous instances in the PDM in which disclaimers and qualifications, often contained only in footnotes, fundamentally contradict the claims of the main text. These disclaimers contain thoughtful and reflective statements about the limits of what conventional “scientific” work can produce in the way of knowledge that can be applied by a particular practitioner with a particular patient. But the full implications of these limits must be denied in order to justify the time, money, manpower, academic dominance and political control that implementing the DSM entails, because, as stated clearly in the fine print by its authors, the categories of the PDM are all oversimplifications that do not, in the end, fit any particular patient’s personality or situation.

Hoffman concludes by asking us to develop our creative sensibility in the psychoanalytic process and to allow theoretical constructs and previous clinical experiences—one’s own and those of others—to contribute to the range of possibilities that an analyst might consider a particular moment, to be “continually open to new ways of understanding and new ways of being that would arise in the context of unique moments in the process, an openness that would yield a series of ongoing revisions” in our understandings of our patients and how we may be of help to them, rather than to seek “knowledge” of people and what they need via fixed diagnostic categories and standardized treatment protocols.
The impact of the Internet and the accompanying virtual reality it provides has irrevocably altered all of our lives. Our culture has embraced this alternate reality in the form of online journals, chat rooms, excessive involvement with video games as well as internet pornography and sexual solicitation. The panel, “Time Out of Mind,” applied psychoanalytic principles to the understanding of individuals’ involvement with virtual reality in a variety of forms.

The first paper, presented by Batya Monder, began with a discussion of shame, a crippling emotion to some. Its effects can range from mild embarrassment to profound humiliation and a paralysis of thinking. The paper covered a partial review of the current literature on shame, noting that the sparse writing on the subject had few adherents before the 1970s and 1980s. Helen Block Lewis’ landmark volume, *Shame and Guilt in Neurosis* (1971), is felt by many to have begun a current re-examination of the subject of shame. Other authors including Benjamin Kilborne, Melvin Lansky, Donald Nathanson, and Leon Wurmser have added considerably to the discussion.

Monder then turned to the Internet and its access to a world of imagery and interactive possibilities—a resource for a wealth of knowledge or a playground for perversions. She presented four clinical vignettes, of two men and two women, to illustrate different ways patients navigate the Web and find sites that fit their particular desires and deficits. In this paper, Monder explored her own thinking about this material and shares what she came to understand about her patients, and what they, in turn, learned about themselves.

The two female patients, one in her mid-twenties, the other in her late fifties, were computer savvy, using the Internet often in their work lives and in their social interaction. Both had a difficult time talking about what they saw on the Internet. Neither elaborated fully about what she felt as she sought out a particular site or exactly what she viewed. For both, there was clearly an erotic component and a voyeuristic pleasure. They each turned to these sites when depressed and/or anxious, and for both women, it was a solitary activity with no desire to share the experience with anyone else.

Depressed and anxious feelings also spurred the two young men to turn to the Internet, but unlike the women, they both wanted contact with others. Each of them assumed a new persona when he went online to be titillated by someone he would never meet. One man was a virgin, but on the Internet he could play the role of a sexually sophisticated male and by so doing become more comfortable with that possibility. The other was struggling with his sexual identity and sought out contact with both women and men. His online experiences allowed him to be everything to everyone while he worked out his libidinal and aggressive feelings about his early objects. “The mask,” says Wurmser, “changes the shamefully exposed into the shameless exhibitor” (1981, p. 306).

In this small sample of patients, distinctive gender differences were noted. The men wanted to interact with others; the women only sought images. All four patients had experienced intense shaming episodes in their childhoods that reverberated for them as adults. Both women were blamed and shamed by their fathers about being sexually active; both men were struggling to separate from seductive mothers and were dealing with shameful feelings about their own masculinity. For one of the men, age 23, separating emotionally from the needy mother who relied on him inappropriately was a struggle but less incestuously tinged than was the case for the other young man, age 30. In his case, he felt a sexual attraction to his youthful looking and unhappy mother who had favored him and babied him, her youngest child; he often turned to her or his sister for comfort. In his analysis, he was trying to individuate from both.

The men sought out older women with whom they could interact sexually while the women acted out their rage at early objects by viewing particular kinds of images on their screens. A better understanding what the Internet experiences meant to each of these patients helped them to dissipate some of the depression, anxiety, and shame that had brought them into treatment.

The second paper, presented by Ellen Toronto, examined patients’ intense involvement with virtual reality as a form of dissociation, a “disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment” (DSM IV, American Psychiatric Association, 1994). Patients’ engagement with the virtual world can thus be disruptive both to productive functioning and the development of relationships but prove difficult to engage in the clinical encounter.
In her response, Dr. Ainslie pointed out, contrary to what some media and even some psychological research emphasizes as the dangers of Internet use, both presenters engaged their patients’ Internet use as a play space—an additional venue on which the play of conflicts, resolutions, trial actions, meaning-making and meaning-finding can be staged. Dr. Ainslie called it a “para-reality,” one that is co-existent and to the side of “regular” reality—an encapsulated “as if” experience very much like the transference in this way.

Monder’s understanding of her patients emphasizes the reasons why they turn to the Internet, that is, as an arena in which to express material they experience as ridden with shameful affects. Monder’s male patients play out sexual fantasies with para-real objects while her female patients, so ridden with shame, are unable to talk about what they’re compelled to view. While her male patients experienced the Internet as a way through their conflicts and anxieties, Monder’s female patients seemed to view the Internet as evidence of their conflicts and anxieties.

For Toronto’s patients, the Internet is not viewed as problematic at all; the manifest behavior is ego-dystonic. For Timmy, the Internet use offers respite from a push-pull exerted by his divorced parents and their terribly different households. For Casey, the Internet use is very much geared to mastering her past. Taking this stance with regard to the material she reads day after day on her job allows her to detoxify it, disassemble it, and drain it of meaning. The price she pays is in her relationship to the object world, her schizoid existence. The ongoing work with Casey is testimony to something more being possible.

Ainslie concluded by noting that the Internet, as a para-reality, offered all of these patients a context for creating symptomatic and communicative actions. The question they all beg is why for them talking about, thinking about, imagining was not enough?

REFERENCES
Task Force on Psychoanalysis and Health Care: Health Care, Psychoanalytic Theory and Career Development

Presenter: Robin Holloway, PhD
Psychoanalysis in the Public Sphere: Fit In, Fight Back, Form Alliances or Flee?

Chairs: Mary-Joan Gerson, PhD
Marilyn S. Jacobs, PhD

This presentation offered participants a reconsideration of issues in health care from a psychoanalytic perspective, with personal account of how things work in a setting where cognitive behavioral therapy is most favored.

Robin Holloway has worked for 25 years in the Canadian publicly funded health care system, where although health care is provincially funded, the federal government sets the guidelines for the utilization of services and allocates funding to the various provinces. Dr. Holloway worked in the Child and Family Services Department of a medium-sized public hospital, funded by the Ministry of Health for 20 years until the hospital was restructured. He is now in private practice.

This paper offered reflections of some of Dr. Holloway’s experiences during the years he worked in the public sector in Canada. Truth be told, his presentation was somewhat cynical, but, given his experiences, this attitude was quite merited. His wisdom led to many insights about how to maintain psychoanalytic psychology in the public sphere. Although his experience was derived from working in the Canadian socialized medicine system, what he speaks about is applicable to the way American medicine is organized.

He expressed concern about the future of publicly funded health care. Psychology has some “tough questions to answer.” Among these: 1) Can Psychology as a discipline survive in a publicly-funded system and if so, can psychologists survive by doing anything other than testing and brief manualized forms of treatment? 2) Can psychoanalysis survive in a publicly-funded health care system, and given the pressures for brief symptomatic treatments, do we as psychoanalysts want to be part of a public system? In a spirit of “guarded optimism,” Dr. Holloway attempted to answer these questions.

His personal narrative was a story of how his work became less important and less useful due to the influence of biological psychiatry and cognitive behaviorism and the consequences of Cartesian dualism. Using a case example, he illustrated the pitfalls of reliance upon these limited philosophies for mental health care.

Although the predominant theoretical orientation in the Canadian system is and has been cognitive behavioral therapy, Dr. Holloway pointed out: “As psychoanalytic psychologists, I don’t believe that we can’t afford to desert the public sphere. This would simply be taken as a tacit admission that psychoanalysis really had nothing to offer. I suggest that it would not be worth staying in the public sphere if we had to betray the basic principles of psychoanalytic treatment. But I think we can adapt to functioning in publicly funded institutions and fit in with at least some of their requirements without betraying psychoanalytic principles. At least, I think that some of us can do this, and can form appropriate and respectful working alliances with our non-analytic colleagues.”

He suggested that the first requirement for such a role is “... to know the tools we work with and their applicability.” He offered sound guidelines: “We need to know when and how to apply techniques such as CBT, clinical hypnosis, and other methods which could be seen as “ego-strengthening” or “ego-supportive” from a psychoanalytic point of view. We need to have genuine respect for methods such as CBT and for the clinicians that use these methods, and we also need to know when they apply and when they don’t. I have used CBT techniques for symptom reduction in cases of OCD. I have also used clinical hypnosis quite successfully for anxiety reduction. But in many cases, I have then gone on to use psychodynamic methods to deal with object relations issues. If we can use the right tools for the right jobs, we are more likely to gain respect.”

Dr. Holloway suggested that psychoanalytic psychologists could use short-term psychodynamic therapies such as Davanloo’s short-term dynamic psychotherapy. Another possibility might be that of Interpersonal Therapy, a psychodynamically derived and evidence-based method for treating depression. In using these short term models, psychologists working psychoanalytically need to know when these methods are useful and when they are not.

He went on to say that it would be useful if our discipline can develop psychodynamically based sub-specializations within public institutions. Also, psychologists have recognition for being able to do testing. One approach that may benefit psychoanalytic psychologists is to combine psychometrically-anchored testing with psychoanalytic theory. Dr. Holloway closed his paper by discussing how evidence-based treatment is defined as evidence obtained from randomized controlled trials. He suggested that psychoanalytic psychologists counter that with their own view of what constitutes evidence.
PSYCHOANALYTIC PERSPECTIVES ON PREJUDICE AND CONFLICT: A MODEL FOR APPLIED PSYCHOANALYSIS FOR THE 21ST CENTURY

Presenters: George A Awad, MD
The New Anti-Semitism: A Convenient Psychopolitical Construct for All
Carlo Strenger, PhD
Belief Systems, Identity and the Function of Prejudice in Israeli Politics
Afaf Mahfouz, PhD
Intergenerational Transmission of Prejudice and the Multiple Narcissistic Wounds in the Middle East
Ira Brenner, MD
A Dissociative Geo-Identity Disorder in the Middle East

Discussants: Hassan Azim, MD
Nancy Hollander, PhD
Steven Portuges, PhD

Chair: Nadia Ramzy, PhD
Moderators: Marilyn S. Jacobs, PhD
Laurel Bass Wagner, PhD

This two-part symposium was sponsored by Section IX, the Multicultural Concerns Committee and the Spring Meeting Planning Committee of the Division of Psychoanalysis. The program was inspired by the International Conference on Prejudice and Conflict which was held in Salt Lake City in December 2005. The International Psychotherapy Institute along with the International Journal of Applied Psychoanalytic Studies and the International Association of Applied Psychoanalytic Studies sponsored that meeting. While there were many outstanding panels at that conference, the panel, “Elements and Dynamics of Prejudice in the Palestinian-Israeli Conflict,” was most compelling. In that presentation, Nadia Ramzy introduced the session. She reflected, “we are here this morning to discuss the consequences of one of the most tragic conflicts of the 20th century.” She provided a framework for the presentations, which developed and evolved from the panel members who are part of a work group committed to a just peace and to deepen psychoanalytic understanding about the Palestinian-Israeli conflict. Analogizing to the clinical situation, she suggested that the discussion would ensue according the following principles: 1) the creation of a safe psychological space for the mastery of the traumatic suffering inherent in the conflict, which requires an ongoing empathy and respect for the Other; 2) all viewpoints are welcome and included in the discourse; and 3) there is nothing that cannot be said or stated.

The momentum for the establishment of the work group was the problems of prejudice and its implications, which were seen as an important and urgent topic. The theses of the presentations are organized around the themes of massive societal trauma and the intergenerational trauma that follows along with virulent prejudice and how these are the dynamic engine behind the intractability of the conflict.

Since the first paper was to have been presented by Dr. Awad, a videotaped presentation made by Dr. Awad was shown instead. He spoke of the changes in Palestinian society because of effects of continual loss and trauma. The latter do not allow for higher defenses. Instead, a new morality developed, along with massive introjections, projections, and magical thinking. The continued conflict has enhanced the identity of the Palestinians but has not helped group cohesion. At present, those who are more extreme are more admired. Those who are moderate are considered to be traitors and risk assassination. There is an unconscious idealization of victimhood, which leads to a new reality wherein martyrdom is idealized and seen as a path to Paradise. Emotionally, the concept of Paradise is the opposite of living in Gaza.

1 It is with sadness that we note here that George Awad, Training and Supervising Psychoanalyst at the Toronto Psychoanalytic Institute, and one of the very few Palestinian psychoanalysts in the world, died of medical causes on the morning of May 25, 2007.
Dr. Awad went on to discuss how archaic representations have dominated in the Middle East. Hatred is the only response to the realities of the life situation of the Palestinians. Living under Israeli rule has become a nightmare that fuels the continued negativity of mental representations. Palestinians suffer from violent attacks, confiscation of their lands, humiliation at checkpoints, destruction of their homes, and uncertainty. As a consequence, archaic structures have become more angry, suicidal, and homicidal. He identified the following five outcomes: 1) sublimation, remain dormant, become apolitical; 2) transmit hatred to other generations; 3) maintain hostility and aggression toward Israel; 4) borrow Western symbols for a new anti-Semitism; and 5) use the intellect to solve the problem.

The next paper presented by Carlo Strenger focused on how much of the confusion in the discourse in Israeli politics is based on the need for a positive identity narrative in the context of needing to integrate facts that are detrimental to that narrative. For the first decades of its existence, Israeli public discourse denied the plight of the Palestinians that was ordered by the higher echelons. This plight was not written about in the books. Israel did not feel that accepting this horrible historical fact would enable it to have an identity that was livable, and so the only way to live with it was in denial. In 1967, after the Six Day War, a group of soldiers said, “If we do not leave these territories within a year it will be the ruin of Israeli society.” It was thought that the only way to create Israel was to expel the Palestinians. Israeli society was not able for many years to live with the tragedy. Two of the major political groups who were struggling for power in Israel—the moderate left and the non-ideological right—had to a) justify the moral position of Israel and b) come to terms with the system of prejudice. The current chaos is not close to resolution.

The right was the group that said Israel has to hold onto the occupied territories for the time being; Israel was in theory in support of a two state solution although this belief could not be spoken out loud as it would endanger Israeli society. Much of the political philosophy of the right derived from a paper written in 1928, “The Iron Wall,” which said that the Arabs could not be trusted; the only thing that would work with the Arabs was force. This was the official line of thought of all political parties. In this regard, the prejudice distorted any sense of reality. The Iron Wall thesis provided a narrative that suggested true negotiations with the Arabs were not possible. There was also a non-differentiation between various aspects of the Arab world and a lack of validation by Israeli society as to what had happened to the Palestinians.

The left refuted the position of the right, saying that Israel could not continue to hold onto the territories and that what had happened since 1967 had been wrong. The left argued that it must be the case that the Palestinians would accept the solutions that were livable for the Israelis, that is, returning to the 1967 borders. The left held onto this set of beliefs in spite of all the evidence to the contrary. This position only worked for so long. The turning point occurred in 2000 with the breakdown of Camp David and the beginning of the 2nd Intifada.

Dr. Strenger provided a psychodynamic hypothesis for change, which he acknowledged was not realistic: the only way in which Israel could move forward was if it came to terms with the guilt of what happened in 1948 and refuted its denial of what had been done to the Palestinians. Dr. Strenger went on to interpret the continued public discourse in Israel of attacking the Israeli government of corruption, which he sees as a defense against the guilt of 1948. For Israel to have such recognition it would need a true statesman with moral stature, leadership, integrity, and emotional strength. This step would lead to mental and psychic healing of the Israeli psyche.

Nancy Hollander discussed how real losses have produced a reliance on primitive mechanisms, which the Palestinians living in exile have been more able to contextualize and sublimate than the Palestinians living under traumatic circumstances, creating conditions that lead to less of an ability to symbolize. Hollander suggested that Palestinians and Israelis are two equally traumatized groups who mirror one another in their use of primitive defenses. She framed the situation in terms of the nature of colonizer and colonized and the resulting cold hate for the other. She suggested that the claim of anti-Semitism might obfuscate the destructive policies among the western powers. The U.S. superpower role in the region is shaped by its identification with Jews in Israel. The Palestinian narrative is experienced as being that of “the Other.” From colonial times on, there has been the dynamic of “the Other” and the manifest destiny of the American West. Other issues that have influenced this conflict during the 20th century include western guilt over the Holocaust, neocolonial ventures due to the need of the West for oil, romanticized narratives of the European on behalf of the Enlightenment and multiple Zionist organizations working to help Israel. In the end, the narrative of the Palestinians is barely audible.

Hassan Azim discussed psychoanalytic research on prejudice. He demonstrated how the Implicit Association Test can be used as an indirect method of measuring unconscious racial attitudes. This test consists of self-report scales. In one study, individuals at age six, ten, and adulthood were tested. It was determined that unconscious prejudice increases in adulthood. Other research was cited which found that Jewish children were capable
of differentiating between an Arab and a Jew and that in Israel there is an early in-group bias against Arabs accompanied by negative feelings against Arabs. In addition, Jews are motivated by a self image that is moral and a negative image of Arabs; Arab children of all ages do not differentiate between images of Arab and Jew, and Arab adults had conscious negative attitudes toward Jews but no unconscious bias. Another interesting study using functional magnetic resonance imaging revealed that the amygdala was stimulated when images of individuals from different ethnic groups were shown to subjects, even though subjects self reported that they were egalitarian with regard to different groups. Also shown in the study was a conscious effort to inhibit the prejudice with activation of areas of the brain related to executive function and affect regulation.

The afternoon session was titled “The Problem of Prejudice and Conflict in the Palestinian-Israeli Encounter: A Dialogue Among Palestinian, Israeli, and North American Jewish and Arab Psychoanalysts: Psychoanalytic Contributions to Working Toward Resolution of Conflict and Prejudice in the Palestinian-Israeli Situation.” Again, Nadia Ramzy began the afternoon session by reaffirming the work group’s commitment to a just peace and awareness of the seeming intractability of the problem. She reiterated that mastery of traumatic suffering entails ongoing expression of the suffering and the importance of grasping the fullness of the Other’s subjective reality. She emphasized that all viewpoints were welcome, no one was to be excluded and there was nothing that could not be said or stated. She returned to the theme of the symposium: that massive societal trauma and the intergenerational transmission of trauma and virulent prejudice were engines of ongoing intractability of the conflict.

Dr. Ramzy stated that Arab anti-Semitism was a new phenomenon and a function of the worsening conditions involved in the occupation of the Palestinian territories. And, that prejudice toward Israel stood in sharp contrast to the attitude toward the Jews in the Mideast. Traditionally, anti-Jewish sentiment was not a prevailing ethos within the Arab world. The dominant perspective in the Arab countries was characterized by inclusion and tolerance. In Arabic, the Jews are referred to as the “sons of our uncles” or “our cousins.” The anti-Semitic and anti-Jewish prejudice is profoundly disturbing and dissonant to the ears of Arabs who have been raised in the tolerant traditions of Islam in which all the people of the Book coexisted in relative harmony. We would do well to reflect upon the factors that support social tolerance and social accord historically. As psychoanalysts, we recognize the importance of accepting the Other. There can be no peace without full understanding of the fears of annihilation of the Jews and the suffering of the Palestinians. In psychoanalysis, we are aware that the most recently acquired psychological structures are the first to be lost under the strain of changing circumstances. We would hope that this principle would apply in a positive way to the recently acquired anti-Jewish sentiment in the Middle East, that as political circumstances improve, this prejudice disappears.

In her presentation, Afaf Mahfouz emphasized the likelihood that the audience was more familiar with the perspective of Israel and encouraged the audience to consider the Arab narratives. She contended that telling one’s own story is the beginning of understanding prejudice and narcissistic wounds. With this, she told her personal story about early experiences in Egypt while she was growing up. She was stirred to ask questions by several incidents at school that made her realize the differences between the Middle East and the West. Her early experiences made her think that even though prejudice is in all of us, it is important to manage it so it does not get out of hand. And, to manage prejudice we need to use psychoanalytic knowing as well as an understanding of the history of the conflict.

Dr. Mahfouz related her feeling that what we are witnessing is a reaction to multiple narcissistic wounds transmitted intergenerationally. For many in the area, Israel replaced colonial Europe and became the mighty power, the Oppressor. In France, terms are used such as “dirty Jew” and “dirty Arab.” The recent historical events are a change in the way history has been played out as in the past, Jews and Moslems identified with each other. Now, most of the people in the Middle East feel humiliated and repressed. Dr. Mahfouz asked, “Where do we go from here?” She reflected, “For me, I think we need to experience multidisciplinary teams of good will to provide healing even before peace.” Another important focus is to help the process of economic development. A major problem is that the people in charge do not know how to handle negative affects such as paranoia and depression. She suggested that if we team up in an attempt to offer something that can be integrated into projects already at work in the area, get a better understanding of narcissistic wounds, and work with the children of the conflict, there may be some hope.

In his presentation, Ira Brenner reasoned that the Palestinian-Israeli conflict has been conceptualized in a number of ways, but essentially it is a fight between different groups for the same piece of land. The kinds of prejudice that have arisen have deep roots. He spoke of the new anti-Semitism, which he maintained was a variation of
an ancient theme. The Jews’ original claim to Israel started with a parcel of land. The British promised different things to each side. The challenge has been Israel’s right to exist that has become the intransigent problem. This also has become essentially a psychological problem. In the case of the disputed land, two narratives exist. Each side denies the legitimacy of the other side. This state of affairs leads to severe trauma and dissociation. There is then excessive internalized aggression. There are two traumatized societies who are regressed and locked in a world of combat over land. Dr. Brenner provided a clinical example of a patient whose story could serve as a parable for the conflict in the Middle East. The conclusion was that no progress can be made until the violence has stopped. He encouraged a thoughtful debate about the future. The goal is to have all parts unite but if this is not possible, then at the very least, there must be mutual respect—a psychological solution of two states with solid borders.

In his discussion, Steve Portuges underscored the importance of realizing the centrality of history and how national forces can help to maintain discriminatory practices. Perhaps with the aid of a psychoanalytically informed interdisciplinary approach the disastrous effects of war and police actions can be realized. An alteration in social reality accompanied by mental changes is needed. Jews and Arabs must work together to end the fratricidal madness.

Dr. Strenger also added to the discussion, relating his belief that the only way of moving out of this situation is to require the United States and Europe to become long-term chaperons and promoters of the peace process. He suggested a move from metaphor to political reality. The Israeli psyche is that of a people being permanently endangered. Israel needs to return to the ideal of liberal humanism. The differing parties in Israel have vastly endangered. Israel needs to return to the ideal of liberal humanism. The differing parties in Israel have vastly divergent views of the situation. The right wing has one overriding view: Jews need to defend themselves. The middle wing has no real coherent policy. In the end, some say that the Zionist endeavor has failed.

A very interesting and provocative discussion followed the afternoon presentations. The complexity and emotionality of the Middle East conflict became apparent in the seminar room as different views were shared by the audience based on political, historical, and ethnic perspectives. In the end, this two-part symposium was an excellent example of applied psychoanalysis. We hope for more such considerations by the Division in the future.

**Further Suggested Readings:**
Paper Summaries

Presenter: Philip M. Bromberg, PhD
“Grown-Up” Words: An Interpersonal-Relational Perspective on Unconscious Fantasy

I offer the view that the concept of unconscious fantasy remains of heuristic value only as an affect-driven experience. It is not something that can be known; it is something that is felt—a ghostly intrusion into the analyst’s subjectivity—an ineffable “not-me” experience. Freud saw these “ghosts” as pathological epiphenomena of unconscious fantasy whereas Klein saw these unconscious “phantasies” as developmental necessities that are potentially transformative. The Kleinian concept, especially Bion’s writing, helped to build a bridge between pathology and creativity, but the clinical problem inherent in our use of this term has not disappeared. By reifying the notion of an unconscious cognitive text, we perpetuate the myth of uncovering a “buried fantasy” that was too experientially dangerous to be contained in consciousness—a kind of unacceptable daydream that was repressed and must be allowed to emerge to the “surface.”

If we take seriously the research supporting what the Boston Change process group calls “a nonlinear enactive theory of psychotherapeutic change,” then what we call reality cannot be distinguished from what we call fantasy in absolute terms because the ability of different parts of the self to recognize other parts as “me” is always relative. What is accepted as reality by a particular self-state is relative to what defines “me” at a given moment, and must always be considered in terms of alternate views of reality held by other self-states. What I call “the shadow of unconscious fantasy,” cannot be linked by words per se, but must be captured as part of a field where the interface between narrative memory and immediate perception permits the simultaneous existence of multiple realities trying to make their presence felt.

What looks like the “uncovering” of a hidden fantasy is in fact the inch-by-inch development of self-reflectiveness in areas of experience previously foreclosed to reflection and permitted expression only through affective, subsymbolic enactment. It is an affective imperative with a life of its own that superimposes itself as an unacknowledged “not-me” intrusion into what is experienced as “me,” and it does so without cognitive representation. The individual is in thrall to an evolutionary survival response built into the human brain—an automatized stimulus-response configuration that is triggered affectively and automatically. It is immune to assimilation into self-narrative and, I argue it is time to proactively challenge the myth that what analytic treatment does is “uncover” bits and pieces of disavowed cognition—derivative elements of a fantasy that has always been there, which if interpreted as parts of a single context will “reveal” itself. If Ronald Laing was accurate that fantasy is a particular way of relating to the world, then “unconscious fantasy” is a repetitive way of relating to the world, and has to do with what we now refer to as, “implicit relational knowing” and procedural memory. In light of the relational shift taking place, away from content-driven treatment toward process-driven treatment, Laing may have been 40 years ahead of his time.

Presenter: Anna Aragno, PhD
What, Exactly, Is Artistic in the Art of Psychoanalytic Dialogues?

During this conversation our discussion centered on the introduction and use of Bakhtinian concepts of Dialogicality to help conceptualize and pinpoint what exactly is artistic in the art of conducting psychoanalytic dialogues. For the most part these concepts were new to participants and their application to the title question stimulated many fascinating questions. Defining qualities of artistry in any art form is difficult enough but to do so in an interpretive situation with therapeutic aims was found to be quite a challenge. All agreed that some defining characteristics of ‘artistry’ are that it ‘objectifies’ and transcends the ordinary; in performance it demonstrates a particular ease and excellence of execution; and in creative spheres it tends toward representing and generating new form.

Artfully conducting psychoanalytic dialogues, it was suggested, entails seamlessly steering the progressive and regressive dynamisms throughout a process that by means of contextual experience, interpretation, and working-through, propels the momentum of conscious awareness (and insight) forward, building accretively toward psychic wholeness and a new co-authored, “filled out,” life narrative. The dominant motif in this conversation focused on drawing parallels between the tensional dynamics of unconscious gestation, labor, and realization in new integrations, as these pertain to both the creative and psychoanalytic processes. The central role of dreams in metaphorizing current unconscious themes and the wide interpretive spread created by “multidetermination” and condensation in all unconscious manifestations was also considered. But the tight presentation pertaining to the title question sought to define artistic criteria in the formative principles and interactive dynamisms of the psychoanalytic
process itself by applying the dialogical principles of the great Soviet philologist Mikhail Bakhtin to our unfolding dialogues. Viewing the psychoanalytic process as a specialized dialogue enabled us to adopt the conceptual vocabulary of Bakhtin’s aesthetics and dialogics, thereby identifying dialogical artistry along various clearly defined criteria.

Presenters: Jesse D. Geller, PhD
Norbert Freedman, PhD

Patients’ Representations of the Therapeutic Dialogue and the Post-termination Phase of Psychotherapy

This paper presented a new evidence-based approach to investigating the ways in which patients construct, recall, interpret, and use emotionally charged representations of the therapeutic dialogue. It specifically focused on the ways in which these representations evolve during what Rangell termed the “post-termination phase” of the process of therapy and the ways these representations contribute to the eventual effectiveness of therapy.

The psychoanalytic literature is rich in hypotheses about the potential ways in which representations of the therapy relationship enter awareness, their subjective meanings, their affective coloration, and the functions that they serve in particular patients’ lives during inter-session intervals and after termination. However, this area of inquiry has received relatively little systematic research attention. To secure basic information, we developed a research interview that elicits detailed narrative accounts of patients’ retrospective reconstructions of their experiences in therapy and a multidimensional scoring system that enables one to classify variations in the cognitive, affective, and motivational properties of patients’ representations of the interactive aspects of their experiences in therapy.

Preliminary findings based on an ongoing study of the perceived effectiveness of the therapies offered at the Institute for Psychoanalytic Training and Research’s outpatient clinic were presented. The paper concluded with reflections on the implications of our findings for the hypothesis that patients will continue to build upon what they accomplished in therapy to the extent that they 1) mourn the final loss of the therapist, 2) analyze rather than act upon the conflictual transference residues that linger after termination, and 3) use benignly influential therapist introjects to serve adaptation-enhancing functions.

Presenter: Sophia Richman, Ph.D., ABPP

Remembering to Forget—and Writing About it

Survivors of trauma know that dissociation is a double-edged sword. It can be a merciful defense but when the crisis is over it can have negative consequences on the rest of one’s life. It becomes a style of functioning which narrows the inner world and leads to a sense of being disconnected from self and others. Aspects of self that are denied do not allow for the integration of self-states and in their most extreme forms result in fragmentation and identity confusion.

Psychoanalysis and psychoanalytic psychotherapy can be of profound help in expanding and integrating parts of self that have been split off or denied, but there are other effective roads to reconnecting with oneself and others. Creative endeavors such as painting and writing can be transforming experiences that give the traumatized individual an opportunity to mourn losses and work through traumatic memories and events.

This presentation examined the complementary relationship between writing and psychoanalysis as two forms of introspection each with its own potential for healing. Similarities, differences, and the interface between them were explored. Both writing and psychoanalysis involve witnessing, communicating, and making contact. Trauma needs a witness to free it from silent memory whether that witness is the analyst in the room or the imagined reader. Expressive writing, like psychoanalysis, uses words to give voice to unformulated experiences, but unlike psychoanalysis, it creates a concrete product that endures the vicissitudes of shifting states. The written words provide the evidence that certain feelings once existed.

Transformation of trauma into autobiographical narrative is of particular significance in the attempt to bridge multiple self-states that exist at different levels of awareness. Individuals with artistic sensibilities often have a special talent for dissociation. When engaged in the creative process they can become so engrossed that they lose all sense of time and place and virtually enter a trancelike or dissociated state. Clinical examples from case material, from literature, and from the author’s personal experience with memoir illustrated the power of narrative to help make sense of troubling confusing feelings and to provide a sense of continuity.
WHEN WORLDS COLLIDE: CROSSING CULTURAL DIVIDES IN TRANSITIONAL SPACES

In her paper, Dr. Fiske presented the case of a 93 year-old-African woman from Uganda who, after experiencing many losses in her life, felt homeless and hopeless. Dr. Fiske, who is British, faced the invisible weight of the colonial divide, and was mindful that the colonial patterns of engagement might be replicated in the therapist-patient dyad. As she observed, when the therapist-patient dyad is nonconcordant in terms of race, nationality, age and culture, the weight of political history and historical inequities may color the relationship, and past historical events and recent political upheavals may impact transference and countertransference dynamics.

Yet, for the elderly Ugandan woman who had witnessed three or more decades of civil strife and upheaval in her native country, colonialism represented order, a place in society, a sense of protection. Her reactions toward the colonial past were influenced by the fact that during that period her family was together and the losses had not begun to accrue. In contrast, this history of imperialism evoked anger in Dr. Fiske, in part because of transfersences from her own past. To become familiar with the social and historical context in which her patient grew up, Dr. Fiske began to read the history of Uganda. In undertaking that task, Dr. Fiske not only avoided the Eurocentric bias of ignoring pre-colonial African history but also conveyed to her patient that her history and culture mattered. It is not clear whether her patient’s acceptance of the invasion of her country was a reflection of her depression and sense of hopelessness or whether it was a vestige of the psychological impact of colonial practices, where realities and histories of the indigenous population were treated as insignificant.

What is clear is that under the gentle gaze of Dr. Fiske, a gaze that searched for the patient’s reality past stereotypes and conveyed a strong interest in her patient’s world, the elderly woman began to narrate her story, to name her losses and share her past. For her, the politics of the colonial rule were not that important. What mattered to her were the losses she had witnessed and had to endure: the loss of her mother, the death of her siblings and later, the death of her children. In her words, the Uganda she knew “was gone” and there was nothing for her anymore. Telling her story could not undo the past and could not change the present. It was simply an act of narrating her life and giving meaning to it, to someone who was interested in her life and her world.

Dr. Fiske’s interest in the history of Uganda conveyed the message that the past mattered, that the context in which her patient lived her life mattered. It also conveyed her willingness to explore colonial and imperial practices and to contemplate the impact of such practices and ideologies on the lives and experiences of the people who were subjected to it.

In her paper, Dr. Simha-Alpern presented the case of a young Hispanic male, a patient who felt lost between several cultures, a man who knew more what he was not than what he was. The young man felt that he did not belong in any culture, that he was invisible and not accepted by anyone. He had a profound ambivalence toward the white middle class he wished to belong to but made him conscious of his otherness, and the Latino culture that he dismissed as inferior and with that his own ethnic identity and background.

Citing Neil Altman, Dr. Simha-Alpern observed that a common transferential enactment of minority patients who are treated by white middle class therapists is their expectation of not being understood and of being rejected. This theme was repeatedly enacted by her patient either by trying to provoke her or by withdrawing and treating her as the other. Dr. Simha-Alpern became aware of her own countertransferential reactions, and specifically, her fear of injuring, misunderstanding, and rejecting her patient. For Dr. Simha-Alpern, experiences of prejudice, idealization, and devaluation are inevitable parts of the multicultural experience and therefore, are likely to be reenacted in the therapeutic relationship. Drawing from Bromberg’s work, Dr. Simha-Alpern sought to help the patient explore and articulate previously hidden parts of himself and to tolerate the coexistence of conflicted emotions and internal contradictions.

Dr. Simha-Alpern felt that for her patient to begin to grapple with different parts of himself, the ugly parts and the deformed parts, she had to be tolerant herself of his self-states and multiple enactments and attentive to his different self identifications without favoring or encouraging any. For Dr. Simha-Alpern, the young man’s conflicting self-states and internal turmoil undermined any experience of his and confirmed his sense of the world as
uncaring, biased and rejecting. By attending to the different parts he presented in the room, and by exploring his rigid views without dismissing him or the emotions that gave rise to them, Dr. Simha-Alpern enabled her patient to begin to contemplate previously unformulated parts of himself and to begin the process of integration toward a single, more tolerant self system.

On the surface, the two cases, in fact the two therapeutic dyads, seem very different from each other, not only in terms of the patients’ age, race and cultural backgrounds, but also in terms of the sociopolitical and historical realities that leave a distinct mark on the tone and feel of the two treatments. Dr. Simha-Alpern’s case is not fraught with the weight of past colonial practices and is not framed by the context of diametrically opposite national experiences. There is no colonial past that is shared, in fact, what she and her client shared was the distance from each other’s ethnic identity and the lack of experience with and exposure to each other’s cultural background. Yet, underneath the apparent socio-cultural and historical differences between the two cases, one can also notice the similarities. Both clients felt marginalized in the United States and seemed resigned to an alien present; both sought to distance themselves from their ethnic history and cultural background; and both expressed an idealization of the white middle class other.

Unlike their patients, both Dr. Fiske and Dr. Simha-Alpern are middle class, educated immigrants who have not experienced the sense of marginalization and invisibility their clients have. Yet, both sought to actively engage with the marginalized part of their patients’ identities, by exploring their own identities and self-states and by searching for their own rejected and split off cultural experiences. Both analysts were willing to go deep into their own experiences and to embark on their own self exploration; both were willing to question themselves, their prejudices, and blind spots.

In doing that, both analysts conveyed to their patients that their histories and discarded parts were valued, that the context in which they experienced themselves, however denied or dissociated, was part of their present. Both analysts also conveyed that cross cultural work with patients who have dissociated themselves from their cultural experience requires that therapists actively search for the context in which their patients have experienced themselves, not to justify or emphasize the differences but to find the private and to validate one’s own inheritance however dissociated that might be.

Does it matter, one may ask, whether a therapist is an immigrant? Not really, one might say. Both analysts did what any good analyst would do—they searched for their patients’ discarded experiences, they searched for their patients’ yearnings and wish to be listened to and to tell the story underneath their denials and dissociated reactions. Beyond the initial familiarity and recognition that an immigrant analyst might have with some of the experiences and cultural mores that are described, the task ahead remains the same: to explore, to understand patterns, and to help the patient develop a better understanding of himself or herself and the world. Yet, there might be a fleeting edge, at least initially, one that is not created by the similarities between the therapists’ and the patients’ ethnic or religious backgrounds, but by the fact that, like their patients, the therapists also had to experience and maybe are still experiencing their otherness as well. It comes from the implicit understanding that like their patients the therapists too had to leave the familiar to seek safety and meaning in a place where they cannot help but experience their otherness. It comes from the subtle, tacit recognition that, however differently or fleetingly, they too have experienced themselves as strangers in the world, they too at times feel like they have left a part of themselves elsewhere; like their patients, they too have turned their backs to the place they were born and raised.

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For those who are interested in the future work of this group, contact Nadia Ramzy, PhD, ramzyland@gmail.com or (314) 725 7659.
TRANSMISSION OF TRAUMA IN THE WAKE OF LOSS: IMPLICATIONS FOR INTERVENTION DERIVED FROM THE WORLD TRADE CENTER PROJECT

PRESENTERS:  
SALLY MOSKOWITZ, PhD  
PRIMARY MATERNAL PREOCCUPATION  
DISRUPTED BY TRAUMA  
DONNA DEMETRI FRIEDMAN, PhD  
PRE-NATAL LOSS OF THE FATHER AND  
DIFFICULTIES IN MOTHER-CHILD AND ADULT ATTACHMENTS  
RITA REISWIG, MS  
WHAT IS TRANSMITTED FROM THE MOTHER TO THE CHILD ABOUT THE FATHER LOST ON 9/11: PRELIMINARY SKETCHES OF THE THREE STYLES OF TRANSMISSION  
SUZI TORTORA, EdD, ADTR  
THE USE OF NONVERBAL MOVEMENT  
ANALYSIS IN THE TREATMENT OF WOMEN PREGNANT AND WIDOWED ON 9-11  
K. MARK SOSSIN, PhD  
PLAY IN THE WAKE OF TRAUMATIC LOSS

CHAIR:  
PHYLLIS COHEN, PhD

DISCUSSANT:  
BEATRICE BEEBE, PhD

This panel comprised a group of therapists who have been working together for over five years on the World Trade Center Project. Dr. Phyllis Cohen explained that the project was conceived of by Drs. Beatrice Beebe, Phyllis Cohen, and Joseph Jaffee in collaboration with Drs. Anni Bergman and Sally Moskowitz as a primary prevention and intervention project for pregnant 9/11 widows and their unborn or newly born babies and their older children. After 9/11, there were 101 babies born who lost their father pre-natally. The WTC project has seen approximately 40% of those families.

Dr. Cohen described the various components of the project including support groups for mothers and their babies and preschool children, mother-child video bonding consultations, feedback sessions with the mothers using the videotapes and a team of therapists, and an ongoing therapist peer-supervision and support group. Dr. Cohen spoke about how each of us brings his or her own feelings to the work with the mothers; she shared how moving an experience this has been for all concerned. All of the panelists presented specific aspects of their work with these families.

In her paper, Sally Moskowitz described themes heard over the course of the first three years in the groups and in individual sessions. Dr. Moskowitz described patterns seen in some of the mothers and in interactions between them and their babies. The mothers were heroic in their attempts to accomplish mothering a new baby while mourning, but in many ways, the work of primary maternal preoccupation seemed to be incompatible with the work of mourning. It does not seem possible for the psyche to be “consumed with the lost object” in mourning and also consumed with the infant in primary maternal preoccupation.

Dr. Moskowitz discussed ways in the early years in which normal states of mind critical to “good enough” mothering were disrupted and altered by the effects of trauma and loss. In particular, themes commonly aroused by pregnancy such as change in identity, body image disruptions, and the regression to dependence on the family of origin seemed to have been made more complicated and difficult to manage. The intervention focused on strengthening the connection between the mothers and their babies, and on helping the mothers distinguish the work of mourning from the work of caring for a baby. Bonds among the mothers were also encouraged in various ways, as were connections among the babies as they developed into toddlerhood and early childhood.

Donna Demetri Friedman presented a paper describing how the women who were pregnant on 9/11 and lost their husbands had experienced violent trauma. This combined with their own early attachment styles made it difficult for the women to initially connect with outsiders offering help. Many seemed to develop ambivalent attachments to the therapists, which improved over time. The mothers with the most traumatic pasts seemed to have the most difficulty. A striking example of this was shown by mothers who expressed hostility and anger toward their child or who seemed unprotective of their child. These mothers had the most difficulty holding their babies and toddlers in their minds.

Some mothers tended to have interpersonal difficulties, complicating efforts to enter new romantic relationships. Some have gotten involved with a romantic partner who has become the potential “new daddy” only to end in another loss for the mother and children, hence recreating the earlier loss of the father. Dr. Demetri Friedman reviewed the complexities pertaining to new marriages and step-parenting.

Rita Reiswig’s presentation discussed the depth of difficulties that preoccupied the widowed mothers’ minds. She described how, in the early years following the WTC
disaster, simultaneous and contradictory tasks were at hand, both conscious and unconscious.

Three different ways the mothers transmitted memories and attributes of the lost father were described. In the first style, this loss has been mixed with other significant and unresolved losses from childhood. The second style described mothers who were not “moving on.” And the third description was of a specific mother who developed a transitional idea as a way to represent the lost husband-father. Many unanswered questions remain pertaining to how these feelings, behaviors, and attributes are transmitted.

In her presentation, Suzi Tortora described how many of the mothers had to both navigate their own intensely complicated lives while they had to raise their newborn infants and other children. As the mothers’ fantasies and thoughts began to shape their mental representations of the lost husbands—representations that would be shared with their children—a simultaneous nonverbal process that was immediate and ongoing, was greatly affecting how the mothers communicated and transmitted their thoughts and feelings.

Dr. Tortora explained how the emphasis on nonverbally communicated thought specifically represented the mothers’ immediate states of mind, which were wrought with tremendous complexity. The nonverbal dialogue between mother and child was used to explain how these “simultaneous and conflicting tasks” affected the developing attachment relationship, and in turn, the infant’s developing sense of self. Dr. Tortora’s perspective included observing the mother-child nonverbal exchanges within the role of sensorimotor, kinetic experiences, and vitality affects and the dynamic moment-to-moment organization and re-organization that occurs in the maternal–infant primary interaction.

Dr. Tortora explained that through the video feedback sessions, when video clips from the lab along with nonverbal observations are shared with mothers, the therapists have provided a supportive environment enabling the mothers to share their concerns while giving them tools to consider, discuss, and reflect on how they relate to their children. By sharing observations of both verbal and nonverbal communication patterns with the mothers, the therapists have supported their capacity to think about the minds of their children, fostering the development of an optimal attachment relationship, and therefore transforming a traumatic experience and loss into a healing cohesive narrative that mother and child can share. She concluded by saying we must not overlook how the quality of the nonverbal exchange might be influencing the child’s processing, formulating and generalizing these experiences into a cohesive whole as a sense of self and other develops.

K. Mark Sossin described lab observations as creating a special window into the mindfulness, affect sharing, play experiences, and nonverbal patterns of interaction of our participating mothers and children, which also allowed us an opportunity to directly engage each child. Alongside video feedback consultation, our “intervention” incorporated an aim of increasing mentalization/reflective functioning in the mothers.

Themes of trauma, disruption, irretrievability, and disillusionment were notable in play. Mothers had lost their assumptive world experiences of security, control, choices, a sense of being protected, and predictability. Some were frozen in time and motion. Self- and other-regulatory experiences of rhythmicity, kinesthetic attunement, use of referencing, perceptions of affectivity and continuity, sustained conjoint play, and the attainment of intersubjectivity seemed at risk. Scaffolding and symbolic elaborations in play were at times disrupted as a function of loss. Some children entered a role of regulating mom’s mood, with reduced freedom to create, pretend, and play. Responsive and regulated interchanges laid a foundation for resilience. The child’s need to have the mother contain, understand and validate meaning in the play was met, at times, by the mother’s discomfort, manifested in diversion.

Dr. Sossin noted that play themes bearing on destruction and survival were prominent as were repair themes. Play was often marked by the child’s expressions of intense affect in a world that seemed beyond the child’s control. As children developed the capacity, we introduced an affect/picture-story task, developed by Howard and Miriam Steele, which has been very helpful in appraisal.

Dr. Sossin shared his impression that through our observation and intervention, mothers often heightened their awareness of their children’s experience of loss, of how representational their play was, and of the importance of allowing the child to lead in the play. Video feedback allowed an emotional resonance to be evoked: the mother could see the child’s play themes and related feelings as ones related to her own experience. Video feedback increased the mother’s mentalization of her child’s representation of the lost father.
THE ROYAL ROAD REVISITED: DREAMS AS SOURCES OF MOMENTUM IN WORK WITH DIFFICULT-TO-REACH PATIENTS

JANE KENNER, PhD

Despite the neglect of dreams in the psychoanalytic discourse of recent years, dreams played a pivotal role for the presenters on this panel and functioned as a source of momentum in their work with two seemingly impenetrable patients. In Dr. Kenner’s case, the dream in question was her dream about her patient at the time of converting the case from long-term intensive psychotherapy to a training analysis. Dr. Golden presented a study of the gradual changes in the content of her patient’s recurrent dreams over the course of a nine-year weekly psychotherapy.

Dr. Kenner’s presentation was an abbreviated version of her paper exploring the many meanings of her own dream about her patient. After 25 years of full time work, the patient, Fay, had collapsed into depression. Estranged from her family and from her daughter, Fay had lived her life in a self-described “bubble” that functioned to keep everyone outside and protect her from the threat of loss. After work, for most of her adult life, she had gorged on junk food and then purged. The treatment was stalled by two factors, the first, Fay’s incessant chatter and dread of her own internal psychological processes and, the second, Dr. Kenner’s belief that Fay was endlessly deserving of empathy in compensation for the abuse she had experienced as the “servant” of an angry, overworked mother. Adding to the picture was Fay’s relationship with an alcoholic father who had gloried in depriving his family of money and spending it instead on expensive dinners in fancy restaurants. He taught Fay that, because he and she were exceptionally bright, the rules and limitations that applied to other people did not apply to them. Although she drank in his words, the sexual undercurrent between the two of them made her increasingly uncomfortable and she eventually fled from home.

At the time of converting Fay’s case to a training analysis, Dr. Kenner dreamed that she was inside an expensive boutique, gazing at an exquisite handmade outfit she wanted to buy for Fay. Once outside on the street, however, she ran into her supervisor, who told her it would not be appropriate to buy the outfit for Fay. Throughout the first three years of Fay’s analysis, Dr. Kenner discovered new connections between her dream and Fay’s treatment—for example, the dream’s anticipation of the change in her technique once she recognized the perverse basis of Fay’s behavior. With the help of the dream, Dr. Kenner came to realize she had been trying to cover over the messy, primitive aspects of Fay’s functioning but would have to confront the truth about Fay if she wanted to become an analyst. The more confrontational approach she adopted eventually led to Fay’s more honest engagement in the treatment, including the revelation that, all her life, Fay had had a Cinderella fantasy. She awaited a prince charming who would recognize her beauty and a fairy godmother who would provide her with the gown she needed when the prince arrived. Dr. Kenner then understood that she had unconsciously wanted to be Fay’s fairy godmother and had been both the recipient of and participant in Fay’s Cinderella fantasy.

In exploring the many meanings of her dream about the power of a third—namely, Dr. Kenner’s new supervisor—to challenge the fantasy shared by the analyst/patient dyad, Dr. Kenner drew upon a wide range of theoretical sources. These included Freud, French psychoanalytic, neo-Kleinian, ego-psychological, and American relational thinkers. The contributions of this array of thinkers demonstrated that no one individual school of psychoanalytic thought offers the final word on the interpretation of dreams. Rather, Dr. Kenner argued, the truth seems to be that dreams offer unparalleled insights into an individual’s unconscious and into treatment issues, but only when allowed to unfold in meaning over time. Pinning down the meaning of a dream in the service of illustrating a given theoretical orientation, or because of the analyst’s anxiety regarding not knowing, is tantamount to denying the complexities, uncertainties, and mysteries that characterize unconscious communication.

Dr. Golden’s presentation retrospectively examined the long, slow, yet fruitful process by which persistent dream work significantly enlivened a hard-to-reach patient in a nine-year, weekly psychoanalytic psychotherapy. The paper showed the slow reshaping of dream images as the exploration of dreams deepened the connection between the patient and the therapist, and between the patient and her split-off inner world. Erin, the patient, was a married, middle-aged, career woman with three children, who came...
into treatment vaguely aware of a long-standing loneliness and emptiness. In the early years, patient and therapist built a tentative alliance that led to some meaningful external changes in Erin’s life. Yet, Dr. Golden found the sessions largely static, unrevealing, and unsatisfying. She came to understand her feelings as a projective identification with a part of the patient that remained starved and neglected. Five years into the treatment, the patient began reporting recurring dreams of mutilated and starving kittens and chickens; these dreams indeed seemed to reflect the sense of deprivation that Dr. Golden felt in the work with Erin and that Erin felt in her life. In these dreams Erin appeared as a detached observer who was suddenly shocked into awareness of her neglect of helpless creatures. She was strikingly lacking in curiosity about her own dreams and would say, “Here is another one of those dreams that pleases you; I will talk about it but only to humor you.”

Despite the patient’s initial resistance to exploring her dreams, both therapist and patient became involved in a relaxed, playful, lively extended dialogue about the dream images—their sources, their meanings, and their resonance in the transference. Over several years, the beings in Erin’s dreams morphed from neglected animals into neglected babies, and then from neglected babies, into satisfied, well-attended babies. Interestingly, for nine months, the dreams of animal neglect ceased, and were replaced by dreams of severe aggression—human against human. This development opened the way for major interpretations about the link between Erin’s repressed rage and her deadened sense of self; instead of expressing her rage, she was severely repressing her own feelings and thoughts. It was after these interpretations, that the animal dreams resumed and the creatures in the dreams began morphing into healthier beings. Erin was now integrating, at a rather steady pace, a new awareness of her previously split-off rage about subtle emotional neglect endured in both childhood and adulthood. Finally, she had begun to comment with a sense of wonder about her own detachment from the neglect and abuse she observed in her dreams.

Dr. Golden turned to Bion to understand the path by which the dream work led to genuine change for the patient. In accord with Bion’s notion of the therapeutic relationship as a safe container, the dream-focused interaction with the therapist allowed the patient’s overwhelming emotions to surface in a safe space. The therapeutic relationship became a haven for otherwise unthinkable thoughts, and interpretation and change proceeded from there. Winnicott’s true self/false self concept also played a part in Dr. Golden’s understanding of the case. Repeatedly, excerpts from the dream transcripts showed the patient’s preoccupation with a search for the real self, and as the dreams changed, Erin herself was changing from a detached presence to an active one in her dreams. Essentially, she was recovering parts of her self that had long been split off from awareness. Although the work had been slow and had involved considerable struggle, the therapy itself had taken on new life.

The panel moderator was Dr. Joyce Slochower of the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis; she was filling in for Dr. Jeanne Wolff Bernstein of the Psychoanalytic Institute of Northern California. Dr. Slochower discussed the Winnicottian and relational themes embedded in both Dr. Kenner’s and Dr. Golden’s cases. She explored the relational dimension of the dream work, considering how the dreams represented the analyst’s experience of herself and the patient, and might be studied as an illustration of the nature of relational treatment dynamics.
**Beyond the Boundary of Analytic Revelation: Culture, Self-Disclosure (Analyst and Patient) and Anonymity**

**Presenters:** Roy Moodley, PhD  
With (holding) the Missing Portion: Disclosure, Concealment and Seduction in Cross-Cultural Psychotherapy  
Ruth M. Lijtmaer, PhD  
*I Cannot Hide: Struggling With Anonymity and Disclosure as an Immigrant Analyst*

**Moderators:** Roy Moodley, PhD  
Ruth Lijtmaer, PhD

The argument that self-disclosure will change the psychoanalytic process into a socio-cultural niche that will distort the therapeutic alliance and compromise therapeutic effectiveness is still the widely held belief among many psychotherapists. The purpose of this panel was to consider the issues surrounding culture, concealment, and seduction since they remain largely untheorized and clinically problematic.

Dr. Moodley’s paper critically examined the theory and practice of psychoanalysis across cultures, its response to the critiques, and its return to the cultural. Next, he looked at the current thinking on self-disclosure and the specific problems of self/other disclosure in cross-cultural settings and its impact on the analytic relationship. The analyst’s decision to disclose its (dis)contents can be part of an elaborate fantasy experience for patients across cultures. In this presentation, he also explored published empirical research showing that psychoanalysts’ need for knowledge can result in seductive motivations and acting out rather than in objectivity neutrality. Finally he discussed the reasons why cross-cultural patients need to conceal rather than disclose, however strong the alliance, so they can maintain and protect their fragile ego defenses in the analytic relationship.

Dr. Lijtmaer’s presentation questioned the decision whether or not to self-disclose, what to disclose, and when and how. This decision should be guided by the analyst’s perspective on neutrality, conceived as a mental stance in which the analyst assesses and decides what, at any given point, seems to contribute to the analytic process and the patient’s therapeutic benefit (Meissner, 2002). However, in the consulting room, distinct nationalities, boundaries and regions are communicated, as dialects, accents and intonations can “give away,” or at least provide clues to the therapist’s and patient’s origins.

As an immigrant analyst, as soon as Dr. Lijtmaer speaks, patients know that she is an immigrant and that she has an accent. Some Spanish-speaking patients easily recognize where she comes from; however, her last name can cause confusion. It is common for patients to ask, “Where are you from?” Just as her language usage can be a point for collective identification, her name can be a potential for difference. The issue of self-disclosure is at stake here; she cannot be anonymous. The positive aspect of this type of revelation is that it may serve to de-mystify the way the patient thinks about the analyst (Rosenbaum, P., 1997).

Additionally, revealing personal information can bring some emotional closeness and identification: patient and analyst both speak a pre-oedipal language, which is the language of attachment and intimacy. For some patients similarity threatens the sense of self, and perceived differences become a reassurance that the patient-therapist boundary is secure (Smith & Tang, 2006). While the deliberate disclosure may indeed open the space, it also runs the risk of closing it (Ipp, 2006). Therefore, the
ON FACILITATING THE FORWARD MOTION OF CLINICAL ENGAGEMENT: RELATIONAL MODELS OF CHILD ANALYSIS

Christine C. Kieffer, PhD

BEYOND BULLYING AND BEING BULLIED: FROM DISSOCIATION TO NEW MODES OF RELATIONAL ENGAGEMENT

Peter Carnochan, PhD

FOSTERING AFFECTIVE AND RELATIONAL SKILLS IN CHILD THERAPY

Chair: Estelle Shane, PhD

This panel examined the role of the child analyst as participant and co-author of play in creating clinical momentum. The papers explored how the analyst can enter into play in ways that facilitate the development of affective expression and modulation, and help the child expand relational capacities.

The first panelist, Christine Kieffer, examined how modes of play in psychoanalytic child treatment can enable a resumption of psychological growth through a process of procedural enactment, empathic immersion, ongoing rupture and repair of fragile relational bonds—allowing an engagement of previously dissociated affect states and building expanded capacities for both self-reflective thought and creative action. Dr. Kieffer argued that an enactment of the patient’s split-off states often precedes empathic immersion and that interpretation of a rigidly enacted scenario serves to develop mutative understanding. She maintained that the analyst often first gains awareness of this split through countertransference participation in this enactment. Interpretation of this “vertical split” (Goldberg, 2005) serves to mitigate symptoms while promoting self-reflection and “mutual recognition” (Benjamin, 2004). However, therapeutic action lies not only in interpreting what is already present but also takes place within the co-constructed development of new relational modalities both through the ongoing rupture-restoration cycles in the internalization of new interactional procedures and, most important, through a process of mutual responsiveness to “spontaneous gestures” (Winnicott, 1958) that are contributed by both dyadic partners.

Dr. Kieffer provided a clinical vignette that portrayed work with a school yard “bully”—a nine-year-old girl with a history of severe trauma—and the ways in which the patient’s relational history manifested itself in the clinical encounter, allowing the analyst to taste the experience of both victim and aggressor. She reported that, while it was a challenge to find a way to empathically convey these experiences and connect with a girl whose sadistic and controlling modes of interaction had developed in the service of dissociating overwhelming traumatic affect states in order to protect a vulnerable self from further injury, an opportunity presented itself through the medium of “playing school.” Dr. Kieffer’s assigned role—that of a recalcitrant pupil who has been asked to write a daily diary, gave her a vehicle for conveying her countertransference reactions to the patient, through empathic immersion in what she imagined that patient’s experience had been.

She argued that this encounter provided a fulcrum by which disowned affect and experience could be engaged and worked through, while also helping the patient to establish new empathic capacities—for both self and others. Later, patient and analyst together assembled a cardboard toy boat together, which came to serve both as a vivid depiction of the vicissitudes of the emergent “analytic third” as well as a symbol of hope. Her paper also expanded upon an integration of nonlinear dynamic systems theory and the analytic third, through the lens of relational self psychology, a project that she has previously written about (Kieffer, 2007).

Peter Carnochan examined how play therapy can be a forum for the development of affective-relational skills. Using two clinical examples, he addressed how the analyst can go beyond interpreting what is already present in the play and begin pointing toward the development of new possibilities within the relationship. Hence, Dr. Carnochan maintained that, by participating as a narrator and co-author of the play, we have a chance to give voice to the threatening thoughts and feelings that govern the child’s difficulties, and this process can be a powerful agent of change. Dr. Carnochan asserted that, in his experience, in order to help children make more extensive changes—to allow momentum to develop in the treatment—there are times when we must go beyond interpreting what is already present and begin to point toward what might develop. In Looking for Ground: Countertransference and the Problem of Value in Psychoanalysis (2001), Dr. Carnochan argued that advances in psychoanalysis and psychotherapy have increasingly shown that well-being requires more than the capacity to be in unbiased contact with reality. He believes that virtue requires the development of a wide range of affective-relational skills and these skills must be learned through experience.
Dr. Carnochan’s presentation of two case vignettes—with David and Jacob—were presented in a very lively and vivid way, as he depicted the moment-to-moment interaction in his work with them. In each case, Dr. Carnochan described how his therapeutic actions were first, efforts at interpretation of their experience, and then were directed, plainly and unswervingly, toward providing the help they needed to develop more adaptive relational skills. Playing competitive games with David revealed to Dr. Carnochan his patient’s rather “casual and sloppy relation to memory.” In chess, for example, Dr. Carnochan worked with the patient on paying attention and sharpening his cognitive skills—skills that are necessary for the accurate processing of events. At the same time, opportunities to work on affective regulation and interpret genetic roots to conflict were provided. With Jacob, Dr. Carnochan worked interpretively with his patient’s sadistic attitudes toward his mother and younger sister, but also worked more directly to help Jacob develop alternate skills that incorporated “love, desire, control of his hatred, and his mourning of the past.” Dr. Carnochan believes that the analyst might have to ask the child to actually try out with him alternative modes of thinking and acting, risking the child’s experiencing this as a repetition of traumatic authority, but “when the analyst can speak both to the past, the alternate constructions of the present, and the hopes for the future, these efforts to create new affective-relational skills . . . remain in accord with the analytic conviction that change, to be durable, must eventually be experienced as radiant change, one that is in accord with the child’s deep interest.”

Estelle Shane, the moderator/discussant of the panel, who graciously stepped in for the original discussant, Pasqual Pantone (who had to miss the conference because of a family emergency), provided an illuminating elaboration of the material presented in each presenter’s paper. Dr. Shane maintained that the two papers seemed to “encompass the essence of what is meant by contemporary analysis”: that is, they “demonstrate the imaginative freedom accorded the therapist in current practice to go beyond the traditional frame, to deviate from established boundaries of therapeutic action and therapeutic outcome” in order to foster affective and relational skills. She maintained that the bold actions taken by both presenters in working with children might be more easily accepted, even applauded, by an analytic audience, than might be the case were their papers about treatment of adult patients. She noted that therapists of children, and even adolescents, are allowed greater liberty because they are working at expanding development rather than only expanding consciousness or resolving conflict. However, since Dr. Shane believes that analysis is, in itself, a developmental process, and that developmental processes extend beyond childhood and are ongoing throughout life, then therapeutic action for patients of any age can go beyond interpretation, to promote expanded therapeutic outcomes. Dr. Shane further asserted that, if development is recognized as a significant therapeutic outcome in adult analysis, much more than verbal interpretation and understanding, much that lies in procedural, nonverbal or enacted relational engagement may be perceived as acceptable modes of therapeutic action, designed to enhance, for the patient of any age, affective and relational skills in the dyad.

References

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negative side of revealing personal data is the fact that these tend to be enduring aspects of the analyst’s social self; once they are known, they can never be unknown. Hence, the knowledge of the analyst’s origin, once confirmed, set up transference–countertransference responses, which were explored in the paper. Individual psychodynamics and cultural identity may not be easily disentangled.
This panel was part of a developing collaboration between Section VIII: Couple and Family Therapy and Psychoanalysis and Section II: Childhood and Adolescence, which began about a year and a half ago to develop forums in which issues at the interface of child and adolescent therapy and family therapy could be explored.

Dr. Phyllis Cohen, a child and family therapist and member of Sections II and VIII, presented her work with a child that involved both individual child therapy, work with the family in differing configurations, and work with the larger systems, including the school and the legal systems. Dr. Lawrence Zelnick, a member of Section II and a relational child therapist and psychoanalyst, commented on the case from an individual child psychotherapy perspective. Dr. Richard Fulmer, a family therapist, psychoanalyst, and member of Section VIII, commented on the case from a family systems perspective.

Case Presentation and Discussion
The two-year nontraditional treatment of 13-year-old Esther, who was coming of age in the context of court, culture, and family chaos, was presented as a narrative interrupted by choice points at which the therapist had to make a deliberate decision as to how to proceed. Dr. Cohen stopped at four points in her presentation to allow comments from Drs. Zelnick and Fulmer with the focus on the interface between the individual and family approaches.

These were the four points: 1) at the time of the referral when setting the frame and establishing a therapeutic alliance with two warring, divorced parents; 2) at the point of establishing a therapeutic rapport with the child; 3) setting up work with the dyads of the child with each of her parents; and 4) deciding to change the therapeutic stance in relation to court proceedings and the girl becoming a rebellious adolescent. Issues related to dealing with lawyers, testifying in court in the midst of a custody battle and staying connected to all the involved parties were discussed.

Dr. Zelnick was very interested in how Dr. Cohen represented an alternative presence to the child, as someone who had a subjectivity that the child could begin to know without having to give up her own identity. Dr. Cohen was a caring adult who could accept Esther’s feelings, be willing to think out loud with her, and intervene on her behalf with a myriad of adults. In addition to these intrapsychic processes, Dr. Zelnick noted that the therapist had to be active in the patient’s literal environment. She was called upon to recommend the more viable parent and help the parents assess their responses to the child’s age-appropriate behavior. For example, Dr. Cohen demonstrated how far she would go beyond the intrapsychic to engage the mother when she spoke about her work with the mother alone, with the mother and child, mother and ex-husband, and mother and mother’s therapist. Dr. Zelnick also raised the question of whether Dr. Cohen was an agent of the parents, society, and/or religion.

Dr. Zelnick appreciated Esther’s remarkable resilience. With a great deal of loss and trauma in her background, Esther had achieved developmental milestones and was capable of feeling and sharing her despair about her life and her gratitude for the therapist’s intervention. Although Esther was often silent or seemingly removed in therapy sessions (looking down and being obstinate), Dr. Zelnick was impressed with how Dr. Cohen brought her out in her individual sessions. Dr. Zelnick noted that Esther was so preoccupied with caretaking of her parents’ trauma-driven psyches, that she did not have the space in which to express her own “craziness” in an age-appropriate way.

Dr. Fulmer demonstrated a systemic perspective by tracing how Dr. Cohen’s interventions affected the emotional distance between Esther, her parents, and outside influences. At first Esther was too close to her mother (being slapped by her in public) and too distant from her father (who refused to share custody himself.) The parental executive subsystem had been deeply divided for years. Dr. Cohen was able to join this family by refusing to side with either parent and limiting their executive goals to Esther’s future well-being, excluding their past hostility toward each other.

Dr. Cohen then drew much closer to Esther through playing the game of backgammon in play therapy. The consistency of Dr. Cohen’s non-anxious proximity permitted Esther to become more self-possessed and an agent in her own life.
Having abandoned the attempt to bring the parents closer as too difficult, Dr. Cohen then made an effort to bring Esther closer to each parent in a series of dyadic meetings. The chaotic encounters between Esther and her mother established that the mother was too anxious and reactive to bear the stresses of custody, but did allow the mother to experience Dr. Cohen’s fairness. In Esther’s sessions with her father, both parties were less reactive and Dr. Cohen became close enough to the father to persuade him to seek permission from his rabbi (part of the father’s extended support system) to accept custody of Esther.

Dr. Cohen made a dramatic decision to enter the court system. She stepped into the executive position previously vacated by both parents and supported the removal of custody from the mother. Systemically, she was trying to make Esther more distant from her overreactive mother and closer to her previously distant but now more accessible father. Dr. Cohen’s drawing closer to the court caused the judge to reinforce this therapeutic move by transferring custody to the father. Amazingly, Dr. Cohen did not lose her relationship with Esther’s mother. Perhaps the considerable attention Dr. Cohen had given the mother (and the father’s indicating that he was now closer to his daughter than to a religious ideal) permitted her to bear the separation.

In this improved emotional environment, Esther began to withdraw from Dr. Cohen and her parents and become closer to her friends, appropriately showing more independence. Dr. Cohen finally drew closer to the parents (even helping them draw closer to each other) to help them not over- or under-react to Esther’s new adolescent rebelliousness.

**Conclusion**

Dr. Cohen’s flexibility in working out of multiple frames and her willingness to struggle with difficult clinical decisions at various points along the way provided a rich context in which to explore these varying perspectives.

The comments among the presenters revealed many points of concordance and some interesting speculations about what might have been gained or lost if another avenue had been pursued. It also demonstrated the benefits of both child therapists and family therapists being familiar with the other perspective. The lively and enthusiastic interaction between audience and panelists affirmed the importance of continuing this kind of dialogue.
Male Heterosexuality: The Final Frontier in Rethinking Gender

Bruce Reis, PhD

From Gender Absence to Straight Talk

Robert Grossmark, PhD

Two Men Talking

Adrienne Harris, PhD

Bruce Reis’ paper began with the observation that white heterosexual men tend to not be described in terms of gender and are at once the standard of gender and its non-appearance. He suggested that male heterosexuality has not been granted the fluidity and the multiplicity accorded to female and queer sexuality and has been seen as monolithic. As a result, male heterosexuality has remained under-theorized, and heterosexual men have become fenced in by the socially constructed definition of their desire and behavior; their supposed normativity has created a restrictive and regulatory position. While agreeing with the feminist and queer theory critique that Freud’s idealization of phallic masculinity debased femininity, Reis suggested that it also delayed the theorization of masculinity.

Reis offered a critique of theorists who describe a limited and limiting outline of male heterosexuality. He took issue with Blechner (1998) who, while designating many queer identifications and practices as “masculine,” described male heterosexuality only in terms of fears and defenses. Similarly, Reis critiqued Elise (2001) whose “Citadel Complex” involved seeing male heterosexuality as a defensive reaction to maternal separation with a resulting compensatory phallicism and avoidance of penetration. In this theory, Reis argued, paternal presence is conflated with patriarchal power structure, and straight men and fathers are seen as oppressively forcing women and children to submit to phallic supremacy. Echoing Kaftal (2001), Reis suggested that this theory imposes an absolute binary between men and women and homogenizes heterosexual men, while not allowing them to claim their own difference. Reis asserted that within such a theory, difference and recognition are only for the oppressed.

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Reis cited Ken Corbett who has also noted the flat descriptions of heterosexual men in current gender theory, and Reis sought to unpack this one-dimensional view of heterosexual men as oppressive, abusive, and lacking. He focused on the limitations of the disidentification/counteridentification hypothesis and pointed to the work of Michael Diamond, Ethel Person, and Andrew Samuels as offering alternative conceptions of male development, where the father is not simply reduced to the ‘other’ parent and where the positive and nurturing presence of the pre-
A successful in his business, felt something amiss. Grossmark presented process notes that included a dream in which the patient’s daughter was represented as having lobster legs growing out of her groin area. The patient’s associations and the session led to the emergence of the patient’s sadness and loss at not having had a son and his old fears that he could never offer a son what he had believed to be the requisite heterosexual role modeling. The session illustrated the interweaving of the struggle to realize one’s heterosexuality in all its multiplicity and contradiction with the construction of the self.

The second case Grossmark presented also captured this struggle, but in this instance the patient struggled with issues of deeper psychopathology in terms of self and affect regulation, porosity of boundaries, and an addiction to child pornography. In this case gender identification and sexuality had been in the foreground from the beginning. Grossmark described a session where the patient brought in his infant son and both patient and analyst became involved in the changing and management of the infant in an enactment that played with multiple gender and family roles and constructions all at the same time. The patient’s recounting of a horrific dream that involved trauma, hyper-sexuality and violence, in the presence of his infant gave form to an enactment of early trauma in the nursery.

Both of these cases, suggested Grossmark, illustrated the ongoing construction of multiple and changing experiences of the heterosexual as it emerged between himself and these patients.

Adrienne Harris responded to the presentations, saying that she picked up a sense of both relief and anxiety within the two papers suggesting that to bring the study of heterosexuality firmly into the gender discussion was both timely and bold. As she had listened, she had sensed the dissolving of the category “heterosexual” and felt a radical process of re-signification was underway. Certainly, she suggested, gender categories can be a citadel, but also a prison. Just as change so often comes from the outer margins, there has developed an interior margin or avant-garde that seeks to change from within. Harris dwelt on the tensions between fixity and fluidity and noted how the issue of normativity tugs at all of the clinical material presented.

**REFERENCES**

Ethics Committee Panel: Slipping Through the Cracks: Ethical Issues in Everyday Practice

Jennifer Cantor’s paper echoed Chessik’s (1994) call to therapists to examine their “position on the corruption scale,” and ended with Cushman’s (1995) challenge to “confront [our] unconscious contributions to the political and philosophical problems of our time (p. 299). Dr. Cantor expands the concept of ethics to include a sense of responsibility for the global impact of our lifestyles and government policies; she asks whether or not we as a community have the courage to redefine “the normal” and “the good” in a way that takes the majority of the world’s people into account. Acknowledging the economic pressures intrinsic to private practice, the paper also explores the role of class anxiety in perpetuating conformity to social norms, including identification with the imagined lifestyles of analysts, supervisors and peers, with implications for our patients, our profession, and the political and economic status quo.

In her presentation, Elizabeth Goren explored the new ethical challenges presented by the shift in model toward utilizing the analyst’s self-expression and relationship with the patient to forward the treatment process. From minor lapses to the most serious ethical breaches in the analyst’s functioning, a review of the literature reveals the degree to which the analyst’s self-interest and narcissistic vulnerability inevitably influence the patient and treatment, and need to be considered in the two-person model. Examples include unconscious longings for gratitude from the patient, needs for recognition, and the impulse to rescue, particularly in the context of negative transference and counter-transference, all of which are subject to the added factor of stress in the life of the analyst, regardless of age and stage of career, and have become exacerbated under the increasingly difficult socio-economic conditions which govern practice today. The diminishing prestige, autonomy and financial rewards of being an analyst, in the context of a trend in the field toward privileging the analyst’s experience, creates a situation vulnerable to serving the analyst’s needs more than the patient’s, where the use of interpretations such as projective identification can allow the analyst to disavow responsibility and unconsciously ‘blame’ the patient for enactments.

Having abandoned the ideal of abstinence and neutrality as impossible, do analysts now hold themselves to a new, equally unrealistic image? One that simultaneously idealizes self-sacrifice and self-expressiveness on the part of the analyst, and that unfairly relies on the analyst’s capacity for self-analysis to control for undue influence. The shifting model with its emphasis on the analyst’s use of self as an instrument, with techniques such as self-disclosure, calls for the development of principles and specific guidelines for the analyst’s disciplined self-expression and for limits in the relational paradigm. It was suggested that greater emphasis should be placed on the part of individual practitioners as well as the profession for the importance of self-care and maintaining a commitment to peer consultation and supervision throughout one’s career. Finally, it was recommended that psychoanalytic organizations need to create avenues of professional recognition for clinicians similar to those now accorded theoreticians.

In her paper, current Division 39 Ethics Committee chair Karen Maroda, noted that the majority of therapists practicing today accept referrals from current patients, even if those referrals are close associates who include friends, family members, co-workers, some neighbors, and anyone involved in the patient’s life. Dr. Maroda made it clear at the beginning of her presentation that the APA Ethics Code does not prohibit this practice. However, the acceptance of these referrals does fit the definition of multiple relationships, which the ethics code says should be avoided if there is the expectation of harm. Dr. Maroda argues that seeing close associates simultaneously, especially for psychoanalysis or long-term psychoanalytic psychotherapy may compromise all parties involved and hamper objective inquiry when the analyst is privy to information obtained from the close associate rather than the patient. She recommends that current practices be changed with the emphasis on referring out close associates of current patients to other analysts.

The general feeling from the audience was that no change should be made to the ethics code that actively discouraged or inhibited the acceptance of referrals from current patients, even if they were close associates. Several members of the audience stated strongly that individual

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**Section III Panel: No Mother, Not Good Enough Mother: What Happens to the Daughter?**

**Presenters:** Marsha H. Levy-Warren, PhD  
Can Daughters Be ‘Good Enough’ When Their Mothers Are Not?  
Eileen A. Kohutis, PhD  
Sex and Death: Failed Autonomy

**Moderator:** Rita Frankiel, PhD

Section III of Division 39, Women, Gender and Psychoanalysis, includes in its mission the ongoing consideration and re-evaluation of gender and of how the “prevailing wisdom” about gender affects public and private roles as well as how we understand childhood development and the therapeutic process. At Section III’s invited panel this year, Dr. Marsha H. Levy-Warren and Dr. Eileen A. Kohutis presented empirical papers considering two sides of the question of “good enough” mothering. Dr. Levy-Warren introduced data based on a large interview set and Dr. Kohutis focused on a clinical case. Dr. Rita Frankiel was the discussant and moderated a lively discussion with the audience.

Dr. Levy-Warren’s presentation posed the question: How do daughters grow up to be “good enough” when their mothers clearly were not? Dr. Levy-Warren used empirical data to discuss how girls of “not good enough” mothers get “mothered.” In so doing, she opened up the question of what we mean by “mothering”: from whom or what set of experiences do we get “mothered?” And, in what ways might “not good enough” mothers, mother in “good enough” ways?

Dr. Levy-Warren drew her data from two sources: 65 structured interviews conducted with stable adult women ranging in age from 20-80, who grew up with “inadequate” mothers suffering from major psychiatric disorders and a cohort of patients with like situations from a psychoanalytic private practice. Dr. Levy-Warren described patterns of coping that emerged in these populations, with specific regard to how these daughters felt attended to, nurtured, comforted, and supported in their development: both in identity-formation and in the growth of competence—that is, how they felt “mothered,” both by their not “good enough” mothers and through other experiences in their socio-cultural contexts.

Dr. Levy-Warren offered an interview excerpt from this research project, in which some of the ways that we think of “mothering” were illustrated. Then she discussed a clinical vignette in which a young adult woman’s relationship with her manic-depressive mother proved to be both a hindrance to her healthy development but also a resource for it, and how the therapeutic work with this patient unfolded in such a way that Dr. Levy-Warren had to work counter-intuitively. Belief in the prevailing wisdom about “good-enough” mothering and its critical significance for healthy development had to be suspended in order for understanding and connection to be achieved in this analytic dyad.

Ultimately, this paper called for a re-examination of the concept of the “good-enough mother.” Dr. Levy-Warren asks that we think of “good enough” mothering not as something that individual mothers do or do not offer to their children, but as a set of experiences that we believe children need to have for healthy development. She asks that we remain open to the many ways in which children, adolescents, and adults may develop in a healthy fashion, with or without what we have historically considered to be “good-enough” mothers.

In her paper, Dr. Kohutis discussed a young woman whose efforts to achieve psychological separateness were derailed by her mother’s illness and eventual death when the patient was nineteen. Adolescence puts both parents and kids to the test. Like the years of triangular conflict, it is a time marked by fierce tension between the need to attach and the need to separate, both of which are exacerbated by the pressures of sexual maturation. And the stakes are high; adolescence is the time for reworking childhood sexual and relational solutions, and for finding the way to intimate relationships outside of the family. It’s an intense period for both parent and child and may strain a parent’s otherwise good-enough “good-enoughness.” Teenagers need parents who can encourage their attempts to separate while remaining available with love and support in the face of the new practical, sexual, and relational anxieties of adulthood. Certainly, children’s different dispositions influence the way they approach psychological autonomy. But so do the dispositions of the parents, who for their own reasons may be unwilling or unable to facilitate a child’s increasing separateness.

The aforementioned young woman in her early 30s had difficulty achieving psychological separateness. The unfinished business of the oedipal and adolescent years came to the fore in an explosive erotic transference several years into her adult analysis. Work with this crisis delineated in surprising ways some of the limits of “good-enough” mothering as well as the difficulties of resolving them after the death of a parent.

The case material highlighted the complex and
difficult relationship of this mother-daughter dyad with examples illustrating how the daughter’s nascent attempts at separation from the mother were met with conflicted responses from the mother. Moreover, this young girl had a father who was also emotionally unavailable and unable to encourage the daughter’s separation from the mother.

During this patient’s adolescence, her mother was diagnosed with cancer. The mother’s death sentence, along with all that had been unresolved, precluded this patient from having the opportunity of learning how to handle more than one relationship at a time and to separate herself from dyadic mergers. In her therapy, she is working on the capacity to tolerate triadic relationships and eventually to experience herself as separate from dyadic relationships. Our goal is for her to be able to develop relationships in which she can find real companionship and friendship as well as sex—in whatever measure she wants them.

Dr. Rita Frankiel’s discussion touched upon the role of the father and the critical importance of early caretaking. Dr. Frankiel then moderated a lively and provocative audience discussion. People responded to the ways in which Dr. Kohutis’ patient did and did not get “mothered” in the ways that Dr. Levy-Warren discussed, for example, commenting on the patient’s excelling as a singles tennis player, but not in doubles. Among other questions raised by these papers were the ways in which profoundly shaming experiences such as sexual molestation might further complicate a child’s capacity to find and engage nurturing opportunities to develop autonomy and competence, and how both parents can foster development and separation. These two qualitative studies, one case-based and the other utilizing data from structured interviews, invite a more complex reading of developmental, interpersonal, and social psychoanalytic theories, and deepen our ability to connect with and help our patients.

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clinicians should make their own decisions on a case-by-case basis. Dr. Maroda withdrew her suggestion that the ethics code be changed, provided that there be more emphasis placed on the very significant self-interest involved in accepting these referrals, since the issue is rarely, if ever, discussed as potentially problematic.

Audience members expressed appreciation for Dr. Cantor’s focus on the cultural emphasis on materialism and self-interest and the moral dilemma that clinicians face everyday as a result. Dr. Goren’s complex paper was equally appreciated for its examination of our apparent pursuit of perfection, and the vulnerability we face as a result. In closing, Dr. Maroda noted that what all three papers had in common was an emphasis on examining the analyst’s self-interest in cultural, personal, and clinical terms.
The year 2002 commemorated the 100th anniversary of Erik Erikson’s birth. It seems only fitting to use this centenary to honor his transforming contributions to the field of psychoanalysis. While he has achieved international acclaim as a psycho-historian, as a developmental life-cycle theorist, and as an essential contributor to the notion of the identity crisis, clinicians are much less familiar with his technical work as a practicing psychoanalyst with children, adolescents, and adults. My thoughts for this presentation were generated by the excitement I experienced while collaborating with Erikson as the editor of a volume of his selected papers, *A Way of Looking At Things*. An investigation of his early monographs on child psychoanalysis, a review of his later clinical writings, and an examination of his psychotherapeutic case studies at the Austen Riggs Center have revealed a clinical-psychoanalytic treatment perspective of extraordinary richness. This clinical material seems to have been obscured by his other pioneering contributions and never received the deserved visibility and recognition.

The psychoanalytic literature of the past decade has focused on the intricacy of the interpersonal encounter, while highlighting a shift from content to context that utilizes immediate experience as the primary data for treatment. This period in our history has also seen a shift toward the essential role of countertransference as a key instrument that provides vital data for the analyst’s understanding of the complexity of the treatment process.

This paper systematically surveyed Erikson’s clinical writings and also some of his unpublished papers and notes from his psychotherapeutic case studies and investigated the impact of the treatment relationship, while highlighting some of the essential ingredients of an interpersonal-relational method that add depth and vitality to the therapeutic process. These are questions for consideration:

1) How does one conceptualize an interpersonal-relational treatment process and articulate which interactional dimensions facilitate growth?
2) What are the psychotherapeutic agents of change that have restorative potential?
3) How does one understand the therapeutic action that helps maximize treatment possibilities?
4) How can one utilize the essential mutative, actualizing, and transforming ingredients that foster new experience?

The paper illuminated Erikson’s vision and demonstrated how he adds to our understanding of the restorative processes of treatment, thereby reflecting the evolution of his ideas over the course of a half-century, beginning with his earliest training experiences in Vienna in the late 1920’s.

The essential component explored was Erikson’s psychoanalytic method and his interpersonal-relational perspective that emphasizes interactive phenomena, including the human spirit of personal collaboration and engagement. The spirit of his ego psychological perspective that has at its core the powerful belief in human potential, emphasized what one person can do for another in the actualizing–interactive therapeutic process. He was ahead of his time while writing in the 1930s, 1940s, and 1950s, and his remarks then about the process of treatment and the therapeutic relationship were so much in tune with what we now call an interactive vision of the analytic situation. His thinking anticipated and sheds light on much of the current ferment in the field today.
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“A Mind Is A Wonderful Thing To Reach”: The 10,000 Minds Initiative and Outreach Project of the American Psychoanalytic Association

Most of us are well aware that psychoanalytic concepts face real challenges in today’s intellectual environment. This is most visible in the college classroom. When undergraduates are exposed to psychoanalytic thinking—and this happens too rarely—they are usually presented with a version of psychoanalytic theory that is abstract, confusing, and very out-of-date at best or ridiculed, and harshly criticized at worst.

Recently, one of the authors was told by a PhD candidate that she had learned in her doctoral program that “psychoanalysis is dead.” This young psychologist was surprised to learn our actual numbers. There are about 11,725 members in the International Psychoanalytical Association (IPA), 3400 in the American Psychoanalytic Association (APsaA), 3600 members in APA-Division 39, and 1400 members in the National Association for the Advancement of Psychoanalysis. Additionally, a number of psychoanalytic psychotherapists and psychoanalysts belong to other organizations; still others are non-affiliated. Allowing for multiple memberships, which would reduce this total of 20,125 members, the data demonstrate that we remain alive, if not happy and well.

It became clear to us that if the common cultural understanding of psychoanalysis is to change, the college classroom would be a valuable place to direct our energies. In December 2004, Prudy Gourguechon conceptualized the 10,000 Minds Project within the American Psychoanalytic Association. Its goals were at once modest and excessively ambitious. We wanted to devise programs that would expose as many undergraduates as possible to psychoanalytic ideas and the potentials of psychoanalytic treatment by the time they were graduated from college.

When in January 2005, the American Psychoanalytic Association formed the Task Force on Undergraduate Education, there was immense enthusiasm and eager participation by undergraduates, psychoanalysts in Division 39, and others outside of APsaA as well as within it. The Task Force has developed a number of projects, which will be completed by June 2008. In 2008, this task force will be “sundowned.” Unfinished work will be transferred to ongoing committees, and/or the staff of APsaA, or to a Division of Education.

The planning principle behind the overall project was to brainstorm all possible “gateways” to influence undergraduates. These include the obvious: psychology courses, mental health services, and cross-disciplinary courses in literature and film as well as the less obvious: information posted on bulletin boards in residence halls, Wikipedia, film series, and summer courses.

We then planned programs to address these gateways. The programs we chose were meant to be viable, realistic, varied, and practical. We did not come up with a program or project to reach every gateway. We preferred to be reasonable, not perfect. These are the projects of the 10,000 Minds Initiative.

The Undergraduate Advisory Board (UAB)
This turned out to be one of our favorite components of the projects. A few weeks before one of our national meetings we asked our members to invite undergraduates they know who might be interested in psychoanalysis to join our Undergraduate Advisory Board. We offered nothing but our interest in them and lunch! The response astonished us. One APsaA member who teaches at the University of Chicago simply sent an e-mail to his students. Three of them came to New York at their own expense. Some of the UAB members are children of analysts in the Association. In addition to the University of Chicago, the colleges represented include Columbia, Amherst, Hiram College, and Emory.

We asked the UAB for feedback on our programmatic ideas. The students never ceased to amaze us with their sharp and astute observations as well as passion behind the suggestions. Prudy Gourguechon, at one meeting a few years ago, asked the members where freshmen and sophomores would look for information to learn about psychoanalysis. They answered in unison: Wikipedia! At that time, the adults at the table had never heard of Wikipedia. Now they know of its power.

On another occasion we were, perhaps condescendingly, probing the UAB members about their career development; for example, how they would become psychoanalysts. The conversation was going nowhere until one of them said, “Well, how did you become psychoanalysts?” The analysts in the room included a former president of APsaA and other experienced leaders. We all felt moved, but shy, as we struggled to answer. No one had asked us this question in a very long time.

In the UAB, we believe we stumbled upon a tremendous model for the direct engagement and participation of a population we view as a target worthy of an outreach effort—college undergraduates. We plan to transfer this structure to the Association’s other outreach endeavors.
**Development of a Web site: www.teachpsychoanalysis.com (Lisa Damour and Heather Davidson)**

We developed this Web-based resource to collect materials that would be useful to those teaching psychoanalysis to undergraduates. The site is bulging with all the information and resources we could gather, including personal accounts of successful teaching techniques, reading lists, film lists, compilations of the empirical evidence for psychoanalysis, and anything else we could think of or solicit. Members of APSaA, the IPA, and Division 39 all received e-mail requesting contributions to the site, which remains open to additional materials. One of our challenges is to find funding to keep this exceptional resource alive and up to date. There is a link to www.teachpsychoanalysis.com on the Division 39 Web site.

**Textbook Research Project (Dr. James Hansell, Director; Jan Habarth, Researcher)**

In this project, we looked at the most widely used introductory psychology textbooks to examine their treatment of psychoanalysis. We are currently waiting for the final results of this study. One of our goals is to produce a publication in a non-psychoanalytic journal if possible. Also we have recently developed the idea for a follow-up project that will direct us to contact the authors of those textbooks found to contain inaccurate and misleading information, and to respectfully offer them alternatives.

**Undergraduate Course Research Project (Michael Shulman, Director; Jonathan Redmond, Researcher)**

Now complete, this project has produced a paper that has been submitted for publication. Shulman and Redmond devised an innovative methodology. Using the US News and World Report “Best” lists, they downloaded the course catalogs of 150 colleges and universities and then searched these catalogs for various keywords related to psychoanalysis (Freud, psychoanalysis, etc). Their findings featured two remarkable results: 1) about 80% of the undergraduate classes where psychoanalysis is taught are outside of psychology; and 2) the version of psychoanalysis that is taught in many subjects (film, literature, gender studies, etc.) is virtually unrecognizable to the average psychoanalytic clinician.

**College Mental Health**

We explored a number of avenues to reach this important gateway, but were not able to settle on an achievable project in the time frame of the task force. Among the ideas we considered was a multi-site research project studying psychoanalytic psychotherapy utilizing college mental health centers and trainee therapists. We also considered a conference for clinicians who deliver care in college mental health centers. Another unexplored possibility is to find a way to increase the exposure of interns working at these centers to psychoanalytically informed supervision. Although we couldn’t begin the projects just mentioned because of a lack of time and resources, we nevertheless hope to accomplish some modest goals in relation to this “gateway.” We are organizing a panel presentation at a college mental health association meeting next year and encouraging analysts to seek opportunities to consult at college mental health clinics.

**Summer Conference for Academics (M. Gerald Fromm)**

To bring academics and analysts together to explore a broad central issue of mutual interest, we are planning a two-day conference in June 2008, in the Berkshires, in conjunction with the Erikson Institute.

**Analysts on Campus**

Task Force member Shana Adler interviewed a number of analysts who have found their way on campus and have taught or are teaching undergraduates. Most of us have mental health degrees but do not have entrée or a clear path to the campus as teachers. Some of those who have successfully crossed the divide between clinical practice and academia shared their stories. Adler reported her findings in the Spring-Summer issue of The American Psychoanalyst (available at www.apsa.org).

**Resource Packet for Local Societies and Institutes**

We are in the process of assembling a resource packet—to be available electronically and in print—that will provide local societies and institutes with suggestions and guidelines for a variety of outreach projects that they can initiate with local colleges and universities. The project guides include:

- Establishing liaison relationships on campus.
- Consulting to college counseling services.
- Offering a for-credit summer course in conjunction with a college.
- Establishing an interdisciplinary “brown bag lunch” program.
- Setting up a film program.
- Organizing a Psychoanalysis Club.

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This project represented a collaborative effort between Division 39 and APSaA. Greg Lowder, with the help of Nancy McWilliams and Jim Hansell, developed an excellent 45-minute PowerPoint presentation about psychoanalysis, which anyone can download and adapt for students or other groups. The presentation covers the empirical evidence for...
psychoanalytic treatment as well as the interesting empirical evidence for key psychoanalytic concepts.

**Implications and Plans for the Future**

Where do we go from here? As of this writing, the Task Force will sundown in 12 months. Nevertheless, we are in good shape. We have enough time and resources to finish the projects we have begun. We plan to assess our work and come up with recommendations for what needs to be done next. We can already draw certain preliminary conclusions:

1. There are practical ways to monitor undergraduate texts and courses and to intervene by providing accurate information.
2. There is a tremendous need for coordinated and sustained efforts for psychoanalysts to present papers and panels at the meetings of other groups. All the varied associations representing academics in the humanities and the social sciences are possible targets, as are the associations that represent college health and mental health practitioners.
3. The collaboration of psychoanalytic groups, in this case Division 39 and APsaA, is so obviously rewarding and yields results greater than the sum of the parts.
4. The model of the UAB is one that psychoanalytic organizations should considering replicating, as it yields immediate and invaluable suggestions and criticism regarding contemplated programs.
5. College mental health and counseling services warrant special attention. A general impression we draw from this project is that the services are rarely psychodynamic and almost never long term. These services rarely offer comprehensive diagnostic and referral services. However, these are impressions, not study findings. The psychoanalytic profession needs to look for more ways to reach clinical settings that for many people are the first encounter with psychological services. Providing supervision and/or consultation services to the often young and inexperienced treating clinicians is one avenue to consider.
6. The Internet offers vast potential for outreach that we have just begun to tap. We can use the Web to provide an enormous variety of resources to students and teachers. The challenge is to find and keep up with human and financial resources to maintain high quality Web-based materials.

**Conclusion**

For the individuals involved, and for APsaA, the 10,000 Minds Project has been an exciting and rewarding experience. It has crystallized for us the importance of an outreach to academia (especially college undergraduates) as a high-yield effort that can engage future generations of intellectuals, analysts, and patients in settings where we can reach hundreds and even thousands of people.

We would like to close with what we hope is an inspiring beginning. One author, PG, just heard from a colleague that he will be teaching a course that fully one half of the freshman class at his University will take—that’s approximately 650 students per year—who will spend one quarter reading Freud. So in four years, that one college professor can teach 2600 students something about psychoanalysis. Quite a bit can be learned in a quarter. Think of the other outreach programs you’ve been involved in. They can’t compete with these numbers. These young students are our future patients, our future colleagues.

In closing we acknowledge and are grateful to the International Psychoanalytical Association (IPA) for its financial support via the Developing Psychoanalytic Practice and Training (DPPT) Program.
A frequent complaint against modern poetry is that so often it doesn’t make sense. But making sense in a literal and linear way is not what a poet is trying to do. The ambition is different. Here’s a famous formulation (from a much earlier epoch) by the English Romantic poet John Keats—from a letter of his written in 1817:

... at once it struck me what quality went to form a Man of Achievement, especially in Literature, and which Shakespeare possessed so enormously—I mean Negative Capability, that is, when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason . . . . with a great poet the sense of Beauty overcomes every other consideration, or rather obliterates all consideration.

There’s no better example of a modern master of “negative capability,” of a poet rising above “any irritable reaching after fact and reason,” than Wallace Stevens. This is his “The Emperor of Ice-Cream” (published in 1922) a puzzling poem, high in the modernist canon and wonderful for its sense of beauty.

The Emperor of Ice-Cream

Call the roller of big cigars,
The muscular one, and bid him whip
In kitchen cups concupiscent curds.
Let the wenches dawdle in such dress
As they are used to wear, and let the boys
Bring flowers in last month’s newspapers.
Let be be finale of seem.
The only emperor is the emperor of ice-cream.

Take from the dresser of deal
Lacking the three glass knobs, that sheet
On which she embroidered fantails once
And spread it so as to cover her face.
If her horny feet protrude, they come
To show how cold she is, and dumb.
Let the lamp affix its beam.
The only emperor is the emperor of ice-cream.

Of course, for a poet to rely on negative capability means that his or her reader will be expected to rely on it too. (“The only emperor is the emperor of ice-cream”) are of the essence. This is an experience he is creating, not an argument he is making. “The Emperor . . . .” evokes a feeling-image and a rich sense of time and place. (It makes me think of a Hopper painting, of his scenes of America in an age gone by, the familiar “Nighthawks,” for example. And, more contemporaneously and more personally, I think of Eddie’s Sweet Shop, an old fashioned ice cream parlour near my house in Forest Hills where you can see Eddie—my own nominee for emperor of ice cream—whipping the cream with a huge wire whisk in a copper bowl.)

And if one masters one’s own irritability, if not one’s reaching after reason, it becomes apparent that there is idea as well as image in this poem: lust (“concupiscent curds” and “wenches dawdle”), and therefore, life as against death at the wake of an ordinary old woman whose “horny feet protrude . . . to show how cold she is and dumb.” And more, one sees that the whole statement is self-consciously theatrical: the poet is creating a tableau, like a stage manager, or a ring-master. His tone is imperious, but mock imperious: playful and ironic, tragicomic, mindful of the absurdity.

So, who is the emperor? Who rules divine over the circus of life and death? An ice-cream man? A roller of cigars? The poet himself?—that is, the poet as the maker of a world? One persuasive reading of “The Emperor . . . .” is that it’s a poem about making poems—and about making art generally. But who knows? The body of discussion and serious criticism of this poem is vast—a Google search for “Wallace Stevens + emperor” yields 260,000 URLs! The point is there’s much, very much, in this puzzling poem—and much that is beautiful.

Psychoanalysts should be particularly appreciative of the power of negative capability. Who more than we should value the capacity to be in “uncertainties, mysteries, doubts, without any irritable reaching after fact and reason”? You could say our method depends on it. We rely in our daily work on our capacity to sit quietly with the absurd. We expect that this forbearance will take our patients organically to a coherence—that words which make no apparent sense, that ideas in obvious contradiction, that feelings in profound ambivalence will eventually (and in our embrace) lead to truth—and maybe even to beauty.

The Case of the Disappearing Profession

Have you noticed, for some time now, that few people speak about what’s going on in their analysis? I exclude, of course, the unending analysis of Woody Allen. For many years, reaching a high in the 1950s and 1960s, psychoanalysis was a rage (strange way to describe a profession, but true nevertheless). It was a time when many texts poured from analyst’s pens, including one of the most influential and informative, Theodor Reik’s Listening With the Third Ear. It brought home the best that analysis could offer people in search of themselves—a search that involved a commitment of time and finances for thousands of people the world over, who sought psychoanalysis. And then, gradually—puzzling to many, perhaps not so puzzling to others—the whole profession seemed to slip, almost unnoticed, out of cultural awareness. By the 1990s, people spoke of seeing their therapists or analysts, but it was usually on a once or twice a week basis, and sometimes group therapy was a substitute for the second session. Individuals no longer had the time or the inclination for an unhurried three-, four- or even five-time a week treatment. Psychoanalysis came to be seen as quaint, perhaps archaic, a treatment that did not fit into the busy, high tech, exercise-conscious world in which we now live.

Today, many psychoanalysts see their patients on this abbreviated once- or twice-a-week schedule, calling the therapy psychoanalytic psychotherapy. There are positive results to such treatment, but there are losses, also.

Of course there were shortcomings within the theory of psychoanalysis itself. One has only to think of the pervasiveness with which many analysts spoke of penis envy for women, or the condescending pathologizing of homosexuality—with all the attendant pain such dogmatic positions entailed—to see some rather serious errors this therapeutic discipline perpetuated. Such shortcomings, although acknowledged and slowly corrected, have contributed to the eclipse of this profession. Perhaps, too, psychoanalysis was held too high and exalted as a cure-all for psychological conflicts when, in fact, its primary benefits lay elsewhere.

For many years troubled individuals came to quiet, somewhat darkened rooms, and spoke in confidence to a psychoanalyst and told the story of their pain and their hopes. Some analysts said little, some spoke openly; some were overly rigid in the application of their technique, others responded with more flexibility. But they all offered the possibility for individuals to experience what I would like to call a sensitivity to interiority. Sensitivity to one’s personal insides is the ground place for any resolution of conflict and the easing of psychological pain—it is the soil where our sense of dignity grows. Sensitivity to interiority is an experience not of our specialness (we generally call that narcissism), but of our uniqueness: a uniqueness that reflects a quiet internal place where we come to terms with our personal history and try to resolve the leftover pain it may entail—a quiet place where we can look at ourselves, unhurriedly, in order to find what is real, and what we want to be real, in our lives. “Unhurriedly” was the rationale for a four- or five-time a week treatment. “Unhurriedly,” in order to find the values we can make our own, the creativity that life asks of us, the awareness of the utter gift of life and the obligation, so to speak, we owe it. This is the best that psychoanalysis offers—along with the relieving of painful symptoms that usually propel a person to seek treatment initially.

Why would such a profession slip from our cultural awareness? Is it the result of “do-it-yourself” help books? Is it the result of other more goal-oriented, time-efficient therapies that offer answers and quick solutions for specific problems? I have no problem with quick solutions for problems that can be solved quickly, nor for self-help (ultimately there is only self-help! . . . that is a most basic premise of psychoanalysis). I am, however, questioning the disappearance not just of a profession but of the opportunity to experience self-presence and self-awareness in a setting that is unhurried, so that such experiences can take deep root within us.

We humans are complicated creatures. Would we not be suspicious of anyone who offered us the possibility of completing four years of college in two? Would we not wonder if, perhaps, something important might be missing in our education? The goal of a humanistic education, as we know, is not geared to promoting the immediate job prospects of a graduate. Rather, it is to sensitize individuals to the human enterprise, to human complexity, so that they will bring a certain fund of knowledge to whatever they learn. (There is a reason why totalitarian regimes outlaw psychoanalysis. Psychoanalysis is profoundly democratic; its goal is for each person to find his or her own voice.)

It was Norman Mailer, not too many years ago, who bemoaned the fact that people were being taught to think in five to ten minute segments—that television, with its constant interrupting advertisements, was affecting our thinking abilities, was limiting our capacity to stay with any thought for more than the periodic sound bites allowed. I believe he was right. We live in a world of computers and television that bombard us with words and avalanche us with images; we live in a world of portable CDs, walkabout radios and the omnipresent cell phone. We benefit

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The massacre at Virginia Tech last April recalled for me what sparked my initial interest in psychoanalytic psychology. The “problem of evil,” once the province of religion and demonology, later of philosophy, was passed to psychology. Psychoanalysis is the most serious attempt to deal with its complexities. Freud offered a method that was both a therapy and a means of understanding. Rejecting medicalization of his findings, he saw and stressed the continuities of the normal and abnormal in a broad theory that aspired to be inclusive of individual and mass psychology as well as of the creative products of the human imagination. Heinz Hartmann and David Rapaport elaborated Freud’s vision, developing psychoanalysis as a “general psychology.”

This grand plan reached an apex about 35 years ago and has fallen on hard times since. We seem no longer to have a comprehensive theory, but instead a host of competing formulations. Some ideas are offered as new paradigms and others are eclectic. Some seek integration or common ground, say, in the clinical situation.

Leo Rangell believes that theoretical pluralism has fragmented our field, accounting in good measure for its decline both as a therapy and as a respected social and intellectual force. A major extender of the Hartmann/Rapaport project for over half a century, Rangell has promoted his “total composite psychoanalytic theory” for at least a decade. This book is his latest attempt at restoring theoretical unity.

Readers of this newsletter, the house organ of perhaps the very hotbed of pluralism, might need a reminder of Rangell’s credentials. In 1954, he presented what was to become one of two overlapping standard definitions of the treatment method of mainstream psychoanalysis (Merton Gill’s was the other). He was twice president of the American Psychoanalytic Association (APsaA) and twice president of the International Psychoanalytical Association (IPA). His publication list is vast in number and scope. A nonagenarian, he is honorary president of IPA, a distinction held by just three others before him: Ernest Jones, Hartmann, and Anna Freud.

Rangell published a professional autobiography (2004) that I reviewed in this newsletter (Golland, 2005). The current volume reprises psychoanalytic history and his own place in it; the author goes beyond, though, to answer criticism and to advance a program for promoting reunification.

Unlike the autobiography, this is a short book (for the statistically-minded: 17 chapters; mean, 7 pages, median, 6 pages). I will not repeat my discussion of the rich detail provided in 2004. Rangell’s central and repeated points are but two: False dichotomies characterize most psychoanalytic controversies. Rangell offers a “both/and” approach in place of “either/or” splitting. He emphasizes the centrality of Freud’s (1917, p. 347) “complemental series” concept and Waelder’s (1962) use of that idea regarding levels of abstract and clinical theory. Formulations other than his total composite theory have erred with pars pro toto thinking: they exaggerate a new issue while ignoring or discarding older discoveries that should be retained.

In, Out, Pending
Rangell is clear with regard to what is included in total composite theory, what is excluded, and where the jury is out. “In” are objective rationality, transference from the past, uncovering unconscious conflicts, interpretation and reconstruction, and the Oedipus complex. “Out” are idiosyncratic concepts that have not found general acceptance: “self-object,” concrete early fantasies, “without memory or desire,” and symmetrical two-person psychology. Decisions pending are projective identification, depressive and paranoid positions, “analytic third,” and
“analytic space.” He explains how many ideas can be subsumed within existing theory: for example, mind and body; attachment and mentalization; asymmetric two-person psychology; and narcissism (not as a diagnosis, but as a central psychological issue on a par with anxiety).

Who decides? The general theory evolves by consensus; individual analysts work with preferred ideas that may or may not survive. When innovation arouses group excitement (e.g., Owen Renik’s challenges to received technique), modifications are widely attempted in what is intrinsically a flexible method. The faddish falls away, leaving enduring contributions. Theoretical conflicts are routine in any evolving science; contradictions are not allowed.

Rangell summarizes his own additions to the overall theory: 1) similarities and differences between psychoanalytic and psychotherapeutic treatments; 2) a theory of choice and action; 3) the concept “compromise of integrity” on a par with neurosis in human affairs; 4) the concept “human core,” with sexuality remaining a central issue; 5) unification of theory; and 6) advances in large-scale group psychology.

POLEMIC
This book is a polemic. Its aim is to return us to a time when theoretical argument was captivating, and psychoanalysis was an inspiring social movement. Rangell sees the irrational, our subject matter, as having invaded the method—inevitable in large group process where democracy rules over science, where each analyst is an uncalibrated instrument defining personal practice, and where every child can overthrow parents. Pluralists, like groups in general, are seen as dominated by irrationality.

These are meant to be fighting words, and while I am sympathetic with their aim, I question the likelihood of their efficacy. Rangell cites Martin Bergmann (from an historical perspective) and Arnold Richards (from a political one) also as sympathetic, each offering skepticism similar to my own. Bergmann emphasizes the ferocity of dissidence. Rangell believes history is moving his way, citing as evidence recent work by Renik, Green, Chused, Greenberg, and Schafer, and noting that Wallerstein, Kernberg, Fonagy, and others are writing about theoretical convergence. Rangell praises Reed and Baudry’s (1997) questions designed to promote rational discussion, as against affective decision—making.

Interestingly, Rangell does not directly challenge fellow nonagenarian Charles Brenner, as he had done in the earlier work (Rangell, 2004). In his sole citation of Brenner (p. 76), he finds agreement that psychoanalysis is a natural science. In his concept of unconscious choice, Rangell directly opposes Brenner’s central formulation (that all psychological products are compromises) but he does not address Brenner’s more recent elaborations. Nor does he note that Brenner’s theorizing entails a radical paring of concepts, in striking contrast to his own additive approach (Golland, in press).

LAY ANALYSIS
In my earlier review (Golland, 2005), I faulted Rangell for his discussion of “lay analysis.” Although he now devotes four chapters to the topic, two of every seven pages of text, I remain disappointed. Rangell separates the politics of theoretical pluralism from the issue of political exclusion, a position I had taken much earlier (Golland, 1991), and he provides many examples of medical and nonmedical analysts in different theoretical camps. But his list of theoreticians does not reflect the demographics of exclusion. When I began my analytic training in 1968, programs admitting psychologists were nowhere to be found in the United States outside of New York City. Many of my teachers were products of “bootleg” training. As we know, it took a lawsuit to end exclusion by APsaA, the settlement of which Rangell claims here was “universally applauded” (p. 47). The lawsuit was initiated in the face of intractable conflict; its resolution was not easy. The defendants’ applause was mostly for APsaA’s avoiding bankruptcy; there was hardly a warm welcome for the plaintiffs or their group.

Rangell considers his discussion of “lay analysis” a digression (p. 77), one taken, perhaps, in response to my criticism. He seems not yet to recognize its centrality to his earlier thesis (Rangell, 2004), the interaction of personal factors with theory, nor that righteous indignation is a legitimate part of the political psychology in which he is a pioneer (Rangell, 1980). The very phrase “lay analysis” still rankles. Rangell credits my home base, the predominantly nonmedical New York Freudian Society, with hosting his theory in 1996. Many in Division 39 consider those like myself who have recently joined APsaA to be sleeping with the enemy. That this controversy remains affectively unresolved for so many represents an essential psychoanalytic truth: traumas of the past manifest themselves in the present.

IS A PSYCHOANALYTIC SOCIAL PSYCHOLOGY POSSIBLE?
Psychoanalytic controversy has often centered on the issue of inner versus outer reality. Freud’s complemental series concept, consistent with the Hartmann/Rapaport model and with Rangell’s position, should resolve this conflict. But a psychoanalytic social psychology remains elusive. Pluralism and exclusion are each highly charged issues. Group emotions are more difficult to comprehend than individual ones, especially since there is no evading the
participant/observer dilemma.

Rangell’s theory encompasses person and society (p. 76). Yet, unfortunately in my opinion, neither “compromise of integrity,” nor his more recent discussion of public opinion (2005) has gained consensus—even as being proper psychoanalytic topics. Freud’s own essays in social psychology have experienced a similar fate. Alfred Adler, the neo-Freudians, and even Erik Erikson go unrecognized within much of current theory, apparently for their external emphases.

Rangell notes pressures for social applications of our theory, as well as the demand for results, but he recognizes that pragmatism is often at odds with an open search for coherent understanding, our primary refined tool. Group applications (e.g., Sklarew et al., 2004) are often disparaged as diluting theory for pragmatism. Untangling subjectivities is a major focus of psychoanalysis as practiced today. How much more difficult is it to separate oneself in trying to analyze group or political issues in which one is a participant? Rangell’s own application of psychoanalysis to the larger political arena is often viewed with suspicion, as are psychoanalytic commentaries on politicians from Barry Goldwater to George W. Bush.

In the clinical setting, confrontation is a technical intervention used sparingly; exhortation is not consistent with an analytic attitude. Can polemic be more effective (and analytic) in achieving consensus in our own professional group—or in any group?

Rangell presents a sophisticated discussion of “applied” psychoanalysis, but states that confirmation comes from “free associations of living beings” (p. 75). Clinical technique remains a matter of much controversy; surely, we are further from consensus about any methodology beyond the consulting room.

Rangell is a keen observer of the interaction of personal factors with theoretical development, but can he separate them any better than analysts can separate affect and intellect in our offices?

**Is Theoretical Unity Possible?**

I am a scion of the Hartman/Rapaport era, and I identify myself with Rangell’s phrase, “developed Freudian” (p. 8). His work supports Freud’s (1927) sentiment: “The voice of intellect is a soft one, but it does not rest until it has gained a hearing” (p. 53). His strong voice and emotions are entwined with his life in theory. I have highlighted here issues that might limit his success. It is far from clear that psychoanalysis will reunify, but Rangell’s efforts are admirable and his words merit a respectful hearing.

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**Jeff Golland**

Continued from page 65

greatly from such conveniences, but we pay a price.

Several years ago I attended, a well–known psychoanalyst, the late Dr. Peter Giovacchini, remarked that if psychoanalysis disappeared from our culture, an essential aspect of our civilization would be gone. This may be a dramatic way of saying what I have tried to indicate in this short article: if psychoanalysis goes, then we had better find another way for people to explore who they are and where they find themselves on the road of life. Unending busyness, continuous anxiety over money, excessive use of drugs (therapeutic and otherwise), and constant stimulations increase the shadows we walk through. Human beings are made to live in the light.

No one knows if psychoanalysis has just momentarily gone from our cultural awareness or not. If we abandon the search within, we will be left in a world of things and facts, where we would be sane but nevertheless poor. The great literary masters of the West remind us that we are made of our dreams. Psychoanalysis is one discipline and one profession, which understands that it takes time to know our dreams and more time to hold them as one’s own.
Daniel Stern defines the “present moment” as a lived story and, like most stories, it has not just a beginning and an end, but also a plot containing intentional characters, together with a “temporal contour along which the experience forms during its unfolding” (p. 219). The present moment is lived through as it is happening and thus, is not distanced by language or abstract explanation from those experiencing it. Stern’s theory of the present moment is both an intriguing addition and a challenge to psychoanalytic theory and practice.

Stern draws upon his earlier work, *The Interpersonal World of the Infant* (1985), as he relates how the mother and child dyad, or the therapist and the patient, move along a trajectory linking new ways of being-with-the-other as the relationship develops. Stern’s descriptions of infant-parent studies illustrate the many aspects of the present moment in life-as-lived, which he generalizes to psychotherapy.

To round out his theory, Stern elaborates two dynamic concepts, the “now moment” and the “moment of meeting.” The now moment consists of an emerging interpersonal process that is unpredictable—hence “sloppy.” Created conjointly, these momentary interactions, sloppy as they are, illuminate two important dyads—the parent and child, the therapist and patient. They set up an interpersonal crisis that begs for resolution.

Happily, the now moment is often followed by the moment of meeting. When this occurs, the dynamic between self and other dramatically alters a family relationship or an emerging relationship in the therapeutic hour. The partners to these relationships are experiencing the unfolding of a piece of reality. Since they share the now moment to an important extent, they “read in the behavior of the other a reflection of their own experience” (p. 220-221). The experiential sharing, in turn, assures that the co-created ambience becomes intersubjectively conscious.

Not incidentally, Stern’s theory unites two aspects of psychological theory into a parsimonious integration of theory—of-mind events with attachment behavior. The shared narration of the child’s or patient’s life sensitizes the parent–child and the therapist–patient dyad to the other’s mind, and provides the glue to the intersubjectivity so important to the therapeutic exchange and to healthy recovery. When events become intersubjectively conscious, writes Stern, “. . . this opens the door for the experience to be verbalized and narrated and to become a landmark reference point in the narrative history of the treatment.” Thus, Stern echoes Donald Spence’s earlier work, *Narrative Truth and Historical Truth* (1982).

A 13-year-old boy with whom I once worked seized upon a “now moment” in psychotherapy to advance his adolescent agenda. He came to his last session with a huge bouquet of flowers and shyly held them out to me upon his arrival. He must have known I would appreciate flowers since he had, for some two years, walked by my flower garden as he approached the office. This one act—the giving of flowers during his last appointment—was at once playful and linguistic. He had written a brief, appreciative note of our work together to accompany his gift. He was still distrustful of verbal communication, so he depended more on actions than on talk to determine what others were all about, and what he, himself, was all about.

I didn’t offer even an “experience–near” (Pine, 1985) interpretation of his gift, such as, “You know I like flowers because of my garden which you must have noticed for many months.” This would have minimized an appropriate social act in the present moment. The gift of flowers is an accepted social gesture indicating affection for the other person and gratitude for the relationship.

Unpacking the meaning inherent in the boy’s gift would have added an unnecessary layer to a spontaneous interaction between the boy and me as he left psychotherapy. Nonetheless, the present moment took center stage as a *sub rosa* segment of the therapeutic moment. Such present moments, according to Stern, have not been given their proper due, compared to that given to elaborate interpretations uniting past and present. Stern’s attention to the present moment is a theoretically important contribution, with far-ranging implications for therapeutic technique.

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The year 2006 was the 100th anniversary of the birth of Hannah Arendt, one of the major philosophers of our times, and numerous conferences were held to celebrate the work of a woman whose political engagement was demonstrated throughout her life. A theme in one conference I attended was her insistence that, in order to understand evil—the sort of evil embodied by the Holocaust, or totalitarianism in its many 20th century forms—one must truly understand the position of the Other—in her time, the Eichmanns, the Arabs, in our time the Hutus and the terrorists. Taking such a perspectivist view is not the same as obliterating the sense that evil has been done, but it helps to grasp why it has been done.

In Psychological Interventions in Times of Crisis, edited by two well-known psychologists, Laura Barbanel (one of our current APA Council Representatives and a former APA Board of Directors’ member), and Robert J. Sternberg (a former President of the APA,) a somewhat unexpected theme along similar lines emerges. Especially in a chapter about the aftermath of the genocide in Rwanda, there is a sense that healing, reconciliation, and progress forward require that the victim and the perpetrators hear each other out. That is surely not the sole or even the major way in which to move forward, but it is not the least. That is one of the many unexpected illuminations in this ground breaking, educational, and heart-breaking book.

The title alone, coupled with the cover photo of civilians ministering to other civilians lying on a dirt embankment, tells us that we are in uncharted territory. This is not a book about the interventions we as psychologists and therapists know so well, where we minister to individuals or even small groups, in times of personal crises; it is about responding to the effects of natural disasters and man-made sociocultural catastrophes like war, nuclear plant explosions and terrorism. The book’s strength is in collecting several accounts of actual crisis intervention work: responses to 9/11 here at home; living in the midst of civil warfare in West Africa while trying to support cross-cultural workers there; efforts to promote healing in Rwanda after genocide; working with traumatized Israeli children; studies of the effects of the Chernobyl nuclear disaster; and efforts to help Bosnian mothers support their children. If the book has limitations, they are the inevitable result of its being an early player in the job of trying to feel our way into working out helpful responses to unthinkable events.

These chapters vary significantly in style and as a result, the effect is uneven. Among the most compelling, naturally, are first person accounts of work done among the traumatized, often while the traumatic conditions continue: Karen E. Carr’s heart-stopping account of her work in West Africa under conditions of siege; and Esther Cohen’s description of her play therapy sessions with young children “identified as having been directly exposed to terrorism” (p. 156). This, incidentally, is the only report on the use of fairly standard psychological interventions. There are drier accounts, such as the detailed summary of the facts of the Chernobyl disaster and all the research on its aftereffects, the only crisis for which there was little or no intervention of the sort recommended elsewhere in the book (a matter of governmental reluctance to acknowledge the events and the government’s total unpreparedness in dealing with them), but even these convey massive amounts of information about the effects of disasters on people, places, and communities. In fact, merely reading some of these chapters exposes the
reader to one of the dangers the authors often warn about: the risk of vicarious traumatization of the rescuers. This book is necessary reading, but it is not for the faint of heart.

The book is divided into three sections, with a foreword by Karen Saakvitne, whose work is often cited in the chapters that follow, and an introduction by the editors. Part I deals with theoretical issues, with an overview by Judith Alpert, (founder and current president of the Division of Trauma Psychology), and her colleague P. T. Mukherjee. There is a helpful discussion of the difference between bereavement, depression, and PTSD as well as a useful presentation of the concept of psychological first aid, an essential form of immediate psychological support that even nonprofessionals can be readily trained to give.

As early as this opening section of the book, one discerns a repeated theme: interventions must be community–based and culturally sensitive in order to be effective in a devastated community.

The core of the volume, of course, is the set of eight chapters each of which tells the story of a different traumatic event. Except for the chapter on Chernobyl, where interventions and rescues were sadly lacking, each one describes the more or less successful efforts to mitigate the effects of unspeakable trauma. Themes turn up recurrently: local community members must be recruited as care givers; caregiving proceeds best in teams and in coordination with various local institutions that provide for needs other than mental health needs, such as medical care, food, and shelter; the local culture, traditions, and myths must be understood and folded into the intervention process; basic survival must be assured, which is often a very challenging thing to arrange; helping sufferers know that their reactions are normal responses to terrible situations is helpful to them, as are almost any forms of accurate information; and the process of providing help may itself retraumatize victims, as when telling their stories risks re-opening wounds and renewing enmities (for example, imagine a Tutsi in Rwanda telling his or her story to the communal “courts” in the presence of Hutus, or a Hutu reciting his or her story to that same court without expressing remorse); and it always risks traumatizing the helpers, either directly, through exposing them to danger, as in West Africa, or indirectly, when reading a mother’s description of believing her surviving son to be dead because her daughter’s brains covered his face (p. 174).

The final part of the book is just one chapter long. In it, co-editor Robert Sternberg summarizes twelve lessons learned. He notes the difficulty of helping those most in need of help precisely because they are the most difficult to reach; the importance of identifying those who can be of service (complex support networks need to be activated); the risks of caregivers themselves being traumatized; the problems of diagnosis (in emergency conditions, how do you differentiate acute grief from chronic depression?); the absolute primacy of cultural comprehension and the use of local culturally—credible structures, systems, and people; the need to function even when information is lacking or erroneous; the profound and hitherto unknown ethical dilemmas that arise (should, for example, the perpetrators of genocide be kept separate from the families of victims from their own villages?); and the willingness to accept imperfect results. It is impressive that a book whose chapters mostly describe action with very little outcome research nevertheless yields so many solid guidelines for future crisis interventions of the sorts that, sadly, will come.

This book is assuredly the first of many soon to come that deal with its topic, and its considerable strengths issue from that position. For example, it posits on the basis of experiences in the field what is not necessarily intuitively obvious: the same approaches that are helpful in dealing with natural disasters like floods are also helpful in such man-made of catastrophes as Chernobyl, war and genocide. As for shortcomings, it is hard to fault the book for its main one, which is a certain absence of useful detail, since the urgent conditions it describes often preclude such detail.

Fortunately, some chapters do in fact tell us all that we could want to know about what happened (and sometimes more than we wish we had to hear), who did what, and what psychologists and other caregivers said and did—to each other and to those they were helping. The chapter on the Firehouse Project is a good example of this. The several authors, all of them psychoanalysts and Division 39 members, report specific exchanges they had, sometimes in a single episode, sometimes over extended periods, with firemen in companies that had lost members on 9/11. But then there are also chapters about “workshops” or “seminars,” mostly intended to train the local caregivers who then fan out into stricken communities, but sufficient details are lacking about just what happened in those workshops and seminars. What went on that was so effective? For example, a four-and-a-half day workshop that “provides training in key knowledge, attitudes and skills . . . for developing and maintaining healthy relationships . . . listening, building trust, living in community . . . .” (p. 90) and so on, sounds like something we should all be told more about, and in some detail. There is also a great deal of description about the effectiveness of the interventions, but very little data. Even though one can sympathize with the paucity of information about how programs were evaluated, the fact that there are occasional reports of respect-worthy research, complete with control groups (for example, regarding the effectiveness of community work in Rwanda when groups were run by seminar-trained facilitators as compared to untrained facilitators) suggests that in the future more outcome research could be done, and that it would serve to sharpen
This book is an important and interesting contribution to the history of the psychoanalytic movement and the definition, history, and literature of gestalt therapy by a prominent German gestalt therapist with Polish roots currently living in Italy. Bernd Bocian has made a number of excellent contributions to the historical relations between psychoanalysis and gestalt therapy. His book is also a fascinating glimpse into other histories: leftist innovators and pioneers in psychoanalysis, such as Wilhelm Reich; the counter culture movement in the Weimar Republic, such as the expressionism; and the important role played by anarchist and psychoanalyst Otto Gross in the Berlin Bohème circles. Perls’ participation in these avant-garde milieux and collaboration with the Dadaist movement became an inspiration for his counter-culture activities in the United States and his teamwork with Paul Goodman, the Greenwich Village guru and leader of the youth protests of the 1960s and 1970s. Bocian also illuminates German-Jewish relations in the Second Reich, the Wilhelmine German Empire between 1871 and 1933, the Weimar Republic between 1918 and 1933, and the infamous Nazi Third Reich, from 1933 to 1945, which resulted in the forced mass emigration of Jewish intellectuals and psychoanalysts (see the 2003 special issue of *International Forum of Psychoanalysis*, Psychoanalysis and the Third Reich, edited by Zvi Lothane).

The holistic concept of “gestalt,” the German word for whole structure and form, was launched in Germany in 1912 by Max Wertheimer and his two younger coworkers, Wolfgang Köhler and Kurt Koffka, with further elaborations by Kurt Lewin and Kurt Goldstein. It was a reaction to academic atomism, the latter grounded in associationism and organicism in psychology. This psychological revolution took root in the 1920s and spread to many American universities. Psychoanalysis did not readily embrace gestalt psychology; however, Fritz Perls, who studied with Goldstein, became a remarkable exception.

We follow the life and work of Perls: from birth to his training as a doctor, which was interrupted by the traumatic experiences of World War I; later as Freudian psychoanalyst and member of the International Psychoanalytic Association; and his emigration first to South Africa and then to the United States. It is a fascinating personal odyssey of a man fleeing anti-Semitism and persecution. His fate exemplifies the complex and tormented relationship between Germans and Jews and the special role of German Jewry in the German cultural and intellectual history. It shows that Hitler’s most heinous crime was not only genocide but also *culturocide*, the destruction of the European tradition of the march of ideas, intellectual freedom, and the rule of democracy. Bocian brings his profound humanism and sensitivity to probe these painful chapters in German history.

Thus, the book commemorates those German Jewish emigrants of the so-called expressionistic generation who championed modernity. In his gestalt approach, the dissident psychoanalyst Perls embodied, integrated, and saved from oblivion the rich life experiences of the Berlin avant-garde culture in which Jews played such an important role. The book is an excellent read, of interest to psychiatrists, psychoanalysts, social workers, and the lay public. It holds the reader’s interest from beginning to end.

Ayaan Hirsi Ali’s autobiography, *Infidel*, is an extraordinary document. It is the story of a highly intelligent, courageous young woman, contending with widely opposing traditions at a time of enormous historical transition. It describes a different culture of childhood and its effects. The story demonstrates the way in which the early emergence of the capacity to self-reflect can have an impact on later ability to think clearly, especially when anxiety is high.

Ali, an elegant woman of Somali descent and a past member of the Dutch parliament, came to world attention in 2006 as a result of the murder of filmmaker, Theo van Gogh. He was slaughtered in broad daylight by a Dutch Moroccon, Mohammed Boyer, after the release of *Submission*, a film-short about the unchecked abuse of Muslim women, upon which he and Ali had collaborated.1

Born in Somalia in November, 1969, Ali was the second of her parent’s three children, a boy and two girls. Because her clan lineage defined her status, her maternal grandmother (a person from “the equivalent of the Iron age,” illiterate, a nomad) beat and cajoled her at an early age into learning by heart eight hundred years of her father’s ancestry. “The names will make you strong,” her grandmother said. “If you dishonor them, you . . . will lead a wretched life and die alone” (p. 3). To her grandmother “feelings were a foolish self indulgence” (p. 8).2 The grandmother told stories about brave women who presumably sacrificed to save the honor of their clan. From those stories, Ali learned that a girl must guard against the unauthorized loss of her virginity or risk a punishment worse than death.

Ali’s parents had been brave in other ways. As a young woman, her mother had defied tradition by divorcing her assigned husband and had moved with her young son to Mogadishu. Ali’s father, from a patrician family, had also come to Mogadishu. A “bold, learned, popular [man], born to rule” (p. 14). He had political ambitions and had started a literacy campaign. It was in one of his classes that she met her assigned husband and had moved with her young son to Mogadishu. Later the children moved first to Saudi Arabia (where they were called “she with a clitoris,” i.e., unclean), by other children, whom she was taught to fight. Both of her parents were opposed to female genital mutilation (FGM), but her grandmother was not. Thus, once, while her mother was away, her grandmother arranged for all three children to be circumcised.3 This was a terrible ordeal, especially for Haweya, whose rebelliousness re-opened wounds that then had to be recut.

From the earliest time, Ali coolly affirmed her own sense of the reality of things, in spite of the power wielded by her grandmother and by religious belief.

With her father gone, life at home was organized when her mother was around, but often her mother disappeared, abandoning the children to the neglect of their grandmother. Beatings were common and not particularly feared. Her beloved sister, Haweya, a rebel from the start and the one punished most, was Ali’s main companion. The family moved in and out of Mogadishu. Later the children went to school, where Ali was hit frequently by teachers and called kintirleey (“she with a clitoris,” i.e., unclean), by other children, whom she was taught to fight. Both of her parents were opposed to female genital mutilation (FGM), but her grandmother was not. Thus, once, while her mother was away, her grandmother arranged for all three children to be circumcised.3 This was a terrible ordeal, especially for Haweya, whose rebelliousness re-opened wounds that then had to be recut.

Thanks to a clansman, Ali’s father eventually escaped prison, whereupon his family moved to be close to him. Always dependent on the clan for care, they moved first to Saudi Arabia (where they were called slaves because they were dark skinned), then to Ethiopia, and then to Kenya. Her parents fought constantly, and her mother become more rigidly Muslim and unhappy.

1 For a provocative discussion of the cast of characters involved in this murder, see Baruma (2006).
2 According to Dwairy (2006), Muslim children are routinely trained not to honor their own feelings, and to put their clan above all else.
3 FGM predates Islam, as a tribal practice. Thus, it is practiced by people of different faiths, somewhat differently from place to place. See US Gov’t Report of FGM, (2001).
In Saudi Arabia, Ali discovered that her father “thought we children were wonderful.” He let his daughters pray with him, to the horror of their mother. At ten, she says, under the eyes of her father, “I opened up the way a cactus blooms after rain. He showered me with attention . . . told me I was clever and pretty . . . He encouraged us to ask questions . . . From the beginning I was Abeh’s favorite . . . he would hug me and say I was his only son” (p 44-45 and 50).

Independently she understood that, despite what she was told about the honor of being female, her educated father, with his beautiful shoes, had a far better life than her barefoot, burdened mother.

Each new country meant new customs and new languages to learn. By the time she was eleven, Ali had learned Somali, Arabic, Amharic, and English.

Meanwhile, at the behest of her mother, Ali was doing all the housework. This, Haweya had refused (to be hit unendingly by their mother), but Ali submitted, in spite of the fact that her grades suffered as a consequence. She submitted to beatings as well, but never to religious teachings that confused her. Once, as a result, she received a fractured skull at the beating hands of a religious teacher, whose teachings she had dared to question. The decision to submit to beatings was a choice she made, in the context of her culture. When it came to beliefs, however, her father had valued her need to ask questions, which had solidly reaffirmed her own determination to do so.

In Nairobi, she read Nancy Drew, Huckleberry Finn, The 39 Steps, and later Jane Austen, the Brontes, Danielle Steele, Daphne De Maurier, and Dr. Jekyll and Mr. Hyde, taking seriously that lives were lived differently elsewhere. There were crushes on boys, forbidden meetings, kisses. When menstruation happened, in lieu of any kind of earlier sex education, it was her brother who explained things and helped her to buy what she needed at the pharmacy.

Later Ali learned that her father had married someone else and had a child. “This was betrayal,” she writes. “In the next days and weeks I told myself that I would never let this happen to me. I would never be dependent on anyone in this way,” presumably as her mother had been on her father for support and affection (p. 93). Thus, the early capacity to hold a point of view, encouraged by her father, was emerging in the adolescent Ali in a clear resolve about her future.

Having identified dependence as the condition to avoid, Ali struggled with traditional Muslim ideas, nonetheless, because of a respected teacher. “It was as if Muslim men can marry four wives.

4 Islam requires men and women to pray separately.
5 In my own experience of people from Ali’s part of the world, favored children are publicly treated better than others by the person who favors them, with no thought to the pain this might cause siblings. Ali writes: “When I told people I wanted to grow up to be like my Abeh, he would glow . . . It made Mahad (her brother) hate me even more” (p. 50).

6 Muslim men can marry four wives.
Once she arrived in Germany, “the women were bare—they
seemed _naked_. So many white people.” “Everyone was
anonymous here . . . I felt . . . free . . . safe . . .” (p. 185), a
plan of escape began to form:

I didn’t worry about loneliness or how I would live
without my family . . . I had my certificate from
Valley Secretarial College . . . if I went to Canada
. . . I would be dependent always—on someone
treating me well . . . I knew that another kind of life
was possible. I had read about it. (p. 186-187)

So, from Germany Ali went to live in Holland, where she
had a friend.

There isn’t space here to review in detail the long
list of Ali’s accomplishments in the West. Suffice it to
say that in a trial by clan elders, she was liberated from
her marriage. “There was no regret, but I knew that I had
cut myself off from everything that was meaningful and
important to my family” (p. 208). In addition, eventually
she gave up Muslim dress, got permanent residency,8
learned Dutch fluently, and became a government-
registered translator. She had a five-year live-in relationship
with a Dutchman, went to Leiden University, graduated
with a degree in political science, went to work as a
researcher for a political party, and wrote articles on
Muslim women. Later, Ali ran for a seat in Parliament
(VVD party, center right) and won. Her thoughtful
engagement with life intensified.

This was in sharp contrast to her adored sister,
Haweya, who fell apart in Europe and eventually died.
“I think it had something to do with . . . the limitlessness
of Holland,” wrote Ali. “[Haweya said] ‘I was used to
fighting for every little thing, and suddenly there is nothing
to fight for—everything is possible’” (p. 254). Ali became
more secular in her beliefs and more certain of the role she
wanted to play: to protect Muslim women and to warn the
West about the threats she believes are implicit in Islam.

At age 30, Ali gave up being Muslim, having to
overcome her fear of hellfire to do so. This act is forbidden
in Islam; it makes one an apostate, which is punishable
by death, according to the Koran. Perhaps for this reason,
no other female reformer that I know of has taken this
radical step. Iranian Shirin Ebadi, (2006) for example,
who won the Nobel prize for work in defense of Muslim
women and children, remains a strong proponent of her
country and its religion. She attributes the brutal treatment
of Islamic women to “culture” rather than to Islam itself
(2007).9 Others, for example, Irshad Manjri, (a Canadian

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8 In order to obtain asylum Ali lied about her situation, which she had
acknowledged many times.

9 See Macfarquar (2007) for a recent account of various ways to translate
the verse in the Koran which describes the way in which an errant wife
should be treated (a range from brutal to more humane).
of Pakistani descent); Zainab Salbi (from Iraq); and Queen Noor of Jordan (an American who converted to Islam), in spite of their activism in defense of Muslim women, remain in the faith. To leave it, in fact, may limit one’s power to be heard by other Muslims—those, at least, who fear a similar death threat themselves. (See Laurence, 2007, for more on this).

Ali, meanwhile, lost her Dutch citizenship in the uproar over van Gogh’s death, because of minister Rita Verdonk, who cancelled it because of false statements, already acknowledged by Ali on her asylum application. She is now living in Washington, an employee of the American Enterprise Institute, a conservative think tank. Indeed, this may be a reasonable choice for a woman who sees Islam as a faith bound by teachings 1300 years old, which insist on violence as a means to the end of Mohammad’s words about rightness. Ali believes we take this point of view too lightly in the West, that we are unaware, as we preach tolerance, to what dangers tolerance may lead. Whether or not I agree with her opinions or her professional choice, her position seems to have emerged from a long-honed capacity to assess personal and political experience carefully and then to act, in a manner which to her seems correct. How her thinking will develop, given her remarkable abilities, remains to be seen.

References

Psychodynamic Diagnostic Manual (PDM)

A collaborative effort of the
American Psychoanalytic Association
International Psychoanalytic Association
Psychoanalytic Division [39] of the American Psychological Association
American Academy of Psychoanalysis
National Membership Committee on Psychoanalysis in Clinical Social Work

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CALL FOR SUBMISSION: DIVISION 39 PROGRAM AT APA CONVENTION

The 2008 Annual Convention of the American Psychological Association will be held from Thursday, August 14 till Sunday, August 17, 2008, in Boston, MA. Division 39’s program theme is “Psychoanalysis at the Limits.” The members of Division 39 will have the opportunity to articulate the many ways that psychoanalytic concepts and techniques have expanded the clinical and theoretical base of psychoanalytic psychologists as well as practitioners from other disciplines and fields.

For many, the pluralism of contemporary psychoanalysis challenges us to overcome the limits of theoretical bias as we devise clinical approaches based on models of the mind once perceived as contradictory rather than complementary. Were he alive today, perhaps Winnicott would agree that such theoretical multiplicity has created a “potential space” for psychoanalysis where tradition and innovation sit side by side. Others of us have traversed the formal boundaries of psychoanalytic practice and thinking, drawing from fields that initially may seem unrelated or even antithetical to a psychoanalytic approach. And yet we have found that both psychoanalysis and our patients have benefited from these forays.

At the same time, psychoanalysts have made inroads into domains not normally identified with a psychoanalytic method. Among the myriad arenas that come to mind are the mind-body continuum, forensics, trauma studies, the socio-political arena, and the cognitive sciences. Still others in the field hold firm against the bulwark of social and economic pressures that currently inhibit psychoanalytic practice and treatment.

The following questions are to be considered. How has psychoanalysis enhanced clinical practice outside its theoretical domain? And concomitantly, how has psychoanalysis been enriched by developments in other fields? Are there joint ventures that currently draw psychoanalytic practitioners and colleagues from other disciplines together? Finally, are there antipathies between psychological disciplines, and even within psychoanalysis itself, that can never be resolved?

We invite you to join the lively and perhaps even fractious conversation that these questions and ideas evoke. We encourage you to submit proposals that address the theme of “Psychoanalysis at the Limits”—whether these limits are theoretical, interdisciplinary, or practical. The convention also provides a setting for spirited conversation and debate across divisions, and we encourage you to submit proposals that will include colleagues from other divisions and disciplines.

All submissions for presentations and programs must be submitted electronically via the APA Web site. Instructions for accessing the specific site are listed in the “Call for Program” in the September 2007 issue of the Monitor on Psychology as well as on the APA Web site at www.apa.org/convention. For questions regarding proposals, please contact program co-chairs: John Rosario-Perez, PsyD (jrp1956@verizon.net) or Douglas DeVille, PsyD (dmdeville@msn.com).

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our understanding of how to help.

The oft–repeated discussions of unprecedented ethical concerns raises, in my mind, another issue never addressed directly in the book. While it is clear that the goal of all the interventions is to relieve suffering, and in that sense the goal is entirely apolitical, often unexpressed political issues are nibbling at the edges. For example, when we are talking about large scale efforts in devastated places, what groups and individuals finance these operations? Sometimes they are openly religious, as with various missionary projects, and at other times they seem international, as when the United Nations becomes involved. But who or what is the Rwandan National Unity and Reconciliation Commission (p. 213)? When the failures of the Russian government in response to Chernobyl are cited, are there no political implications? Without minimizing the urgent need to help first and engage in political analysis afterwards if at all, it is worth noting that questions like this may arise and ought to be addressed if only later on, once the crisis is over.

What would Hannah Arendt have made of this painful, important book? She would, I think, have approved. She would have seen that the concern of the book is to promote healing, especially for the victims, though also for their adversaries. Arendt would have recognized and applauded one of the underlying recommendations for achieving this: know the Other. To know those who perpetrate evil is not to forgive (though that might happen), but to understand evil. While Arendt would have unflinchingly gone on to explore the political chasms between victims and others, she would probably have acknowledged this book and its understandings as a major step in the direction of healing.
There have been many changes in the CPA Section since last year. First of all, we changed our name from the Section on Psychoanalysis to the Section on Psychoanalytic and Psychodynamic Psychology to reflect a more inclusive membership. Second, we have a new online newsletter connected to our Web site. Third, I am stepping down after my third two-year term as president and will be handing the reigns over to Dr. Paul Jerry who will assume the presidency in 2008.

Our annual conference held in June in Ottawa hosted the largest number of presentations, panels, and workshops since the Section was founded five years ago. Dr. Nancy McWilliams was given the Otto Weininger Award for Psychoanalytic Achievement and delivered the keynote address on the art and wisdom of being a psychotherapist. She was given the award personally by Mrs. Sylvia Singer Weininger, which made the ceremony that much more special. Since the inception of our Section, we have received much support from psychologists and graduate students in Canada as well as recognition and appreciation from abroad. We have instituted two international awards, one for outstanding contributions to psychoanalysis as a profession and one for book scholarship; we also give a student award for the best graduate student presentation, which now accompanies a $300 stipend.

Two scholars were honored this year for their psychoanalytic writings. Professor Paul Verhaeghe was given the Goethe Award for Psychoanalytic Scholarship for his book On Being Normal and Other Disorders, and Dr. Muriel Dimen was given the award for her book, Sexuality, Intimacy, Power. Dr. Verhaeghe honored our Section by coming from Belgium and delivered a paper on his empirical research on actual neurosis. This year’s Freud Student Award went to Michael Sheppard for his contributions to our Section, who has been our student representative since the Section formed. Also, three psychologist psychoanalysts, Drs. Michelle Flax, Judi Kobrick, and Hazel Ipp, all from the Toronto Institute for Contemporary Psychoanalysis, were honored by becoming Fellows of the Section. I would like to extend my congratulations to all.

We are gaining momentum, and we would like to invite the membership of Division 39 to participate in our annual conferences. We welcome nominations for the Goethe Awards that are given on an annual basis. Because we are aligned with the spirit of plurality within unity that embodies Division 39, I am hopeful that we will continue to build our alliances as a community of psychologists who are interested in fostering and supporting psychodynamic thought in both the United States and Canada. I am also optimistic that you will be a part of this endeavor.

Jon Mills
psychologist@symatico.ca

In March of this year the ethics committee sent out a survey on boundaries and office setting to 249 Division 39 members. Approximately half of those members were chosen because they had the same home and office phone numbers in the last edition (2003) of the division directory, indicating the likelihood that they worked out of a home office. Then an equal number of randomly selected members were chosen, and the survey was sent out through the mail. The purpose of the study was twofold: 1) to determine if there were differences in practices related to boundaries between those working in a home office versus those who did not; and 2) to explore boundary issues in general and see what items might be related, and not related. In addition to the 249 that were mailed, (12 of which were undeliverable) 24 were sent via e-mail to members who heard about the survey and wanted to participate. We ended up with 133 returns, which represented a 51% return rate. We were hopeful that this was a large enough sample to produce some significant results. But because the sample was not representative of clinicians at large, the cells being too small to be significant, the results of the data analysis were not interpretable or usable.

Only two participants stated that they had ever had a complaint filed against them. None had been sued for malpractice. Only one acknowledged having been involved in a romantic relationship with a patient, etcetera. So it was impossible to compare populations when there were almost no reported boundary problems.

On behalf of the Ethics Committee, I want to express gratitude to our colleagues who generously took time from their busy schedules to fill out and return the surveys. I am sorry their efforts, and ours, did not produce statistically meaningful results. I also want to thank Stephen Behnke and the APA ethics office as well as the APA research office for their helpful consultation and advice on the survey. Since we do not have publishable results, this article will be the only feedback for members of Division 39. If anyone would like to ask any specific questions, feel free to contact me at kmaroda@yahoo.com or at 414-276-9760.

Karen J. Maroda, PhD, ABPP

ethics committee
Division members regularly receive encouragement from members of the Academy of Psychoanalysis to apply for the diplomate in psychoanalysis from the American Board of Professional Psychology (ABPP). In this newsletter last month, Academy President Joe Reppen outlined the procedures and described some of the benefits of acquiring this additional credential. In talking with colleagues about the ABPP, however, I have found a good deal of both apprehension and even resentment that there might be one more hurdle to jump over, one more set of authorities to please, etcetera. This reaction was certainly one I shared for a number of years and I only reluctantly moved toward applying for the ABPP when one colleague after another collared me at meetings, e-mailed me between meetings, and sent messages through other colleagues, telling me that I should apply. Never underestimate the persistence of Ruth Ochroch! Eventually I applied, sent in my application fee, and waited for a few years until my eligibility was about to lapse (which is more or less how I approached getting my doctorate as well!). I would like to walk you through the rest of the process and illustrate what a rewarding experience it was for me.

I was eligible for the senior option (as explained by Joe in the Spring 2007 issue); and my initial task was to demonstrate an adequate level of training and experience in psychoanalysis. Like many other Division 39 members, I am not a graduate of an institute and did not have formal training. I did graduate from a clinical psychology program that was psychoanalytic and all of my pre- and post-internship placements were in mental health centers or hospitals that were psychoanalytic or broadly psychodynamic in outlook. In addition, the local chapter of Division 39, Appalachian Psychoanalytic Society, has offered a wide range of courses and conferences over the years. In sum, I was able to demonstrate to the American Board of Psychoanalysis in Psychology (ABPsaP) that I met the training requirements of a psychoanalytic education. The board also accepted my involvement at the local and divisional level in psychoanalytic education and training as sufficient contribution to psychoanalysis, and I was allowed to progress to the oral examination. I mention all this to help members understand that the ABPsaP Board is flexible in taking into consideration the real world experiences of psychologists, especially psychologists who were not able, because of geographic or other life circumstances, to receive more formal psychoanalytic education.

The oral examination consists of two parts. The first is a kind of role playing in which the ABPP applicant is asked to play the part of a supervisor of an analyst-candidate, review a case presentation written by the candidate, and decide if the candidate has conducted an adequate psychoanalytic treatment based upon the case material. The applicant’s decision is the focus of the oral interview. I found this exercise to be extremely revealing, both of what I confidently knew and what I was anxiously unsure of in deciding when a therapy process can properly be termed psychoanalytic. The interviewers were extremely acute in their questions and open in describing where they felt I fell short in my answers and where I was accomplished. It was easily the most difficult part of the process and also the most revealing. It was a true learning experience for me. The second part of the exam was on ethics. While the content of the questions was appropriate for a psychoanalytic clinician, the task was to formulate answers based upon the APA Ethical Code.

That was that. I learned later that I passed the exam and so was now a diplomate in psychoanalysis and eligible to join the Academy of Psychoanalysis. And I get to stretch out my name with an additional four letters. I have explained, I trust, how acquiring a diplomate in psychoanalysis is not only possible for many colleagues in Division 39, but also a positive learning experience. It is also valuable to have recognition from my peers that I have demonstrated competence as a psychoanalytic psychologist.

I would like to add one more reason to seek the diplomate. This credential has been established through the hard and sustained work of our colleagues in the Division. This credential is sanctioned through the American Psychological Association and unites us with other specialties in psychology. The Diplomate in Psychoanalysis gives our profession visibility in our parent organization. In order to retain this designation, there must continue to be applicants seeking and acquiring the diplomate. By applying for the ABPP, you express your support for psychoanalysis and its rightful place in APA.

Please consider applying for an ABPP in Psychoanalysis. For more details and information please refer to the ABPP Web site: www.abpp.org.
This article aims to raise awareness about how multicultural psychology is experienced within the psychoanalytic community (i.e., psychoanalysts and psychoanalytic clinicians), and how we may initiate a process of community building around multicultural issues and psychodynamic psychology. Division 39 has been actively involved with promoting awareness and discourse on the relevance of multicultural issues in its programming, committee support, and liaison with APA. As members of Division 39 and our respective psychoanalytic communities, many of us attempt to find ways to integrate individual psychology and social context in our clinical practice, teaching, research, and in dialogue with one another.

Many of us also struggle with being in professional encounters where one or more clinical perspectives (i.e., multicultural, psychodynamic, etc.) are either overlooked or undermined. I recall in one interaction with a group of psychodynamic colleagues, while planning a conference program, a concerned colleague stated that it would be “too risky” to only focus on social context in a psychoanalytic program. On a different occasion, where I was involved with planning a multicultural training conference, I was advised by a colleague that I needed to de-emphasize psychoanalytic perspectives as this type of focus would diminish the importance of social justice issues.

I mention these two interactions as a way of illustrating the profound ways in which theoretical dichotomy between individual and social influences in clinical conceptualizations can create and perpetuate divisions within communities of psychologists. Interestingly, these feelings resonate with many clinicians of diverse backgrounds and with those clinicians who have a significant interest in both issues of diversity and psychoanalysis. They define their professional identities in the face of considerable polarization across different schools of thought.

I believe that we have much to learn from community activists who have long recognized the complexities of building and rebuilding communities. We also have a great deal to learn from psychoanalysts who are involved with community building projects. While there has been a heavy emphasis on outcome evaluation of community programming within the field of community psychology, the role of process in the implementation of these interventions has been noted recently by both community psychologists and psychoanalysts (Borg, 2005; Wandersman & Florin, 2003).

Leon and Montenegro (1998) suggested that while affective processes have not been studied systematically in community psychology, “it is through feeling, action, and understanding that individual consciousness may be transformed and thereby develop changes in the environment” (p. 220). These community practitioners recognize that context and subjective realities of the community and of the practitioners must be considered in order to ascertain the social meanings of interventions.

Borg (2005a) and Darwin and Reich (2006) have extended psychodynamic principles of understanding dyadic relationships to an analysis of communities, which is evident in their implementation of community interventions with the Avalon Gardens community in South Central Los Angeles, and families with U.S. soldiers deployed in Afghanistan, Iraq, and Kuwait, respectively. They underscored the need for community practitioners to attend to collective implicit or unconscious processes that influence and guide decisions about implementation of interventions. For example, Darwin and Reich described the complex nature of planning interventions with families of soldiers who function within a hierarchical military culture that is both protective of soldiers and “wary of outside groups offering services, even on a pro bono basis” (p. 482). The authors proceeded to outline specific details about how best to access families of soldiers in a way that anticipates the potential “outsider” position of the practitioner.

Borg (2005a) noted that interactions between community members and practitioners often reflect larger community issues. He extended transferential responses to the community context. For instance, he was asked by an African American male resident in the Avalon Gardens community if he was the police, referring to Borg’s Caucasian racial background. Borg underscored the relevance of historical and ongoing assaults against the African American community as well as the derivative transferential responses of community members (i.e., mistrust of individuals perceived to represent aspects of the perpetrators), which contributed to an “us versus them” dynamic (p. 7).

Borg’s, Darwin’s, and Reich’s work offer valuable guidance in conceptualizing community building within our respective psychoanalytic communities, including that within Division 39. Community building around multicultural issues within the Division would then entail a process of examination of the relevance and meanings of multicultural identity as it affects current and future members of the Division through ongoing discourse that can include multiple clinical perspectives. This is particularly important in light of our strengthening of commitment to better understanding issues of diversity and their relevance to psychodynamic practice, teaching, and research.
Section IX: Psychoanalysis for Social Responsibility

Section IX hosted a reception at the Spring Meeting of Division 39 in Toronto, which featured a moving segment from Donna Bassin’s documentary, *The Mourning After*, about a group of Vietnam veterans. Dr. Bassin also received the Section IX Achievement Award, honoring her important work educating the public about the traumatic effects of war on our veterans. This award honors the achievements of those who have taken their expertise beyond the consulting room into the world to deal with issues of social responsibility. At the Spring Meeting, Ricardo Ainslie, a member of the Section IX Board, also showed a very powerful segment from his documentary about Vietnam veterans. We honor the creative work of those individuals who seek to go beyond the spoken word to capture the pain and promote the healing of traumatized individuals.

Section IX also cosponsored a symposium with the Committee on Multicultural Concerns titled “Psychoanalytic Perspective on Prejudice and Conflict: A Model for Applied Psychoanalysis for the 21st Century.” Laurie Wagner and Marilyn Jacobs organized the symposium. Nancy Hollander and Steve Portuges, based on their participation in an internationally organized psychoanalytic study group dealing with the Palestinian-Israeli conflict, were discussants. The panels reflected the many sides of this difficult conflict, and while it was readily discernible that no easy solutions can be found, what was most striking were the feelings of mutual respect expressed, despite the differing feelings and points of view held by the panelists, many of whom came from the Middle East, including Israel, the West Bank, and Egypt. Panels were chaired by Nadia Ramzy and also included Carlo Strenger, George Awad (by video), Ira Brenner, Afaf Mahfouz, and Hassan Azim.

In addition, Section IX held another early morning open forum to discuss psychologists’ involvement in interrogation at military detention centers, like Guantánamo Bay, and to develop strategies for section intervention. The forum chaired by Lu Steinberg began with presentations by several section members who have been at the forefront in dealing with this critical issue: Neil Altman authored the resolution calling for a moratorium on psychologist’s participation in the interrogations of detainees, a resolution which will be voted on at this August’s APA Council of Representative’s (COR) meeting in San Francisco; Steven Reisner debated General Kevin Kiley at last years’ APA COR meeting; Ghislaine Boulanger has been a leading figure in the movement to withhold APA dues as an expression of protest and to put pressure on APA; and Nancy Hollander (Section past president), along with Ghislaine, and Neil and Stephen Soldz, presented at a recent conference sponsored by Psychoanalytic Institute of Northern California (PINC). While differing views on this issue were encouraged and expressed, most who have been participating on list discussions and in the Toronto forum have voiced support for a generally critical stance.

Discussion at the open forum focused on ways to support the moratorium resolution, including a rally at APA in San Francisco as well as contacting those divisions that have not yet signed on in support of the moratorium resolution. The Section IX list provides a continuing forum for discussion, and we welcome all points of view on this critical issue affecting psychology.

Section IX hopes to continue to provide a forum for the expression and exploration of sociopolitical and cultural concerns. To find out more information or to join Section IX, please contact Lu Steinberg at lu2steinb@hotmail.com, or Neil Altman at neilaltman@hotmail.com, or send a check, made payable to APA Division 39 Section IX, to Ruth Helein, 2615 Amesbury Road, Winston Salem, NC 27103

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Call for Papers: Division of Psychoanalysis Program, Psychoanalysis at its Limits,
at APA Annual Convention, August 14-17, 2007, Boston, MA

We encourage you to submit proposals that address the theme “Psychoanalysis at its limits,” whether these limits are theoretical, interdisciplinary, or practical. All submissions must be sent electronically via the APA web site. Instructions are listed APA web site at www.apa.org/convention. For questions regarding proposals, please contact program co-chairs:

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