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EDITORIAL STATEMENT

This new journal will document a challenging movement that has been developing within the framework of psychoanalysis. A movement that has been steadily extending the scope of psychoanalytic practice beyond the original limits set down by Freud and still observed by those colleagues who continue to practice psychoanalysis within the classical mode. One by one, psychoanalysts have felt constrained to apply psychoanalytic methods to the treatment of emotional conditions other than the transference neuroses, and over the years reports have been accumulating of surprisingly successful results with conditions such as character disorders and psychosomatic symptoms.

Within the past twenty years, advances in theoretical understanding and the development of new clinical techniques have quickened and we are now at a point where it seems possible that the theoretical insights of psychoanalysis can be applied to the treatment of the full spectrum of human emotional disorders.

The policy of the journal is to encourage the publication

of papers reporting upon such new techniques and theoretical formulations in order that psychoanalysts may keep themselves informed about new and challenging developments in their field. But the concepts and theories as well as the newly evolved technical interventions that underly the broadened scope of psychoanalytic practice have important implications for all persons concerned with emotional re-education. Understanding the phenomena of transference and resistance will have immediate and practical value to a wide audience, including the staffs of mental institutions, teaching faculties, counselors, social workers, those who work with groups, and all others who are concerned with human emotional development.

Perhaps we can all share and contribute to Freud's vision of a definitive science of man.

The Editorial Board

THE ORIGINS OF MODERN PSYCHOANALYSIS*

The term modern psychoanalysis is used to describe a body of new developments in psychoanalytic theory and technique that emphasizes the role of emotional communication in the analytic situation, especially in the analyst's interventions. Clinically, the methods and techniques of modern psychoanalysis enable psychoanalysts to treat a much wider range of disturbances than was believed possible using classical methods. In fact experience has shown that modern psychoanalysis can be an effective treatment for all the psychodynamically reversible illnesses, including psychosomatic disorders, organic disorders with a psychological component, psychoses, neuroses, and character disorders.

Scientifically, the findings of modern psychoanalysis have contributed new insights into both the dynamics of emotional illnesses (especially the more severe disturbances such as schizophrenia) and our understanding of the mechanisms through which the analytic process cures these conditions. As in classical analysis, the modern analyst's strategy is to create a transfer-

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*Adapted by the Editorial Board from the introduction to: *Treatment of Narcissistic Neuroses*, by Phyllis W. Meadow and Hyman Spotnitz, in press.

ence situation by having the patient communicate verbally from the couch. Cure is then effected through analysis and resolution of the transference resistances.

Historically, modern analysis dates from the work of Spotnitz, who during the 1940s used psychoanalysis to treat severely regressed, hospitalized patients. Spotnitz, and other modern analysts since then, have found that for psychoanalysis to be effective with such disturbances, it is necessary to establish a narcissistic transference with the patient. This condition differs from object transference because it involves a re-creation of the relationship that existed with the mothering figure before the ego boundaries became defined.

Classical analysts, beginning with Freud, have held that the narcissistic disorders do not respond to psychoanalytic treatment. However, modern analysts have found that the development of a narcissistic transference makes possible the treatment of such patients.

Early work by modern analysts disclosed that the narcissistic patient's major resistances involved defenses against powerful aggressive feelings. This finding suggests another important difference between modern analysis and classical analysis: the primary focus of classical analysts is the resolution of transference resistance to the expression of libidinal feelings; modern analysts, when working with the narcissistic disorders, focus first on the aggressive drive in order to liberate the libidinal drive.

Theoretically, it is fruitful to view the symptoms of narcissistic disorders (depression, withdrawal, ego fragmentation, psychosomatic complaints, and so on) as primitive defenses against acting out murderous impulses toward an object. To prevent action the impulses are turned inward against the patient's own ego or soma.

A number of analysts contributed to the early development of the key concepts on which modern analysis is based. We will now review the work of these precursors concerning the role of aggression in emotional disturbance, on the development of the narcissistic transference, and early methods of treating narcissistic disorders.

ROLE OF AGGRESSION

The pioneer in understanding aggression was Adler, who in 1908 postulated the existence of an aggressive drive in a theoretical paper titled "The Aggressive Impulse in Life and Neurosis." If Adler had developed this idea further, it might have been possible to cure many narcissistic and psychosomatic disorders. However, he did not do so because his primary interest was individual psychology.

In contrast, it was only late in life that Freud came to recognize that the aggressive drive should be separated from the libidinal drive. In 1901 he maintained that every act of hate issues from erotic tendencies. He preferred at that time to adhere to the view that leaves each instinct to its own power in becoming aggressive.

Later, in his *Outline of Psychoanalysis* (1940), Freud mentioned that he had not dealt sufficiently with the problem of the aggressive drive: "All of psychoanalysis has to be reformulated in terms of understanding the aggressive drive as separate from the libidinal drive." And Brill (1949) later quoted Freud as saying that he finally believed that psychoanalysis could eventually be used to cure psychotic states.

In an article about the appearance of aggressive impulses in patients (1921), Nunberg described a case in which he viewed the patient's problem as one of libidinal conflict and emphasized its homosexual aspects. He described a narcissistic identification in which there was "no longer a boundary between us"—the patient experienced aggressive (cannibalistic) impulses and fantasies of sacrifice.

In one situation the patient said, "It seems to me that I am to hit someone, to tear somebody's hair out." Thereupon he struck his own head with his fist and started to pull out his hair. Here the defense against aggressive impulses was enacted by the instinct turning against his own person and changing into its opposite. Nevertheless the aggressive tendency continued to exist beside the passive tendency and even increased in violence.

The patient, however, shed a different light on his fundamental problem as it was reactivated in the analytic relation-

ship. His words provide evidence for the theory that destructive impulses toward his primary object were a crucial factor in his illness. In effect he was saying: My desire to preserve you protects you and defends me against my wish to destroy you.

An early illustration of the schizophrenic tendency to direct aggressive impulses against the self was provided by Reik (1927). One of his patients, while in a state of depersonalization, told him: "Instead of knowing that you want to kill someone else, you wipe yourself out."

Rosenfeld (1947) called attention to the same mechanism in the following statement about a schizophrenic patient: "Instead of attacking and destroying the analyst, the destructive impulses had turned against her desire to live, her libido, which left her half dead, as it were, and so in a state of depersonalization [p. 130]."

In one of the earliest attempts to explain the withdrawal from objects, Klein (1930) attributed this withdrawal to the ego's "exaggerated and premature defense against sadism, beginning in the first few months of life [p. 433]." The turning of destructive impulses against the object, which is first expressed in fantasied oral-sadistic attacks on the mother's breast and later on her entire body, leads to the development of mechanisms regarded as tremendously important for the development of the disorder. In Klein's view, the excessive sadism causes anxiety that is too severe for the infantile ego to master. Thus the earliest modes of defense are set into action against two sources of danger: the sadism itself and the object, from whom similar "retaliatory" attacks are feared.

The concept that the aggressive drive destroys the ego unless it has an adequate outlet was described in some detail by Spotnitz (1966) as it relates to the schizophrenic reaction. The basic pattern is one of the psyche that clings to the object with libidinal cathexis and obliterates it with aggressive cathexis.

> The ego sets up the control of motility so that it operates in the service of object protection. Libidinal energy is used for that purpose when, in the absence of tension-reducing gratification from the object, the obliteration pattern be-

> comes charged with aggressive cathexis. The integrity of the psyche and the fate of the external object are the stakes in the battle between aggressive object cathexis fighting for control of motility and libidinal cathexis checking motility to prevent destructive action [p. 30].

He added,

> In these high tension states, libidinal energy is adequate to inhibit hostile behavior, but is overwhelmed as the organizing force of the mental apparatus. It is on this front that the battle is decided in favor of the more powerful adversary. The patterning of the schizophrenic reaction reduces the tension sufficiently to protect the object, but disorganizes the mental apparatus [p. 3].

Prior to the modern psychoanalytic movement, other analysts were developing parallel ideas. Sechehaye (1956) believed that the schizophrenic defends himself against the "penetration by someone else" and also against an "eruption of affective and emotional life" through the absence of contact with other persons. Hill (1955) and Schlesinger (1962) also contributed to the concept that the schizophrenic process represents inner-directed aggression. And according to Rosen (1953), psychosis serves the basic function of keeping the individual from facing the terror he experienced with the early maternal environment as he perceived it.

DEVELOPMENT OF THE NARCISSISTIC TRANSFERENCE

Freud pioneered the development of the concept of transference after the phenomenon appeared unexpectedly while he was treating hysterical patients by the cathartic method. Eventually he described it as an unconscious phenomenon operating in all human relations. *An Autobiographical Study* (1925), the definitive exposition of his view of the transference, contains the clearest statement of his misgivings about negative transference and also is relevant to his views on countertransference:

> Transference is merely uncovered and isolated by analysis. It is a universal phenomenon of the human mind, it decides the success of all medical treatment, and in fact dominates the whole of each person's relation to his human environment. . . . When there is no inclination to a trans-

> ference of emotion such as this, or when it has become entirely negative, as happens in dementia praecox or paranoia, then there is also no possibility of influencing the patient by psychological means [p. 42].

Here, Freud indicates his belief that negative transference nullifies the possibility of therapeutic effect.

When he reported the case of Dora, Freud (1905) described the transference process as

> a whole series of psychological experiences (which) are revived, not as belonging to the past, but as applying to the person of the physician at the present moment. Some of these transferences have a content which differs from that of their model in no respect whatever except for the substitution. These then . . . are merely new impressions or reprints. Others . . . will no longer be new impressions, but revised editions [p. 115].

Thus, despite his conviction that the analysis of transference is the core of a successful psychoanalysis and that these transferential impressions exist in all human relations, Freud could see no possibility that a person in a negative transference could be amenable to analytic treatment.

Freud's concept of transference, however, was limited to what is now recognized as object transference. We know that to succeed in working with the negative feelings Freud shunned, it is necessary to establish a narcissistic transference.

It was Waelder who in 1924 introduced the concept of narcissistic transference and the use of narcissistic transference as a technical term. He proposed a method of treatment oriented toward the sublimation of narcissism and described a case in which a transference of that nature proved sufficient to sustain the relationship. Clark (1926) described a "fantasy method" of analyzing the narcissistic neuroses and characterized the transference as the "mother type," contrasting it with the "lover type" that evolves in the transference neuroses. Aichhorn (1948) found he could therapeutically influence a young delinquent who was unable to form a meaningful object relationship, except through an "overflow of narcissistic libido," by presenting himself as a glorified replica of the patient's delin-

quent ego and ego-ideal. This was probably the first description of the ego-syntonic object transference. Bak (1939), another early advocate of such functioning, recommended that the therapist should "represent a narcissistic object," so that he would appear to the patient as a part of himself.

Among other isolated references to narcissistic transference in the 1930s and 1940s were those of Stern (1938) and Cohn (1940). Stern offered specific recommendations for working with patients who present "painfully distorted narcissistic transference reactions [p. 467-468]." Cohn described rudimentary and primitive transference reactions and their manifestations. Of special interest is Cohn's observation that the patient at times "refers to the analyst when he speaks of himself and vice versa." Rosenfeld (1947) reported that when the schizophrenic felt love or hate for the object it followed in all the cases which he treated: The patient "seems to become confused with this object." Freeman (1963) described the details of a case in which an "intensive positive" narcissistic transference led to an intractable "resistance of idealization." Searles (1963) described transference psychosis as "any type of transference which distorts or prevents a relatedness between patient and therapist as two separate, alive human and sane beings [p. 249]." Little (1958) introduced an analogous concept when she described a transference state in which the analyst "is, in an absolute way . . . both the idealized parents and their opposites, or rather, the parents deified and diabolized, and also himself [the patient] deified and diabolized [p. 134]." She conceptualized this as delusional transference.

Balint (1952), in conceptualizing transference as a "new beginning," wrote that

> some patients regress in primitive stages in their development, in order to begin the process of adaptation anew. . . . Primitive, undifferentiated states are elastic, capable of new adaptation in various directions . . . if a radical new adaptation becomes necessary, the highly undifferentiated organization must be reduced to its primitive undifferentiated form from which a new beginning may then be made [p. 214].

Lagache (1953) described transference as the "activation of an unsolved conflict; injury to the narcissistic drives . . . is not just a reason for defense, it evokes an unconscious demand for reparation [p. 1]." Elaborating on the needfulfilling function of various transference states, Meerloo and Nelson (1965) referred to negative transference as the "patient's quest for a means of handling negative feelings [p. 00]." Klein (1952) expressed the view that transference originates in object relations during the first year of life and reflects the presence of hatred as well as love, or "the mechanisms, anxieties, and defenses operative in the earliest infancy [p. 433]." Bullard (1960) advised against trying to establish positive transference when beginning treatment with a patient who has rarely experienced "warm and uncomplicated" interpersonal relationships because an approach that "assumes that [the patient] . . . has had these experiences is doomed to failure [p. 137]."

Other writers have expressed similar views: for instance, Boyer and Giovacchini (1967) wrote that "the schizophrenic is terrified of the potential destructiveness of his impulses and when the emergence of hatred of former love objects is discouraged, he thinks the therapist fears his own or the patient's hostility [p. 166]."

Until now we have been talking about persons who not only have contributed to the pragmatic understanding of the role of aggression, object protection, and sacrifice of the ego in connection with the narcissistic defenses but have helped to develop the concept of transference. Next we will consider the precursors of modern psychoanalysis who worked successfully with the aggressive impulses in psychotic states.

THE NARCISSISTIC DEFENSE

One of the first to deal successfully with psychotic states was Josef Breuer (L. Freeman, 1972), who treated Bertha Pappenheim (Anna O.) with hypnosis and "talking cure" and found that after several relapses, she was relieved of her psychosis. Freud adopted Breuer's method and developed the system of psychoanalysis, which eventually became classical psychoanalysis. But as we have seen, Freud did not recognize until late in

life that psychotic states could be treated successfully in psychoanalysis.

The prognosis for schizophrenia, as the years went by, improved continually, and today one gets the impression that as we understand the schizophrenic process better and as more results are reported, the prognosis will improve even more. Bjerre (1911), another pioneer in the field, reported the successful treatment of a paranoid psychotic woman. Among those who have reported favorable results with schizophrenia is Karl Menninger, who originally was extremely pessimistic about treating these patients. As he pointed out in *The Human Mind* (1945): "It is now well recognized that this dread disease is by no means hopeless, granted the availability of prompt and skillful treatment."

Arieti (1961) also contributed to the slowly increasing optimism about schizophrenia, believing that the schizophrenic may "orient himself toward a more productive, mature and nonpsychotic life."

Fromm-Reichmann (1952) also achieved excellent results with psychotic patients. She found that when it seemed impossible to establish a workable doctor-patient relationship with a schizophrenic patient, the problem was attributable to "the doctor's personality difficulties, not to the patient's psychopathology."

Although Sechehaye (1956) used psychotherapy with schizophrenic patients, her theory is difficult to apply because it does not focus on personality dynamics. She conceptualized the therapeutic process as one of meeting the need for discharge of impulses but neither distinguished between erotic and aggressive impulses nor addressed the defense against impulse discharge.

Zilboorg (1931) analyzed a young woman suffering from paranoid schizophrenia and identified the nucleus of her psychosis as an "early infantile conversion" in which the patient displaced her hatred of her parents onto herself. The severe frustration she experienced at age five "dammed up an enormous mass of instinctual energy which produced or activated her hostile impulses to the utmost degree [p. 493]." It was Zil-

boorg's impression that these impulses were permitted to break through only when she was in a psychotic state.

Hendrick's article on the psychoanalysis of a schizophrenic young woman on the verge of psychosis (1931) is an outstanding study of an "immature ego endangered by aggressive impulses." Hendrick attributes the inability of the patient's ego to repress infantile sexual impulses to the fact that all available energy "was mobilized in the service of another function, namely, the control of enormous impulses of aggression."

According to Bak (1954), "the sudden inability of the ego to neutralize aggression (which inherently means the loss of the object in varying degrees) turns the entire aggressive drive loose, and this develops increasing emphasis and destroys the self that has become its object [p. 129]." In some cases, the ego regresses to its undifferentiated phase or employs other defenses such as projection or withdrawal to "avoid the destruction of objects."

MODERN PSYCHOANALYSIS AS A THERAPEUTIC TECHNIQUE

When working with a schizophrenic, the problem seems to be one of determining whether he can be cured by the classical technique. Some analysts claim they are able to do this. Others, who do not use the classical technique, seem to be practicing psychotherapy. The important point, however, is that modern psychoanalysts do not use psychotherapy with schizophrenia, but they do employ transference resistance to resolve it. Modern psychoanalysis can be successful with schizophrenic patients because it is able to deal with tranference relationships and resistances.

A number of practitioners can be identified as the precursors of the modern psychoanalytic technique. As early as 1935, Jung viewed the analytic process as the "reciprocal reaction of two psychic systems." Reich (1951) claimed that countertransference is a necessary prerequisite for effective treatment, and Gitelson (1952) expressed the view that countertransference reactions "exist as facts in any analysis. . . . [to the extent that the therapist is] open to their analysis and integration, he is in a real sense a vital participant in the analysis with the patient [p. 1]."

Rosenfeld (1947), Winnicott (1958), and Searles (1963), have also contributed to the body of knowledge about countertransference. Winnicott and Searles apparently recognized that the patient's problems induce similar problems in the analyst and result in an induced countertransference. Alexander (1961) was influential in developing some of the notions connected with feelings in modern psychoanalysis. His ideas about constructive emotional experience represent one of his most important contributions to modern psychoanalysis. Many feelings created in the analyst when he works with patients with psychosomatic disorders have proved to be significant when used with these patients in treatment, and they demonstrate repeatedly that psychosomatic conditions and organic disorders are accessible to a psychoanalytic approach. Modern psychoanalysis has since accomplished much through research on organic and psychosomatic cases.

At present, modern psychoanalysts are trying to formulate a theory that will help the therapist understand schizophrenic, narcissistic, and psychosomatic patients in such a way that he can treat them successfully. There are many theories about the human personality and its development—all of which may or may not be correct. What modern psychoanalysis tries to develop are theories that, when applied to the patient, help to cure him. Any theory that enables the analyst to understand the patient but becomes a detriment to curing him is discarded. In other words, modern psychoanalysis depends on and accepts only pragmatic concepts. It does not limit itself to psychodynamic treatment alone. Although the modern analyst cooperates with physicians who use physical and chemical methods with patients, he relies on psychodynamic communication to resolve transference resistances that interfere with mature healthy functioning.

All psychodynamic methods are included in modern psychoanalysis: e.g., group therapy; individual sessions that range in number from one session per year, to as many as six per week; and treatment of one patient by several therapists or treatment of several patients by one therapist. In other words, psychodynamic methods are used singly or in combination with other methods as long as they will help resolve transference

resistance, i.e., produce a mature personality. The methodological area is still open to research, and no one knows as yet what the limits to modern psychoanalysis will be.

Many early modern analysts who practiced what they called psychotherapy were intuitively trying to resolve transference resistances but did not recognize their work as transference analysis. We may credit them with being pioneers in that they used methods that we use deliberately today when trying to resolve transference resistance, though they themselves may not have been aware that this was what they were trying to do.

Finally, central to the development of modern psychoanalysis are patients who have worked with modern analysts. These patients have made important contributions because of their ability to progress in analysis and make suggestions about how to make analysis more effective. In other words, they have demonstrated to the modern analyst the potential of modern psychoanalysis. Many failures have been caused by the analyst's inability to provide the proper psychodynamic interventions. Many successes have been related to patient's suggestions about how analysts should intervene to help them resolve their resistances. When the analyst uses his patients as his guide, the treatment plan itself produces growth. Apparently, modern psychoanalysis owes its successes to patients in the same way that Breuer owed to Anna O. his success in dealing with her.

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CLAIRE ERNSBERGER

FREUD AND THE MODERN SCHOOL

Modern psychoanalytic theory offers two key proposals concerning the etiology of psychogenic illness. First, most emotional illnesses seen in practice today, including psychosis and other narcissistic disorders as well as neurosis, are caused by breakdowns in the maturational sequence. Usually these breakdowns are caused by the unsuccessful or incomplete resolution of one or more preoedipal stages— which forecloses successful resolution of the oedipal stage. Second, the blockage of the libidinal drive does not in itself cause the breakdown: rather the mobilization of excessive amounts of aggressive energy deflects the libidinal drives from their normal pathways to protect the object from this dangerous aggressive energy.

A more detailed explanation of how the transference and resistance are analyzed in both traditional and modern analysis may help the reader understand that modern psychoanalysis is an outgrowth of and a contribution to Freud's original conceptions. The advance in technique is especially valuable when dealing with narcissism, because Freud believed that other techniques or refinements would have to be developed to overcome this seemingly invincible resistance. Today modern psychoanalysis is investigating these other methods while staying

within the boundaries of Freud's definition of psychoanalysis as any line of endeavor that uses the investigation of transference and resistance as its starting point.

The principal differences between Freud's original techniques, which classical analysis still adheres to, and the techniques of modern analysis are (1) how the analyst functions—i.e., what he says or does not say to the patient and when, why and how he says it, and (2) what is expected of the patient. In classical analysis, the patient is expected to cooperate with the analyst in a working alliance to overcome his resistances (Greenson, 1967). In modern analysis, the patient is not expected to cooperate in such an alliance because it is recognized that when he enters treatment, he may not have the ego strength necessary to do so. In other words, he is expected to resist and is supported in that resistance for "without resistance there is no analysis (Spotnitz, 1973)."

The following are summaries of Freud's recommendations concerning the practice of psychoanalysis and the extent to which current traditional analysis and modern psychoanalysis follow and diverge from those recommendations.

I. RECOMMENDATIONS TO PHYSICIANS PRACTICING PSYCHOANALYSIS

Freud's first recommendation (1912) was that anyone who wished to practice analysis must first undergo an analysis of his own. At the present time, this is still a requirement for all who enter the profession and is a standard requirement of professional psychoanalytic training institutes. It is particularly essential for the modern analyst, who uses induced countertransference feelings as an objective therapeutic instrument. The modern analyst undergoes an analysis, preferably with an experienced modern analyst, in which his own maladaptive patterns are resolved. He must have the emotional resilience and self-awareness to tolerate his patients' aggressive hostility toward him and must be able to experience the full range of libidinal and aggressive feelings that patients will induce in him without resorting to defensive, impulsive behavior.

II. LINES OF ADVANCE IN PSYCHOANALYTIC THERAPY

In 1919 Freud recommended that psychoanalysis be practiced, as much as possible, in a state of abstinence. The layman has often misunderstood this to mean that the patient should abstain from all sexual activity while undergoing analysis. Freud actually meant, first, that because the patient should experience a certain amount of tension and frustration while undergoing analysis, he should be given as little substitute gratification as possible in which to discharge his tensions. Both classical and modern analysts adhere to this recommendation and try, as much as possible, to bring the patient's acting-out behavior into the treatment situation and help him put his needs and feelings into words rather than actions. The classical and modern approaches to helping the patient follow this rule can be differentiated on the basis of the methods that each one uses to investigate resistance.

Second, Freud meant that the analyst should not attempt to provide the patient with "all that one human being may hope to receive from another" in an effort to help him. The patient, Freud said, must have an abundance of unfulfilled wishes if he is to return to the state of deprivation and frustration that originally caused his illness. Furthermore, the satisfactions he desires so intensely must be denied. Freud did not specify whether the analyst should inform the patient that he will not fulfill these wishes. The modern analyst leaves the patient in doubt because telling him tends to prevent the formation of the transference and thus to render him untreatable. Since the patient's attempts to seduce the analyst into providing gratification for his sexual and aggressive impulses represent a resistance to verbalization, the analyst treats them as a resistance like any other. The modern analyst investigates this resistance and psychologically reflects it.

III. ON BEGINNING THE TREATMENT
(Further Recommendations on the Technique of Psychoanalysis I)

Modern analysts follow Freud's recommendation (1913b) that a verbal contract should be established between analyst and pa-

tient. However, Freud regarded the establishment of this contract as preliminary to and separate from the treatment process while modern analysts view discussions of contractual arrangements as part of the treatment. In other words, the analyst begins to analyze the patient's resistances during the very first contact.

Freud stipulated that analysis should be conducted five times a week. Modern analysts do not necessarily adhere to this recommendation; in fact, clinical experience has shown that once or twice a week is often the optimal number of sessions for patients with preoedipal difficulties. The modern analyst investigates with his patient how often the patient wishes to come and what he can afford to pay. This agreement is based on what is agreeable to both parties; the analyst recognizes that the patient should be seen only as often as the patient can tolerate the contact.

Freud also believed that the patient should be told that he has leased a specific hour or hours and must pay for that time, whether he attends or not. Modern analysis has a more flexible approach to the problem. To facilitate the spontaneous expressions of resistance and to avoid influencing negatively suggestible patients, the analyst does not stipulate rules in the initial agreement. He waits until the patient raises questions. If a patient misses a session, for example, the act is investigated as a resistance. If the patient asks what will happen if he misses a session, the analyst informs him that if he gives 24 hours notice, he will not be charged for that session. All requests for changing the analytic hour are similarly investigated. In other words, the analyst focuses on understanding the patient's resistance to following the rules, and after the patient's resistance and the analyst's counter-resistance are thoroughly understood, reasonable requests are granted.

Freud also urged analysts to tell their patients at the outset how long the treatment would be and what difficulties and sacrifices would be involved. The modern analyst neither asks nor answers any questions about these matters and usually counters the patient's queries about them with investigatory questions of his own. As Spotnitz (1969) pointed out:

> It is preferable not to volunteer information about the length, emotional impact, difficulties, or anticipated results of the treatment. Promises, explicit or implicit, of a successful outcome, are contraindicated. Assurances of this nature have varying effects, and these are difficult to predict during the first encounter. For instance, a negatively suggestible person may labor under an unconscious determination, whatever the cost to himself, to outmaneuver and defeat the analyst; such resolves may be strengthened by a suggestion of recovery. Before responding to a specific question about what the treatment entails, one explores the question thoroughly with the patient until its unconscious meaning is fully understood [p. 76].

According to Freud, a patient should be allowed to terminate treatment at any time. The modern analyst, aware of the strength of resistances to transference during the early phase of treatment and also aware that the ultimate success of the treatment depends on whether the patient learns to tolerate his feelings—particularly his negative, aggressive feelings—tries to help the patient remain in treatment for two years (the minimum period necessary to develop the narcissistic transference) and learn to verbalize his feelings rather than act on them. Although many patients subsequently want to leave treatment and need to know they are free to do so, they generally elect to continue once they are assured that they have this freedom.

Modern analysts follow Freud's recommendation that patients lie on the couch as an aid to regression and subsequent repetition in treatment of the original conflict. The couch also helps the patient control his impulses to action. A patient may, by prior agreement, get off the couch once the analyst is convinced that he can verbalize his aggression successfully, and that being off the couch will resolve a resistance.

Freud said that the subject the patient chooses to talk about is unimportant. However, it is crucial that he be told that he must say everything—i.e., free associate and never leave anything unsaid for any reason. The preoedipal patient incorrectly perceives that thinking and talking are equal to action. Thus the instruction to free associate usually arouses more anxiety in narcissistic patients than they can tolerate. They are afraid of

losing control of themselves if they are confronted with feelings before those feelings are tolerable. Therefore, rather than instruct his patients to free associate, the modern analyst instructs or commands his patients to talk about anything they want to talk about. If a patient says he cannot talk about something, a modern analyst will often tell him not to talk about it at that time.

Freud recommended suggesting at the beginning of treatment that the patient make no irreversible decisions about his life during the course of treatment. As Spotnitz (1969) pointed out, however:

> To suggest at the beginning of treatment that the patient refrain from making irreversible decisions about his life affairs would introduce potentially troublesome ideas before he is confronted with the necessity of committing himself to a course of action. Later on, if such a decision confronts him, the situation is explored with the patient so that he can balance the pros and cons and make up his own mind how to proceed [p. 89].

What the patient does outside the office is of interest only insofar as it affects his functioning in the analytic sessions. Thus he is free to do anything he wishes outside the office as long as it does not interfere with the progress of the analysis. If what he does results in resistance or is understood to be a symptom of a resistance, the analyst may order the patient to stop doing it. The patient's inability to stop then becomes the resistance that is investigated.

Freud stated that a patient should be told the rule of confidentiality at the beginning of treatment. Modern analysts agree with the rule of confidentiality but wait for the patient to bring up the subject. The behavior of breaking confidentiality is then explored and the rule stated. This model applies to all resistances such as smoking or eating during the sessions, talking at length at the beginning or the end of the session while not on the couch, or other inappropriate behavior that does not actually endanger either the analyst or the analysand. The underlying purpose of the rules in both classical and modern analysis is to help the patient to behave cooperatively so that he can put

all of his thoughts and feelings into words. However, the modern analyst reveals the rules only when the patient breaks them or brings them up because it is desirable to resolve resistances rather than overcome them. Rule breaking, then, is allowed to function as resistant behavior so that its function can be explored and analyzed.

IV. OBSERVATIONS ON TRANSFERENCE—LOVE
(Further Recommendations on the Technique of Psychoanalysis II)

In this paper published in 1915, Freud dealt with the difficulties that arise when a male analyst treats a female patient who develops a positive transference and believes she is in love with the analyst. Freud was often unwilling to perceive the hostility hidden behind this kind of transference, and when he did see it, he believed that the negative transference nullified the possibility of effective treatment and that, in general, analysts should not attempt to treat such cases. The modern analyst, on the other hand, assumes that such cases are treatable and that he must understand, accept, and foster the negative narcissistic transference.

Generally speaking, modern analysts follow Freud's basic recommendations about how to handle the transference. As long as the patient verbalizes freely, they believe that the theme of the transference should not be touched. No interpretations or explanations are given until transference is established. The analyst withholds information about himself in order to facilitate the development of transference. If the patient is allowed to see the analyst's true personality, the transference is distorted and the analyst is prevented from clearly seeing the elements of resistance in the transference that must ultimately be resolved.

Freud's recommendations are concerned with the only form of transference he facilitated in his patients: the positive objective transference. Furthermore, he viewed this transference as an ongoing process in the analysis, starting at the beginning of treatment. Modern analytic studies show that this positive object transference usually does not emerge fully until much later, after the narcissistic defense has been resolved.

Therefore, the modern analyst devotes much analytic attention to the negative and positive narcissistic transference, which develops early in treatment.

The narcissistic transference may be manifested in the patient's lack of contact with the analyst: the patient functions in the sessions almost as if the analyst does not exist. Indeed, patients will often say that they feel as though the analyst is not there or that they might as well be talking to the wall. When these patients do relate to the analyst, they sometimes treat the analyst as if he were an integral part of themselves; sometimes as if he were a somewhat alien part of themselves, and sometimes as if the analyst were separate, but a psychological twin. Depending on the attitudes of the early childhood objects, the patient's narcissistic tranference will either be positive or negative or vacillate between the two. Generally, the transference is negative at the beginning and during the middle stage of treatment, although it is frequently hidden behind a layer of positive feelings. Spotnitz (1961-2) described this phenomenon as follows:

> On the surface [the narcissistic transference] looks positive. [The patient] . . . builds up this attitude: "You are like me so I like you. You spend time with me and try to understand me and I love you for it . . ." Underneath the sweet crust however, one gets transient glimpses of the opposite attitude. "I hate you as I hate myself. But when I feel like hating you, I try to hate myself instead [p. 33]."

As the analyst helps the patient drain off his hostility verbally, the transference, although it retains the characteristics of the narcissistic state, becomes positive in the sense that the patient allows himself to feel and express his positive and negative feelings about himself and the self-like object of the transference. The object transference, in which the patient shows a definite emotional interest in and awareness of the analyst as someone separate from himself, may also go through a negative and a positive phase. In the final phase, when the positive object transference predominates, the patient is able to feel and express all his feelings toward the transference object.

Since modern analysis conceives of narcissistic neuroses as

the emotional charge of the patient's early interchanges with his maturational environment which set up pathological patterns that blocked the verbal discharge of aggression and negative feelings, the treatment plan focuses on the resolution of these patterns. Thus developing the narcissistic transference is the first step. Because the degree of narcissistic preoedipal difficulties varies with each patient, the degree to which the narcissistic transference will develop also varies. Thus it must be worked through no matter when or how it appears in the treatment process. When the narcissistic transference is verbalized, the patient becomes less and less self-occupied and more interested in separate objects.

V. REMEMBERING, REPEATING, AND WORKING THROUGH *(Further Recommendations on the Technique of Psychoanalysis II)*

"What interests us most of all is naturally the relating of this compulsion to repeat to the transference and resistance [Freud, 1914, p. 151]." With these words, Freud established the primary focus of the analyst's attention. The analyst investigates how the patient reproduces his preadult life—i.e., how he repeats it in the analytic situation rather than remember it and put it into words. The analyst explores the relationship between this repetition and the transference and discovers that the transference itself is a repetition of the patient's experiences with his early objects. When he studies the resistances, he finds that they too are part of the repetition. Where the transference is a repetition of the feelings and attitudes the patient and his early objects had toward each other, the resistances are repetitions of the repressions the patient instituted in his early life against thoughts and feelings, the representations in the mind of the instinctual drives. By "working through," Freud meant the process in which the analyst interprets the meaning of his associations to the patient and overcomes his resistance by repeating the interpretations each time the resistance appears.

This technical paper of Freud's is the foundation for the traditional analytic techniques of confrontation, clarification, interpretation, and working through. Freud contended that the patient would be cured by a process in which the analyst

told him that the resistance existed; what it meant in terms of his early instinctual life, his current life, and in the transference; and then worked through the resistance each time it manifested itself. The goal of this process was to help the patient consciously recollect and reconstruct his early life rather than unconsciously repeat that life in his behavior.

Greenson (1967, p. 121-122) recapitulates this procedure as follows; (1) recognize the resistance, (2) demonstrate it to the patient by pointing out several instances as they occur or by intervening in such a way that the resistance increases and thus becomes demonstrable to him, (3) clarify the purpose and form of the resistance, (4) interpret the resistance, (5) interpret its form, and (6) work through the resistance by repeating and elaborating steps 4 and 5.

By following Freud's technical recommendations in this manner, the traditional analyst succeeds in making the unconscious conscious. The patient thus regains his repressed memories, achieves insights into how they have compelled him to behave in certain ways in his adult life, and, because the conscious ego can now command more instinctual energy, opens the way for a stable change in his behavior or attitudes.

This technique has proved to be extremely effective in treating patients whose difficulties stem from an incompletely resolved oedipal stage and who are able to form a working alliance with the analyst. However, as Dewald (1972) points out: "It should be obvious from this study that classical psychoanalysis is a method of treatment ideally applicable to only a relatively small number of psychiatrically ill patients. It cannot be conceived of as a generally applicable method of treatment for the mass of the mentally ill [p. 633-634]."

All candidates for psychoanalytic treatment, including those considered suitable for classical analysis, manifest some residues of unresolved preoedipal difficulties. And for whatever sociocultural reasons, many persons who are currently entering analysis show a preponderance of preoedipal manifestations in their symptoms and are unable to form an object transference until late in treatment. Thus in modern psychoanalysis, Freud's recommendations have been modified

as follows so that analysts can work effectively with these patients:

Interpretations. If the analyst offers interpretations before the patient is able to communicate consistently in adult language, the interpretations will be ineffective. The extremely alienated, withdrawn, and negatively suggestible patient will experience them as an attack, and his defense will be strengthened, not resolved, as desired. The modern analyst follows Freud's recommendations (as outlined by Greenson), but he does not communicate his formulations about the resistances to the patient until the patient has verbalized the aggressive impulses behind the narcissistic transference.

Communications. The analyst's communications may be made according to the stage of the patient's transference, timed according to the patient's requests for contact, and phrased in the form in which the patient expresses his requests.

Recognition. When the analyst recognizes resistance, he deals with it according to the priorities suggested by Spotnitz (1969): treatment destructive (any action which would result in premature termination), status quo (satisfaction with repetitive communication), resistance to progress (or, fear of new thoughts and feelings), resistance to cooperation, and termination resistance. He silently analyzes the resistance and works out a strategy for exploring and resolving it by means of emotional communications.

Investigative questioning. The analyst asks the patient investigative questions in response to the patient's contacts. In the earliest stages of treatment, these questions are factual and object oriented. When resistance to expressing the narcissistic transference dominates, ego-oriented questions and joining techniques may be used. When the patient vacillates between narcissistic and object transference, the analyst may reflect, join the patient's resistance, or provide ego-syntonic interpretations. When the patient is in a state of object transference, the analyst may offer verbal interpretations in the traditional manner as the patient requests them or if the analyst believes they may resolve a resistance.

Working through. In modern analysis, the process of work-

ing through leads to an interpretation; it does not take place after the interpretation is first offered. The working through process is complete when the patient tells the analyst the interpretation, when he succeeds in making it a part of his own ego.

Termination. The modern analytic method of working through has made important contributions to psychoanalysis by adding a final step in the procedure which takes place during the resolution of the resistance to termination. Spotnitz (1963-4) called this the "toxoid response." The analyst uses objective countertransference feelings to perform two functions that were not previously available to analysts: first, by giving back feelings aroused by a patient during the course of treatment, the analyst verifies the patient's progress toward maturation and solidifies the gains the patient has made in his mode of functioning; second, by exposing the patient to the emotions he has induced in the analyst, the analyst creates an immunological effect.

SUMMARY

Traditional Freudian psychoanalysis is a process of mutual investigation between the analyst and the reasonably strong ego of the patient, working together in a therapeutic alliance to overcome repression. The goal of treatment is personality change, which is attained by overcoming the patient's resistance to making conscious all the unconscious psychic conflicts of his childhood and by helping the patient assimilate and apply the insights gained in the process. The medium of interaction is the transference, which develops when the patient projects on the analyst all the thoughts, feelings, and attitudes held by significant objects of his early childhood and reexperiences, in his relationship with his analyst, all his early feelings, thoughts, and attitudes toward those objects.

The treatment is based on the patient's ability to form an object transference in which the patient perceives the analyst as an object that is separate and different from himself and is able to assimilate objective interpretations of his conflicts and symptoms without experiencing narcissistic mortification.

This treatment is highly effective with patients who have

successfully worked through the preoedipal stages of personality maturation. Their emotional problems are most often caused by the conflict between the sexual and aggressive impulses of the id and the defenses of the ego that occurred during the oedipal stage and resulted in an unresolved oedipal conflict. These patients, who have made relatively mild and accessible modifications in the defensive structure of their egos, represent a minority of the individuals who seek treatment today.

Currently, the majority of patients present a picture of unresolved preoedipal fixations, regressions, symptoms, and conflicts. Furthermore, their unresolved conflicts are primarily between the aggressive impulses and the defenses of the ego. Thus, the clinical picture is one of an immature ego, severely modified by defensive maladaptations—primarily the narcissistic defense, in which the original hated or hating object has been internalized, confused with the self, and attacked within the patient's own ego.

The theoretical concepts and treatment methods of traditional analysis have been ineffective in treating these patients as well as those diagnosed as psychotic or borderline psychotic. Both the preoedipal neurotic and the psychotic are unable to form an object transference to the analyst: they are only able to form narcissistic transferences in which they view the analyst as being like themselves. In addition, these patients are unable to assimilate objective interpretation without experiencing them as attacks, which strengthens rather than loosens their defenses.

Although modern analysis has proved effective with patients of all types, it is most effective when used with neurotic patients who show residues of unresolved preoedipal conflicts and with psychotic patients. Modern psychoanalysis can be considered a process of therapeutic interaction between the analyst and the defensive maladaptations of the patient's ego—his resistances—which in essence have become the patient. The goal of treatment is to resolve the maladaptive blockages to personality maturation and object relations, and the transference situation is the medium in which the goal is accomplished.

By systematically utilizing the feelings objectively induced

in him by the patient, the modern analyst acts as a maturational agent in the therapy situation and immunizes the patient against reverting to the narcissistic solution when faced with future conflicts.

Modern psychoanalysis recognizes the primary influence of the aggressive drives in the original conflicts that modified the ego and determined the defensive maladaptations. Because modern analytic theory proposes the concept of the narcissistic transference and its inevitability as the primary transference in the analysis of preoedipally fixated or regressed patients, the modern analyst focuses much of his attention on a thorough analysis of the patient's narcissistic transference and his own objectively induced narcissistic countertransference.

Modern psychoanalysis accepts the concept of the narcissistic defense and recognizes its life-preserving aspects. Originally formed in either infancy or early childhood, this defense serves to solve the conflict between the child's aggressive impulses to murder the object and his need to preserve it. The child identifies, wholly or partially, with the object and maintains the conflict internally by attacking himself and thus preserves not only the object but himself from destruction. Therefore, the modern analyst appreciates the importance of supporting the defense as he attempts to resolve the patient's resistance to verbalization.

A successful modern analysis enables the patient to gain the mature ego necessary to (1) form an object transference, (2) assimilate objective interpretations, (3) withstand intense conflicts without reverting to the defensive maladaptations he adopted in childhood, and (4) interact with other individuals in his environment who will meet his maturational needs.

Proponents of modern analysis encourage all who enter the field to continue investigating both old as well as new theoretical concepts. At present modern analysts are working in the field of education, applying these concepts to teaching methods at all levels. Modern psychoanalytic principles are also being used with psychoanalytic groups and in family treatment. Thus modern psychoanalysis focuses on nurturing healthy individuals as well as correcting maladaptive patterns. If widely taught

to and assimilated by parents and educators, the modern psychoanalytic theory of therapeutically maturational interchanges could have far-reaching effects on child development.

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HYMAN SPOTNITZ

OBSERVATIONS ON CHILD ANALYSIS

There is general agreement today that a transference situation can be established in child analysis and can be managed, by and large, according to the principles applied in the analysis of adults (see, for example, Van Dam, 1966). With the discovery of effective analytic approaches to the initial treatment resistances of young children, educational measures that were originally regarded as indispensable are usually dispensed with (A. Freud, 1946, 1965; Klein, 1948). Moreover, good results have repeatedly been demonstrated in the treatment of preoedipal disorders. Child analysis is therefore applied today, with appropriate modifications, to the entire range of psychologically reversible disorders—the milder behavior disorders, the various categories of psychoneurosis, character neuroses, borderline illnesses, and psychotic conditions, including childhood schizophrenia. Thus the scope of the method has expanded, keeping pace with that of psychoanalytic therapy with adults (Casuso, 1965).

While adhering to the analytic framework, the therapist needs to evaluate how each patient functions in the relationship in terms of his physical and mental limitations. All children have strong resistances against verbally mature, emotionally

significant communication. The initial resistance may be caused by inadequate maturation, which limits the child to crying or gesturing. Playing is disguised communication if the child can talk but will not do so.

As the analyst tries to get the child to talk in emotionally significant language, resistances arise, based on maturational lag, regression, unpleasant sensations connected with communication, and the need to shut out feelings and unwanted thoughts. The schizophrenic child, for example, does not want to reveal hateful impulses; he desperately wants to love himself and be admired, or perhaps he is afraid he will explode.

DEMANDS ON THE ANALYST

A successful child analyst can feel love and hatred for the child without being impulsive in the child's presence. He must have the proper feelings at the proper time, actually feel them—not play-act—and be able to use all the techniques needed to (1) help the child talk, (2) reinforce him in his need to be admired and loved, and (3) resolve barriers to releasing his hostile feelings.

The analyst develops the ability to feel proper feelings through a personal analysis in which he learns to discharge verbally all the emotionally significant feelings of his life. He learns to use these feelings in his supervisory experience, to recognize the emotions induced in him by the patient and to verbalize, evaluate, interpret, and respond to them in a therapeutic way. The schizophrenic child, particularly, will sense whether the analyst is disturbed in his presence or is uncomfortable about working with him. This kind of child tends to exaggerate the significance of the analyst's thoughts and feelings about him.

The main problem with children is that they are not as articulate as adults and are less willing to talk about what is bothering them. They need much more patience; the therapist sits with them for longer periods when nothing seems to be happening. To establish contact with them may require more ingenuity.

With so-called unreachable children—those who cannot

communicate—the analyst tries to understand what these children are doing by getting them to know that he is like them. To this end, he reflects any attempts on their part to get into contact with him.

PHYSICAL CONTACT AND PLAY

Love is extremely stimulating for these children, and it is important that stimuli be kept at a minimum. I do not share the notion that such children generally need physical contact or play activities, though these may be resorted to at times to resolve a particular resistance. In my experience with youngsters aged six or older, physical contact or play has rarely figured in the treatment process. Most of them can talk well enough to be brought into contact through speech.

When play is used as a special form of communication, how long should one continue to encourage a child to play? A therapist who enjoys playing with a youngster must also consider whether doing so tends to keep the child at the infantile level or moves him closer to the point of verbalizing his thoughts and feelings.

Removing obstacles to the discharge of hateful impulses is crucial when treating a severely disturbed child who has been trained not to hate or, if he must, to hate himself rather than others. The younger the child, the more necessary it is to structure the analytic situation so that he can release these impulses through the symbolic communication of destructive fantasies. Hence the need for a virtually damage-proof office, which was recognized early in the history of child analysis. If such a child, hypersensitive as he is to the feelings of others, senses that his destructive behavior either stimulates anxiety in the analyst or makes the analyst feel uncomfortable about treating him, the difficulty of achieving the release of destructive impulsivity is heightened. The analyst tends to project his own uneasiness onto the child patient more readily than he does when treating an adult (Casuso, 1965).

A child's tendencies to wander off the path to psychological maturity need to be blocked; his tendencies to proceed in the right direction need to be strengthened. In addition to the

availability of a good object, these tasks require a special kind of retraining and reinforcement from an external environment that is conducive to emotional reactiveness. Under these circumstances, in my experiences, studying the fact of the child's aggressive impulses is the primary road to understanding and influencing him effectively.

Although general hypotheses about the typical nature and range of the problems of severely disturbed youngsters increase our understanding of their therapeutic needs, preconceptions that encourage an emphasis on a particular type of handling from the time a case begins interfere with meeting the totality of needs in that case.

TREATING THE SEVERELY ILL CHILD

The primary task in the therapy of a severely disturbed child is to discover, *by studying and working with him,* what is producing his pathological behavior and locking in his immaturity and to help him receive whatever stimuli he needs to outgrow his particular patterns of deviance. Call this a model if you will, but it is no more nor less than the basic theory of psychoanalysis—that the effects of the patient's original damaging experience must be reawakened in the transference so that the precise obstacles to maturation can be recognized and resolved. Although one can presume what these obstacles are, they cannot be determined in advance. The signs and indications that each child gives in the transference relationship delineate the model for his treatment.

To liberate a severely ill child from the handicapping effects of deprivations that interfered with the maturation of his personality, treatment needs to be aimed at restitution: that is, appropriately timed restorations of a specific nature. Consequently, I have misgivings about the notion that treatment of the schizophrenic child should be oriented toward compensating him for deprivations, including unmet needs for one or another type of sensory stimulation. Compensatory maneuvers lead to some improvement in the child's behavior because they help him feel better. Compensation for a deprivation will not, however, undo its harmful consequences. All the food in the

world won't erase a starved child's memory of starvation. It is open to question what, for example, tactile stimulation accomplishes beyond giving the child some immediate gratification to which he responds favorably.

Let us assume that an experience similar to the one which prevented the child from maturing is created in the transference relationship and that the child demonstrates a need for some form of sensory stimulation. What is the best way to approach the patterns of maladaptation that ensued from the original deprivation?

The objection to any sort of forced feeding, no matter how pleasant the therapist makes it, is that it robs the child of control of his impulses. If the child were dying of starvation, of course one would have to force him to eat. But in a situation that is not life threatening, it is inadvisable to subject him to bodily contact until he indicates an essential need that cannot be met in any other way. If his responses to a variety of stimuli are simply investigated and his defenses are joined in the process, the child himself will develop a desire for the therapist's participation. The advantage of the voluntary approach is that it enables the child to function in harmony with his own will. This lesson is invaluable in resolving the harmful consequences of the infantile training experience.

After the child involves the therapist in his games, it is relatively easy to determine the degree of stimulation that is desirable. The therapist's participation is appropriate as long as it helps the child behave properly. If the child begins to lose control, this is a signal that he is being overstimulated and that his invitation to play should be declined. In short, the child's behavior gauges the desirable degree of stimulation.

Many children who have reached the age of eight are able to lie on the couch and communicate consistently in language, and reports that younger children are also able to do so no longer surprise us. The preschool youngster, however, is permitted to engage in his natural activities. Developing a therapeutic relationship with him is contingent upon the therapist's ability to recognize the emotional meaning of the child's communications through toys, crayons, and the fantasies the child

plays out and to communicate at his level (Bloch, 1968). The therapist's comments on the patient's behavior are couched in the patient's own words, used as he uses them. Primarily, the patient needs help in putting his thoughts, feelings, and memories into language.

Although manipulating the child in the treatment situation to induce him to cooperate or to force an insight on him is inappropriate, some form of environmental manipulation may be indicated. The cooperation of parents—in some cases, to the extent of undergoing treatment themselves—is often crucial for a successful outcome in child analysis (Abbate, 1964; Van Dam, 1966).

FOCUS ON RESISTANCE

As the child's maladaptations come into play in the relationship (transference), the patterns are studied until the therapist understands how they were set up and why they are activated in the immediate situation. When they interfere with the patient's communications, these patterns are dealt with in the same way as are other forms of resistance. Treatment that liberates the child from the stranglehold of emotionally damaging maladaptations creates a foundation for new growth. The patient is then able to assimilate the type of experiences that will reduce his maturational needs.

An adolescent or adult can usually obtain these experiences himself outside treatment. A child can obtain them only with the assistance of adults. To the extent that his parents and other adults do not provide this assistance, the child's unmet maturational needs engage the analyst's attention. In principle, however, interventions to meet maturational needs—for feelings of being loved and understood, for reassurance, direction, and so forth—are made only to deal with resistance. The young child may want the analyst to join him in his play or games simply for the pleasure of the experience but departures from the operational principle of intervening only to resolve obstacles to cooperative functioning are undesirable.

The analyst's role as transference object is crucial for resolving maturational blockages. Unless a transference situation

exists, it is impossible to reactivate the maladaptive patterns with sufficient intensity to resolve them. The analyst who appears to the child as a shadowy figure—the "blank screen"—will find it difficult to create or maintain a transference situation. To a much greater extent than is customary in the treatment of adults or adolescents, he needs to convey the impression that he is functioning like the parent. Departures from this role may be indicated when treating a severely ill child; at times the analyst needs to participate in the child's play and fantasies—i.e., behave like the patient—to help him express his thoughts and feelings. But as much as possible, the analyst maintains the posture of the thoughtful parent, listening attentively and seeking to understand. He does not try to share his understanding unless the child solicits an explanation and, even then, only if the information would help the child function cooperatively at that time.

THE ANALYST'S INTERVENTIONS

Preverbal patterns of resistance are responsive only to symbolic, reflective, or emotional communications from the analyst (Spotnitz, 1966), which are regarded as primitive forms of interpretation. When these patterns are basically resolved, the child becomes more and more responsive to forthright explanations of his problems. Finally, he reaches the stage where interpretation alone creates the type of experience that resolves the remaining blockages, thus permitting him to resume his maturational interchanges without the aid of a therapeutic object.

Psychological reflection, a term applied to interventions that reflect the patient's communications, is often employed with young children. So-called verbal mirroring, in which attitudes or feeling-tones may be reflected rather than words, is the most common form of psychological reflection. A young child's nonverbal activities, such as gestures and sounds he makes while playing, can also be reflected. By this technique the analyst conveys the impression that the patient is relating to someone exactly like himself—a person who thinks and feels as he does, an ego-syntonic object. Repetitive use of the technique

early in treatment facilitates the development of transference on a narcissistic basis with a very young or severely regressed patient.

The same approach can be used to join the patient's resistance to communication. Resistance-joining is not only ego supportive; it has the additional effect of reinforcing the total personality (Spotnitz, Nagelberg, & Feldman, 1956). Moreover, when an extremely negativistic child responds to the psychological reflection of his resistances as permission to maintain his position, he reacts less defensively to the demands of the analytic situation and often moves voluntarily into the opposite position. In this and other ways, the analyst is able to resolve obstacles to the release of impulses without exposing the patient to undue pressure. To be productive, however, these interventions should be accompanied by genuine feelings because children are especially sensitive to artificial role playing.

As the balance shifts in the analysis from primitive to more complex levels of communication, the analyst verbalizes thoughts and feelings that the child conveys nonverbally or articulates inadequately. The analyst can respond to fantasies and other psychic experiences in a similar manner, and on some occasions a summary of the child's behavior is therapeutic.

Verbalization shades into clarification, a technique that is increasingly employed when the child demonstrates interest in understanding a specific emotional reaction or behavior pattern. He may ask, for example, why he stutters or feels angry when he tries to talk about a particular subject. Although in theory the analyst does not intervene to provide understanding until it is specifically requested, unsolicited explanations from time to time may help the child cooperate.

When presenting an interpretation to make the patient aware that he is acting out a fantasy instead of verbalizing it, the analyst may have to appear as a permissive adult who does not really disapprove of destructive behavior. Nevertheless, the explanation is formulated so that the patient learns patterns of conduct regarded as socially appropriate for a child of his age.

APPROACH TO DREAMS

Early in treatment, dreams are used primarily as a source of information, and are analyzed silently. The interpretation is deferred until the child has become responsive to explanations of his feelings and is struggling to deal with them. When he is obviously withholding unconscious material, he may report a dream if he is asked whether he had one. But it is desirable to avoid giving him the impression that dreams are more important than other psychic material.

Interpretations based on one's knowledge of symbolism, general theories, or a hypothesis which the analyst in pursuing may be useful for investigative purposes, but they are not invariably therapeutic. The scientifically oriented practitioner delays making an interpretation until the patient provides overwhelming evidence of its validity and until his therapeutic reaction to it can be anticipated.

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RESEARCH AND EXPERIMENTATION IN PSYCHOANALYSIS

This is the first installment of an ongoing section devoted to the subject of research. The following four articles which represent a preliminary study on the current status of research in psychoanalysis, explore the many aspects of this growing area, including the history of psychological and psychoanalytic research, the latest experiments in research design, and comments on methodology in modern psychoanalysis.

The Editors

PHYLLIS W. MEADOW

PREDECESSORS OF PSYCHOANALYTIC RESEARCH

Twentieth century research in the field of human behavior has emanated from behavior and learning theory, field and gestalt studies of perception, and motivational studies based on psychoanalysis. The functionalism of the twenties investigated the mind as an organ of adaptation. Behavioral research was concerned with acts rather than structure or—as in early psychoanalytic research—content more than structure. In modern behavioral research, particularly that done by learning theorists, introspection has been reintroduced into studies on the modifiability of habits, unlearning through reward-punishment systems, and other extinction studies. In the studies by Mowrer (1960), and Dollard and Miller (1950), we see an increasing dependence on psychoanalytic insights in investigations of intervening emotional variables (e.g. fear) as motivating factors. By the 1950s modern behavioral research, learning studies, and field theory studies were concerned with internal (cognitive, affective and physiological) states and how they affect perceptual or behavioral acts.

THE ROLE OF ENERGY CONSTRUCTS

Early Gestalt theory explained mental activity as the result of an

interaction and counteraction of forces along lines that paralleled Freud's energy concepts combined with his structural model—(id, ego, superego). The views of the Gestalt schools are found in modified form in the work of Lewin (1948), who emphasized the reciprocity between need and the demand character of the stimulus. Lewin described an enclosed system in which internal processes can be explored in a manner that invites predictability. However, the weakness of the theory lies in its inability to incorporate either information on the objective stimulus conditions or on the motor execution and further results of a response. The system and its laws thus remains confined to the postperceptual, prebehavioral field of the mind. In other words, field theory describes the psychic operations at the moment decision making is required by the impingement of an external stimuli.

Lewin's study of conflict was one of the earliest attempts to put psychic energy constructs into operation. Choosing the decision-making process, Lewin defined the moment of choice as a temporary immobilization resulting from a conflict between equally attractive (or repulsive) objects, activities, or potential behavioral acts. Although field studies make no attempt to quantify the attractiveness, they define the term equal as the individual's perception of the objects as equal. Choices and conflicts are then defined in terms of approach and avoidance tendencies.

The value of energy concepts for predictability was first demonstrated by the field theorists (e.g., Escalona, 1940; Sears, 1943; Lewin, 1948) in experiments on "Level of Aspiration"—the goal an individual sets for his next performance on a given activity after he has completed one or more trials. This definition assumed that an individual cares whether he reaches a certain ideal level of performance. It was found that in pathology, there is a tendency to set goals outside the limits of one's past performance, which indicates a need to maintain a particular self-image. Escalona (1940), for example, studied the difference between neurotic and normal reactions and found that individuals with reality-oriented self-images set their goals within the limits of past performance. When she compared the

motivation of self-esteem of manic-depressives and college students, she found that manic subjects chose the most demanding task and after one failure shifted to the least or the next to least demanding task. Subjects expressed boredom, great lability, and variability; many did not pay attention to success or failure, were unable to direct their activity toward a goal for any length of time, were afraid of failure to an absurd degree, tried to leave the field, or rationalized their failures or refused to recognize them. After a failure, many claimed that the task had been too easy for them and tried to direct attention away from the failure or acted as though they had actually succeeded. This behavior was ascribed to the extreme sensitivity and greater lability of aspiration that is typical of manic subjects. Despite their low self-esteem, depressives, unlike manics, reacted similarly to non-psychotic subjects with regard to goal setting.

Escalona drew her conclusions in terms of energy: in manic subjects, the walls between the motor system and the environment are weaker, there is more reaction to stimuli, and the walls between the inner person and the motor system are thinner. After the first failure, which is out of keeping with the manic's mood and pretense of superior ability, the individual becomes extremely cautious, even after subsequent successes, which illustrates not only the degree to which he overreacts to the environment (particularly to personal failure) but his low self-esteem.

Horwitz (1954) reported on the studies by Ziegarnik et. al. on the relationship between tension and goals in experiments on responses to the interruption of a task and discovered that the average person recalls more interrupted tasks than completed ones. Ziegarnik interpreted this as tension to see the task finished. The arousal of task tension is based on the individual's need to maintain an image of competence. In the normal adult, this tension is aroused by his perception of how far he is from achieving the goal and the realization that he may be blocked from attaining it. He recalls the unfinished task because the tension to complete it still exists. The subject diagnosed as pathological, whose need to protect his self-esteem takes precedence over task orientation, recalls more completed tasks than interrupted ones.

Two internal variables have been mentioned in connection with the experiments on level of aspiration and interrupted tasks: self-image and goal-setting processes. The tension systems correlated with these variables are discussed qualitatively, and the distal variables—certain classes of responses—are predicted in terms such as the following: If task orientation dominates the need to protect self-esteem, then Class A responses will follow, and if the need to protect self-esteem dominates the task orientation, Class B will follow.

NOTIONS OF CAUSALITY IN THE DECISION-MAKING PROCESS

The research of field theorists during the fifties shifted to the area of interpersonal relations. Piaget's work on the child's notion of causality (Piaget, 1954; Flavell, 1963) and Heider's interpersonal theory (1959) offer explanations of the observable, rapid shift in the individual's attention from the stimulus to the "cause" or choice.

Piaget noticed that children attribute environmental changes to personal origins; in other words, they attribute to things the properties they have experienced as belonging to their own person or to persons in their environment. This perception of persons as origins leads them to underestimate other factors responsible for effects, and this explains the strong emotional reactions sometimes observed in children.

In his interpersonal theory, Heider also relates tension to this process. He points out that when we see a person moving, we attribute it to a spontaneous act, or as a passive move induced by q. We may locate the origin of a pleasant or unpleasant experience in another person, in ourselves, or in fate. Thus, the individual perceives the change as "belonging" to its origin and perceives the origin as the "cause" of change. This "need for causality," for relating events temporally and causally, enables the individual to predict the future. Heider related tension to the need for causality and viewed the responses that resulted from assigning causality as tension reducing.

Studies emanating from Heider's theoretical formulations have explored the effects of this perception of causality on decision-making, discrepant attitudes, and liking and disliking. Thus interaction studies have moved away from the pleasure

principle of the archaic ego to the perceptual refinements developed in the interest of a reality principle.

Theoretical models of the 1960s utilized the Freudian model of the internalized parental images and their importance to the perceptual process. The assumption was that causal integration is a function of these internal images. Systematic alteration of social environments in small groups resulted in hypotheses about the conditions under which specific (Freudian) defenses will be utilized. In "The Verdicality of Liking and Disliking," Horwitz (1963) described the perception of causality as a substitute for "free" decision. In an ambiguous situation, it helps the individual decide how to behave. Horwitz explored tension as a predecisional state that is created by opposing perceptions—by conflict in the Lewinian sense—and is reduced by decision. From the viewpoint of predecisional causal integration, an injury, for example, is considered in terms of its source. If the injury is self-inflicted, aggression will be turned inward; if it is attributed to chance, frustration or withdrawal of emotion may follow; if it is attributed to another person, aggression will be turned outward. Once the individual has established a "cause," a tension system exists to respond.

To explain states of postbehavioral tension, Festinger (1957) formulated the theory of cognitive dissonance in which he postulated that in the case of opposing perceptions of a given situation, a choice is made and followed by action. Once the individual has decided, but has not necessarily committed himself to a course of action, a tension system operates to eliminate the attractiveness of the rejected alternative.

ENERGY CONSTRUCTS IN MODERN PSYCHOANALYSIS

Modern psychoanalytic research emphasizes *constitutional factors in combination with socialization patterns of the culture* as behavioral determinants. Intra- and interpersonal conflict are viewed as the common denominator in the development of cognitive processes. Spotnitz (1966) expressed this view as follows:

> Inner conflict has two nuclear elements. One is that the child is endowed with a great deal of vitality: strong animal

> drives, healthy appetites, and pressing needs. These may be connected with bodily functioning—for instance, strong urges for closeness, or a need for much physical activity—or with psychological functioning, such as keen curiosity or urges for playful experimentation. The other element of the conflict is that although the child feels it necessary in early life to master his animal impulses and deny his dependency needs because they seem to be disapproved of by those he loves, he experiences an inordinate amount of hardship in undergoing this process of socialization. His outlets for the release of energy are inadequate to cope with his urgent needs or his resentment when these are not immediately gratified. He develops intense anxiety over what is his most overwhelming problem, that of keeping in check the energy which is pressing for discharge. [pp. 224-225].

From this brief review of how energy concepts have been used to explain cognition, it is evident that behavioral research has demonstrated that inner conflict can be defined operationally and studied by the scientific method. Field theorists have helped to clarify the conditions underlying the arousal and reduction of tension. Early psychoanalytic research (e.g., Sears, 1943, and Eysenck, 1962) was devoted to static studies of character defenses and drives, separated from the interaction process of life and confined to drives aroused in the laboratory. Early case studies presented a more dynamic investigation of the analytic process. More recent psychoanalytic research (see articles by Nelson and Davis) indicate increase in studies of psychoanalytic interaction.

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MARIE COLEMAN NELSON

COMMENTS ON PSYCHOANALYTIC RESEARCH, OLD AND NEW

The literature of psychoanalysis is replete with articles and symposia testifying to the difficulties inherent in psychoanalytic research. It is indeed true that the structure of treatment and the non-replicable aspects of the raw data discourage systematic research as an ongoing component of the therapeutic setting. Diligent notation by the analyst distorts the interactive flow, taped sessions fail to transmit nonverbal cues and the parallel associative clusters that develop between the participants. By the same token, videotape and oneway vision screen cannot communicate the thought processes, affects and associations behind the visible phenomena.

Although social scientists in general appreciate the analytic situation as a rich resource of data, the question, practically, boils down to 'data for what?'

For the hard-nosed scientist the data are invalidated at the outset by the fact that the typical analytic session is not observed or recorded by any external agency. Worse, session recording is done—if it is done—by an active participant in the process, whereas the ideal scientific model strives for an experimental situation which—to the fullest extent possible—eliminates the subjective factor. At this very moment the files of the National

Institute for Mental Health, the Fels Research Institute, the Jewish Board of Guardians—and no one knows how many other centers and agencies—are groaning under the weight of treatment protocols, recordings, films and other evidences waiting to be researched—for what?

DEFINING PSYCHOANALYTIC RESEARCH

Clearly, the psychoanalytic community must evolve lines of inquiry which contribute to the development of a theory of treatment—or, put another way, it must address itself to questions of therapist-patient combinations and interactions which legitimately encompass the subjective factor inherent in the situation.

This is not to suggest that clinical data and the many elements contained in psychoanalytic theory are not appropriate subjects for formal research, but simply that the latter may be utilized as resource material by other branches of the social sciences as well. For example, the noted psychologist, Calvin Hall, studied the frequency of appearance of a select number of symbols in dreams, as did the noted psychoanalyst, Jule Eisenbud. A statistician could have done the same. Hence, the research—though of interest to psychoanalysts—was not essentially psychoanalytic.

By contrast, in the late Forties I participated as a Research Associate of the Association of American Medical Colleges in a study, *Films in Psychiatry, Psychology and Mental Health* (Nichtenhauser, Coleman & Ruhe, 1953). Each film was screened before three panels: the first, a panel of faculty at Teachers College, Columbia University; the second, a mixed panel of psychiatrists, social workers, nurses and occupational therapists at the New York Psychiatric Institute; the third, a panel of psychoanalysts of the New York Psychoanalytic Society. After the screenings, discussions were held centering about the content, presentation and audience suitability of the film. From these recorded discussions I synthesized and wrote the reviews. Any psychologist or social scientist could have done the same. However, the study was initiated by psychoanalysts, the

discussions were evaluated and the reviews written by a psychoanalyst. Therefore, the product was in essence a psychoanalytic research, since it explored and stressed issues which other disciplines might have held less central. Conversely, other types of investigators might have stressed areas which I subordinated. (Reviews were submitted to panel chairmen for acceptance or suggested revision prior to publication.)

Any form of research (e.g., statistical, psychological, historical, cultural) may be undertaken on psychoanalytic data, but research into data originating within or outside of psychoanalysis may only be defined as psychoanalytic when it is conducted from a psychoanalytic perspective.

HISTORY OF RESEARCH

Historically, systematic psychoanalytic research began in the area of psychosomatic medicine during the Thirties, much of it under the aegis of psychoanalytically qualified psychiatrists in such facilities as the New York Psychiatric Institute, Mount Sinai Hospital, St. Elizabeth's and Michael Reese Hospital & Medical Center. From the Institute of Psychoanalysis in Chicago emerged the memorable pioneer study of Benedek and Rubenstein (1942), *The Sexual Cycle in Women: The Relation between Ovarian Function and Psychodynamic Processes.* Associated with this surge of research in America were some of the most distinguished names in psychiatry, psychoanalysis, physiology and endocrinology. For example, the Advisory Board of *Psychosomatic Medicine Monographs* included, among others, Franz Alexander, Flanders Dunbar, Walter B. Cannon, Roy R. Grinker, Lawrence Kubie, Howard S. Liddell, Adolf Meyer and Tracy Putnam. Karl Menninger, also listed, has continued to sponsor active psychoanalytic research at the Menninger Clinic to this day, and another member of this group, Felix Deutsch (1962), pursued research on the correlation of sensory modalities and symptomatology with psychodynamic process for a span of more than fifty years.

Still, the yield from those years of psychosomatic inquiry was not entirely commensurate with the effort expended. Di-

rect correlations between disease entity and psychodynamic configuration that were anticipated did not materialize, with the exception of a few sparse findings, such as the isolation of a common psychodynamic profile for patients with peptic ulcer (Alexander, 1961, p. 543). However, many of the studies in this area, particularly of patients with degenerative neurological diseases, did focus the attention of practitioners on repressed hostility as a prime mover in the development of physiological disorder, and the anamneses of chronic sufferers lent confirmation to the psychoanalytic view of the early origins of psychophysical disturbance.

It should be borne in mind that publication of Freud's (1923) *The Ego and the Id* marked the beginning of increased attention to ego function and the decline of a rather simplistic stance which presumed a far more direct casual relationship in mental process than does in fact exist. With a growing body of clinical data that affirmed the impact of life experiences and interpersonal conflict on the developing ego, it became clear—especially to investigators like Alexander—that neither the strength of the instincts nor the vicissitudes of the oedipus complex sufficed to explain resultant character, with its endless variety of coping techniques. And from the model child and family treatment agencies such as the Jewish Board of Guardians and the Council Child Development Center came mounting evidence of the continuing role of the mother as an active agent in the promotion or obstruction of the child's emotional development. (Systematic efforts to involve the father came later.)

As an expression of accelerated interest among psychoanalysts in the mother-child relationship and in ego development, Margaret E. Fries (1938), a psychoanalyst with a background in pediatrics, initiated the first psychoanalytically-oriented longitudinal study of children. In the mid-Thirties, utilizing the assistance of WPA workers, Dr. Fries began periodic psychoanalytic interviews with a group of pregnant mothers attending the prenatal clinic of the New York Infirmary for Women and Children. These interviews continued until the babies were

born. Recorded observations of the mothers' verbalizations during childbirth were made. During the lying-in period interviews were held during nursing and motion picture footage was shot by Dr. Fries and Paul Woolf (1953) of the manner in which the mothers held and nursed their babies. Startle tests were also administered the newborns and their reaction time and degree of infantile startle were recorded. Throughout the lives of these children motion picture records were secured of their home and playground behavior and their responses to stress, such as the dental examination in the Infirmary garden. As the years went by some of the children were lost to the study; others remained and still maintain occasional contact with Dr. Fries. A number of edited films that emerged from this pioneer study may be rented from the New York University Film Library.

More psychoanalytically-oriented child research followed in the Forties, notably the film studies by René Spitz of institutionalized infants with anaclitic depression, studies on grief, on the smile of the baby, on the nursing situation as prototype of the yes-no head movement, and others. Escalona's (1952) research on infant maturation and Bowlby's (1966) investigations in child development likewise contributed to psychoanalytic knowledge.

To my mind it is a matter of significance that Margaret Fries approached her longitudinal studies with an anthropological as well as psychoanalytic orientation. The first Fries-Woolf research venture was a film made with anthropologist Clyde Kluckhohn on Navaho child-rearing practices. Similarly, the research team which evolved the valuable double-bind hypothesis pertaining to communication in the families of schizophrenics included not only Jay Haley, John Weakland and Bill Fry (psychiatrists and psychotherapists), but also the anthropologist Gregory Bateson (1956), who was senior investigator of the group.

Of late most psychoanalytic research has been devoted to cognitive process, a far more mensurable area of research. Exactly how useful such studies are to psychoanalysts is hard to

say; I suspect they will receive more respect than attention. Some of the best are published as *Psychological Issues* monographs by International Universities Press:

No. 23: F. Schwartz and P.H. Schiller: *A Psychoanalytic Model of Attention and Learning.* (1970)

No. 24: B. Landis: *Ego Boundaries.* (1970)

No. 28: E. L. Garduk and E. A. Haggard: *Immediate Effects on Patients of Psychoanalytic Interpretations.* (1972)

No. 30: M. Mayman, ed.: *Psychoanalytic Research. Three Approaches to the Experimental Study of Subliminal Processes.* (1973)

Of the above group, No. 30 will prove most interesting and useful to the average clinician unversed in statistical methodology. This issue not only contains papers illustrating three research approaches, but also three papers on the problems of psychoanalytic research and recommendations for further research design.

For readers who wonder why I have omitted discussion of the works of many outstanding psychoanalytic researchers, such as Erik Erikson, Margaret S. Mahler, Rudolf Ekstein, Edith Jacobson and others, it goes without saying that a great amount of valuable research data is embedded in the literature of treatment and theory; here I have tried simply to illustrate my remarks with mention of research which in design and execution seeks to meet the formal criteria of science in general.

CURRENT STATUS

It is my opinion, however, that the core research problem in psychoanalysis has not begun to be tackled, namely, the culling of case material in the published literature for the purpose of studying rationales for the execution of certain interventions, and comparing different orders of intervention introduced to solve common problems of treatment. We speak of psychoanalysis as if we shared a unified approach, but every seminar con-

firms the presence of highly individualistic processing of the data before us.

In conclusion, a final observation seems in order. If one systematically compares psychoanalytic writings to the literature of other disciplines, one cannot help but note how much old wine appears in new bottles. Perhaps a selective factor operates in the choice of a profession which rewards—even requires—an ability to dismiss data from mind as willingly as one receives it. Certainly this is the essence of free-floating attention, and the practitioner who cannot suppress the content of one patient's session is therapeutically diminished with the patient who follows. Nevertheless, the carryover of this capacity to forget into the body of psychoanalytic writing makes for a discontinuous science, one which repeats but does not systematically build to the point of qualitative leaps in its accretion of knowledge. It also perpetuates the image of psychoanalysis as lacking in rigor vis-à-vis other disciplines and encourages cultist attitudes among the various schools of thought operating within the mainstream of analysis.

To help counteract our ahistorical bent I have elected to mention some of the earlier researches that stand as landmarks in psychoanalysis. For readers interested to discover the unique scope of some of the earlier writings I also recommend a collection of essays gleaned from fifty years of publication from the *Psychoanalytic Review,* the first psychoanalytic journal printed in the English language. This commemorative volume is entitled, *Psychoanalysis in America* and edited by Murray H. Sherman (1966), then Editor of the *Review.* A number of papers in the collection will be found especially relevant to modern analysis: "The Conception of Narcissism" (1927), by Havelock Ellis; "The Fantasy Method of Analyzing Narcissistic Neuroses" (1926), by L. Pierce Clark; "The Oral Complex" (1925), by Harry Stack Sullivan; "On Inhibition, Disinhibition and Primary Process Thinking" (1961), by George S. Klein, and lastly, "Problems in the Technique of Psychoanalysis" (1930), by Paul Schilder, who worked almost exclusively with psychotic and neurologically impaired patients.

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DON SHAPIRO

MODERN PSYCHOANALYTIC RESEARCH

It is admittedly easier to train someone to assume the role of researcher than it is to train him to do research. The psychoanalytic researcher does research in psychoanalysis rather than presume to define acceptable methodology in isolation from the problems presented by data.

Freud's remark about methodologists—"forever polishing their glasses, but never looking through them"—reflects the continuing state of concern with what Langer (1967) calls "idolatry." There is an ever growing jargon: "language more technical than the ideas it serves." There is "prescriptive methodology," with canons of procedure such as "isolated, controllable, repeatable, objective." "It is with the dawn of feeling that the domain of biology yields psychology," writes Langer; she defines "subjective" as whatever is felt as action and "objective" as merely whatever is felt as impact—thereby exposing objectivity as an idol. It is the pursuit of such idols, she suggests, that makes the harvest of laboratory psychology so meager in comparison with other biological sciences.

The search for a "true" methodology must proceed, of course. Such a methodology recognizes the value of a "permanent image that one can resort to . . . to recover an elusive

idea. While models may permit us to understand many processes, they may lead us to lose sight of what phenomena we are trying to analyze and understand." *To do psychoanalytic research means to deal with the data of psychoanalysis,* at least to the degree that we do not lose sight of the phenomena.

Modern psychoanalytic research focuses on concepts such as transference, resistance, maturation, systematic use of the feelings induced in the analyst, and a range of responses to resistance guided by an understanding of maturational interactions (Spotnitz, 1969). With the broadening of the term transference to include narcissistic transference and the broadening of resistance to include all obstacles to emotional maturity that appear in treatment, a broad range of phenomena awaits exploration.

Unfortunately, when practicing psychoanalysts turn to research, they often turn away from the data that is readily available to them and deal with realms of physiology or sociology, in which they have little special claim to expertise. When they bring to bear important aspects of their total life experience, on the other hand, the results are often gratifying. After the fact, it may appeal crucial for a painter, religious scholar, teacher, historian, or mathematician to enter into psychoanalytic research; psychoanalytic research is amenable to entry from almost any firmly held personal position.

In my view, it is especially unfortunate that researchers follow the operationalist's despair in seeking truth through experiment. Verifiable facts cannot prove an assertion through experiment since any experiment is a biased selection from an unknown universe of possible experiments to test that assertion. Nor can an assertion be disproved with verifiable facts because innumerable unnoticed, uncontrolled, and "suppressor" variables confound any experiment (Chein, 1972). *An experiment has the great advantage of providing a "foray into the world on our terms", which can be a fine tactic.* But if the psychoanalyst focuses on his own concepts and data, then he will know when his problems call for "experimental study, naturalistic observation, . . . developmental studies, . . . genetic explorations of psychoanalytic therapy, etc. (Editorial Statement). Journal

editors and dissertation committees are exploring this level of research design.

The need to map our universe (Toulmin, 1960) propels the researcher in psychoanalysis just as it does in any other science. Because the psychoanalytic researcher cannot know beforehand what techniques will be effective in any particular domain, he will be seeking to make discoveries, will be open to new feelings of his own and others, and will pursue alternative possibilities for understanding and action.

Just as the modern psychoanalyst welcomes patients' resistances and expressions of negative feelings, so he will welcome the views of those who do not accept modern psychoanalysis. Opposing views always point to an important problem and perhaps even to a solution.

Have recent theories about the "self" at the metapsychological level actually affected theories of technique at the clinical level? Has improving the technique with pre-oedipal patients undermined the development of the superegos? Do the intellectually retarded share the dynamics of the emotionally defective, or must we continue to ignore defective intellectual functioning? Do we assert the paradox of increased primitive narcissistic character among individuals parallel to increased social complexity and sophistication among cultures? How is it that children accept as part of themselves, their parents' negative feelings toward them? How can therapists expect to be effective in relating verbally to people who are silent? These are some of the questions modern psychoanalysts will be seeking to answer through systematic investigation.

Although we claim to have answered many questions already, each answer deserves further exploration. The testing of hypotheses that Harold Davis calls for (later in this journal) will keep theory from degenerating into dogma.

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HAROLD L. DAVIS

HYPOTHESIS TESTING IN PSYCHOANALYSIS

Authors who undertake to assess the accomplishments of research in psychoanalysis (e.g., Wallerstein and Sampson, 1971) typically conclude that psychoanalysts have done well in generrating significant hypotheses relating to the theory and practice of their discipline but have failed dismally in testing these hypotheses (investigating them in controlled studies). Scientists who are prone to recognize only the latter kind of activity as genuine research conclude that serious efforts to substantiate the premises of psychoanalysis have yet to be made. Some of them question whether the concepts of the discipline are well enough defined to permit meaningful investigation at all and are doubtful whether psychoanalysis will ever be regarded as a legitimate science.

At the opposite pole are many practicing analysts who regard the generation of hypotheses from clinical observations as the most worthwhile kind of research and look on controlled investigations in psychoanalysis as either unproductive or, in principle, impossible for so complex a subject as the human psyche (see, for example, Shapiro, earlier in this journal). Clinically oriented professionals are typically not motivated to dem-

onstrate to other disciplines that psychoanalysis is scientifically respectable.

NEED FOR CONTROLLED STUDIES

The most useful view of psychoanalytic research probably lies somewhere between these two extremes. On the other hand, authorities on the epistemology of science agree that the process of hypothesis finding is as legitimate a scientific endeavor as is hypothesis testing. In fact, hypothesis finding occupies the attention of the most creative minds working at the frontiers of any scientific discipline. On the other hand, it is also difficult for the clinician to defend his position that there is little need for controlled studies in psychoanalysis. Wallerstein and Sampson (1971) have recently reminded psychoanalysts that Glover's concern about the bias introduced in psychoanalytic thinking by the "great man" effect is still valid:

> Analysts of established prestige and seniority produce papers advancing a new theoretical or clinical viewpoint or discovery. If others corroborate it they tend to report that; but if others feel reason to reject it, this scientific "negative" does not get reported. So ultimately it is canonized "as so and so has shown." [Thus] . . . a great deal of what passes as attested theory is little more than speculation [in our terms, hypotheses], varying widely in plausibility [1957, p. 403].

We see the logical result of the great-man effect in the recurrent splintering of the psychoanalytic community into rival cult-like groups, often identified only by the names of their leaders (modern-day equivalents of Sullivanians, Reichians, Rogerians, Adlerians, and so on). Each group vigorously defends its theoretical approach (i.e., its leader's ideas) against all attacks from "enemy" groups.

Similar examples of passionate devotion to theoretical positions are, of course, found in all scientific disciplines. For example, theoretical physicists who are interested in explaining the properties of elementary particles are currently split into two armed camps: one group champions the "boot strap model"; the other, the "quark model." The difference between this

kind of situation in psychoanalysis and other sciences is that in the latter, the fierce debates between rival groups are eventually resolved by controlled studies which yield evidence that can no longer be questioned by either side.

CHALLENGE OF EXPERIMENTAL STUDIES

Although even the most pragmatically minded clinician might agree that psychoanalysis could benefit from definitive studies of this kind, he can readily join forces with the skeptics from neighboring scientific disciplines who point out the failure of attempts to test hypotheses in psychoanalysis to produce significant results. Research-minded psychoanalysts can only concede to this criticism. Thus Mayman (1973) observed that "few experimental studies can, in retrospect, be said to have contributed significantly to the formulation of psychoanalytic propositions, to the structure of psychoanalytic theory or to the body of psychoanalytic findings [p. 7]."

Those who would venture to accept the challenge of correcting this state of affairs are faced with deciding whether it is more worthwhile to attempt controlled studies with the aim of satisfying the broader skepticism of the non-analyst critic or of resolving issues that are of direct interest to the practicing analyst. Kubie (1952) and others have already recommended that our first priority is to answer questions that would interest the analysts themselves rather than invest our efforts providing for others what most analysts are already willing to accept. Although not the only consideration, an important reason for taking this direction is that analysts must first convince themselves of the value of controlled investigations for their own needs before they are likely to be successful in generating studies that will convince outsiders. Therefore, let us narrow the question before us to the challenge of conducting controlled investigations on topics that are of direct interest to the practicing analyst.

Most analysts who read this journal would probably agree that it would be useful to test the hypotheses advanced or implied by, say, papers elsewhere in this issue with a number of

different patients and analysts under what one could describe as controlled conditions. Obviously, however, nothing less than data generated in actual analytical sessions would provide a convincing test in each instance.

PREVIOUS STUDIES

How does one carry out a controlled investigation using analytic sessions? The existing literature offers little help. Authors cite the great difficulties of gathering data during "live" sessions, and there are surprisingly few reports of controlled experimental investigations using the protocols of psychoanalytic sessions as primary data. Holzman (1973), in fact, credits Luborsky (1973) with the first successful effort to conduct a controlled experiment using tape-recorded protocols of analytic patients. Luborsky investigated the possible relationship between patients' momentary forgetting and three independent variables: cognitive disturbance, anxiety, and awareness of the therapist. After working out operational definitions of these variables, Luborsky asked independent judges to examine portions of protocols containing the forgetting events as well as portions of control protocols and rate the variables quantitatively using prescribed methods of content analysis. (The study is more accurately described as a controlled ex-post-facto study than as an experiment because Luborsky did not manipulate independent variables to produce momentary forgetting; he simply noted the events and observed in retrospect which independent variables were present at the time.)

A second controlled experiment using data from analytic sessions has been reported by Meadow (1974), who investigated the relative effectiveness of two kinds of interventions in resolving the resistances of patients in her private practice. *This study can be regarded as a true experimental investigation* because Meadow used a random number sequence to determine which interventions (or independent variable) she would employ in a particular instance. She also developed operational definitions of the experimental variables including a rating scale that judges could use to determine the effect of the intervention on

the patient's resistance by examining the tape-recorded protocol.

To what extent do these two studies serve as promising examples of controlled investigations aimed at questions of interest to the practicing analyst? The typical practicing analyst may not be intensely interested in Luborsky's results because the topic is only tangentially interesting to the clinician in the first place. However, of greatest relevance to this discussion is the contribution Luborsky has made by demonstrating that it is feasible to carry out a controlled study of respectable precision and rigor using the data gathered during analytic sessions. An important aspect of his demonstration is the strategy and methods he evolved for storing and retrieving the tape-recorded data of the session.

Meadow's study is more likely to strike the practicing analyst as being directly related to his daily occupation. The resolution of resistance is the ultimate objective of all the analyst's interactions with his patients. But, again, Meadow's most valuable contributions are the operational definitions and methods of quantification she has developed for clinical variables such as resistance.

ANALYSIS AS EXPERIMENTAL INVESTIGATION

Obviously both studies suffer because the investigators were limited to data concerning the patients of either one or very few analysts. However, one feature of Meadow's study seems to suggest a way to overcome this limitation and may point the way for reasonably convincing controlled studies in psychoanalysis in the future. Her study may be the first to take advantage of the fact that the analytic situation is, in a real sense, itself a controlled experimental situation. Thus a properly conducted analysis consists of a series of experimental investigations of the patient's psychological dynamics. Wallerstein and Sampson (1971) have noted that such investigations must involve efforts to collect information about the dynamics of the patient's presenting resistance; formulate a hypothesis about the resistance, including a proposed invervention; execute the intervention

(experimental manipulation); and observe the patient's response (test or hypothesis). This point was articulated best by Kubie (1953):

> Psychoanalysis first creates an interpersonal situation in which all controllable externals are maintained constant, and in which those variables which are not directly and completely controllable, such as the interplay of conscious and unconscious feelings, are managed in such a way that the feelings of A toward B are allowed free play and free expression while the feelings of B toward A are held relatively constant and are deliberately masked. This is the control of the transference-counter-transference situation. Into that system of relatively constant forces, a variable is introduced precisely as one introduces a hypothesis into a laboratory. This variable is the interpretation; and every interpretation should be looked upon as a hypothesis which is to be tested [p. 120].

And in another article, Kubie (1956) concluded that:

> . . . to an unexpected degree analysis, as an experimental design, is an excellent model. It has certain grave defects, but in spite of those deficiencies it provides behavioral science with a framework which approximates most closely to the basic principles of an ideal situation for scientific observation. This quite unanticipated virtue of the analytic procedure has been overlooked, and its importance underrated [p. 133].

> I would venture to say that the situation in which the analyst makes his observations of the patient is a truer model for the observation of behavior than is anything that we have as yet created in the laboratory, whether it is a laboratory for the observation of human behavior or a laboratory for the observation of the behavior of lower animal forms. I challenge the experimental psychologist, the clinical psychologist, the academic psychologist, the animal behaviorist and the ethologist to match in his observational situations the essential components of the observational situation in analysis. These are:
>
> 1. The constancy of the situation and its reproducibility.
> 2. Such a control of variables that among all of the variables which are allowed free play in the situation the majority arise in the object under study and not in the observer.

> 3. A technique for continuous screening and minimizing of all of those variables which the observer cannot avoid introducing.
> 4. The only valid technique for representative sampling of behavior on the symbolic level (i.e., free associations), which enables us to observe unconscious as well as preconscious and conscious linkages.
> 5. The introduction of the tentative nonaffective interpretation, both as a working hypothesis and as a deliberate variable [p. 134].

ANALYTIC DATA BANK

Thus there is good reason to view the psychoanalytic process as one of using the scientific experimental method to investigate an individual's personal dynamics. From this point of view, *countless experiments in psychoanalysis are being carried out every day in analytic consulting offices in which the analyst functions in the role of experimentalist.* However, the information and data generated in these experiments are never quantified and are recorded only rarely in any permanent form that could be used by others in controlled investigations. Yet the happenings in these everyday analytic research investigations are by far the largest potential source of data, directly relevant to controlled (quantitative) investigations that could help decide issues of real concern to analysts. It is tempting to contemplate how this huge volume of potentially invaluable information, now lost as soon as it is generated, could realistically be made accessible to the researcher who is interested in testing psychoanalytic hypotheses.

Of course, frequent efforts to collect and preserve records of the content of analytic sessions have been made, either in written form or on audio tape. But as Nelson points out in this issue, mountains of these records accumulated at centers such as the National Institute of Mental Health go unused by researchers. Obviously, an information retrieval system is needed so that researchers will be able to pull out from stacks of case summaries or full protocols of case materials those that contain information related to a specific topic. This would require an extensive indexing system consisting of subject headings or key words. Thus if a researcher wanted to investigate the effective-

ness of different kinds of interventions in resolving resistance to termination, for example, he would have access to the experiences of many different analysts with many different patients and could use this information to conduct definitive surveys or test hypotheses using an ex-post-facto research design.

An ongoing research project at the Manhattan Center for Advanced Psychoanalytic Studies represents a first step in developing a system of coding data collected by analysts in training and reported in summary form to supervisors both orally and in writing. Present plans call for indexing these data under subject headings that include types of resistance, types of intervention, and feelings induced in the analyst.

Beyond elaborating and refining the existing subject-heading classification scheme, a further improvement in the present system would be the requirement that the process summaries follow a standard format and, in addition, contain a summary of the analyst's speculations about the ongoing dynamics. Thus, for example, we might ask each participating analyst to view each analysis he is reporting as a scientific experiment and report in a formalized way his observations and conclusions about the patient's predominant resistance at any given time. We might ask him to describe the resistive behavior, identify the type of resistance involved (ego, secondary gain, superego, id), the associated feelings communicated by the patient, and the feelings he evokes in the analyst. In addition, we could ask the analyst to summarize his impressions of how the resistance relates to the patient's past experiences, describe his hypothesis of the transference dynamics underlying the resistance and the intervention he proposes to make to resolve the resistance, and report his observations on the success or failure of the intervention. To further improve the collection of data, a data-recording system is needed that would make it as easy as possible for the analyst to report these kinds of summaries. Much of the necessary information could be coded by checking off categories on a form. Other, more specific information (such as the transference dynamics or proposed interventions) could be dictated on audiotape and transcribed later.

The final step in evolving an encoded collection of case

summaries (ECCS) might be to index audiotaped records of the analytic sessions themselves so that investigators would be able to locate specific events mentioned in the analyst's summaries.

Let us look at ways in which such a reservoir of analytic data could be used to test hypotheses. How could we use the ECCS to test the hypothesis for instance, that interventions based on information that includes the analyst's awareness of the dynamics of the feelings induced in him by the patient will often be more effective than interventions the analyst makes when he is not so aware of those feelings? We could interrogate the ECCS data bank to collect two types of situations involving patient resistance: those in which the analyst exhibited no awareness of induced feelings and those in which he claimed that he clearly understood his induced feelings. A team of investigators could then judge the effectiveness of the intervention from the case records of the patient's reactions. (A procedure for making such judgments has been developed by Meadow (1974) in which two or more judges use a special rating scale to score the patient's reactions to an intervention.)

For the skeptical clinician (obviously any analyst who is sensitive enough to be aware of his induced feelings will be more successful than an analyst who is not), we might devise an additional study, using our collection of interventions for which the induced feelings have been identified by the analyst, we could study the interventions closely to determine in each instance how the analyst's knowledge of his induced feelings are reflected in his interpretation and then explore the relative effectiveness of various ways of using the induced feelings as evidenced by the success of the interpretation.

To turn to another example of possible research investigation using the ECCS, let us consider the hypothesis stemming from a paper which advances the idea that the ego-modeling role of the intervention is the key factor enabling the intervention to resolve the patient's resistance (Davis, undated). To test this hypothesis, a collection of interventions from the ECCS could be studied to determine, in each instance, the presence of ego modeling in the analyst's intervention and the presence of imitation or of identification with this modeling in the patient's

reactions to the intervention. The success of the interventions could then be correlated with the degree to which the patient imitated or identified with the ego-modeling activity.

In addition to providing specific information on cases involving a variety of different kinds of patients and many different analysts, the ECCS avoids the problem of bias in the analyst's attitude, which inevitably arises when the analyst attempts to do research with patients in his own practice. Furthermore, the analysts who contribute information to ECCS for research purposes would have no prior knowledge about the specific uses of the data.

Ideally, large numbers of experienced practicing analysts would agree to contribute to an ECCS system, but this hope is not realistic. No matter how simple the coding system is, it is doubtful that many analysts in private practice would be motivated to spend the necessary effort, even if they realize that the endeavor is worthwhile. This is especially true if they were asked to tape all sessions. In exploring the notorious reluctance of analysts to agree to audio recording for research purposes, Gill et al. (1968) found that it is usually the analyst, not the patient, who feels uncomfortable about the presence of a tape recorder.

On the other hand, it *is* realistic to believe that student analysts at psychoanalytic training institutes might be motivated to cooperate in a project such as ECCS. The ECCS summary reports are simply a more structured and elaborated version of the information that students customarily report to their supervisors. In addition, students are more likely to cooperate if the institute formally asks for volunteers to audio record at least some of their cases under supervision.

In making case material available for research, primary consideration must be given to protecting the patient's privacy and other interests. The identity of the patient and analyst should be kept confidential by assigning code numbers to them and by deleting names and other identifying references from all printed or taped material before it is released for research use. In addition, the analyst would have to obtain the patient's permission to enter his case material into the system. The pa-

tient and analyst may also specify a time (say ten years) when the material must be withdrawn from the system and destroyed.

In response to those who believe that this kind of project would place an unfair burden on students, one can make strong arguments that the kind of systematic analysis the ECCS system would require of the participating analyst would eventually be recognized as an excellent training device for students making possible the systematic, longitudinal study of each patient's resistances—the very heart of the psychoanalytic process. And Gill and his colleagues (1968) reported that experienced analysts benefit from studying tapes of their own sessions and pointed out how tape recording of sessions is quite naturally related to the analytic supervisory process.

Even if we had the full cooperation of several analytic institutes, collecting and organizing the data for an ECCS system would require Herculean effort. The financial support alone for such a project would require a major commitment by a governmental agency or private foundation.

On the other hand, it is clear that the primary data of our discipline is generated in the typical psychoanalytic session, and we may continue to fail in our efforts to produce definitive research results until we are prepared to undertake the massive job of collecting detailed information about a large number of ongoing analysis—a number large enough so that we can make convincing tests of the many stimulating but often conflicting ideas that abound in our field.

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MODERN PSYCHOANALYSIS IN THE STATE MENTAL HOSPITAL

The following series of interviews represent the results of a preliminary study on the use of mental hospital placements in psychoanalytic training. Dr. Michael Beck, team leader at Central Islip State Hospital, Dr. Christine Duffey, unit director at Creedmoor State Hospital, and Mr. Fred Levenson, psychologist at Kings Park Psychiatric Facility, are currently working out internship programs for modern psychoanalytic candidates. Drs. Beck and Duffey, responsible for the development of two Manhattan Center internship programs, serve as administrative supervisors for the Central Islip and Creedmoor placements.

While it is premature to determine the effectiveness of these projects, 1972-1975, the following brief statements will give the reader an introductory view. Students participating in the field work program work ten to twelve hours weekly at a hospital placement where they attend staff conferences, hold sessions with patients and receive administrative supervision. At their training institute they attend weekly field seminars where they share ideas with interns from other hospital placements, carry a full program of theory and technique, a personal analysis, and case supervision.

Traditionally, psychoanalytic institutes require their candidates to accumulate a substantial amount of supervised clinical experience with patients in an institutional setting. This institutional internship is considered a prerequisite to the student's control analysis (independent psychoanalysis under supervision) and provides a first opportunity to relate intellectual knowledge acquired in seminars to an actual treatment situation. Here the student begins to learn how to study the patient —to understand what the patient is trying to communicate emotionally, to decide on the best interventions and when to intervene or abstain from intervening, and, finally, to evaluate the immediate and long-term effects of his interventions.

Training institutes frequently arrange for their candidates to obtain clinical experience in community centers with patient populations that are similar to those in the typical practice of a classical analyst. But there are good reasons why institutes now prefer their students to do their internships in mental hospitals.

First, the scope of private practice in modern psychoanalysis has broadened to include patients with disorders that are not substantially different from those of hospitalized patients. So, in a real sense, experience with hospitalized mental patients has become more relevant to the kind of practice a young analyst can look forward to.

An even better reason, however, stems from the observation that experience with the deeply disturbed patients found in hospital wards is an excellent way of introducing a prospective analyst to psychoanalytic work in general. Simply because the patients are deeply disturbed, the various aspects of the therapeutic relationship appear in more dramatic and exaggerated forms than are usually found in private practice. Not only are the hospitalized patient's resistances more primitive and easily recognized but the countertransference reactions induced in the therapist are particularly intense and cannot be easily ignored by the fledgling analyst. The successful working through of these countertransference feelings contributes in an important way to the student's growth as an analyst. By the same token, the hospitalized patient's reactions to successful therapeutic intervention are typically also quite dramatic; thus

the student is provided with vivid demonstrations of how effective the correct procedures can be and why.

The hospital also offers the student an environment in which he can learn to relate as a modern psychoanalyst, not only with patients but with staff, visitors, psychiatrists, hospital supervisors, and clerical personnel.

Of course, in recommending the mental hospital as the best introduction to psychoanalytic work, it is understood that the student has had basic psychoanalytic training and is committed to ongoing personal analysis, supervision, and a relevant program of psychoanalytic studies.

If the student analyst benefits from working with hospital patients, the patients who are fortunate enough to be chosen for analytic treatment benefit even more. Over a period of months, the patient's functioning usually improves significantly as a result of treatment, often to the point where he is able to continue in treatment with his analyst as an outpatient at a nominal fee after the student has completed his internship. The opportunity to continue the analytic relationship indefinitely offers the patient the hope of eventually becoming a functioning member of society.

We hope that mental hospitals everywhere will continue their ascent from the dark ages of imprisonment and neglect of psychotic deviants by encouraging the use of analytic students who are eager to help these patients while at the same time learning to become psychoanalysts.

The Editors

The following three articles were prepared from a series of interviews conducted by ESTELLE BOROWITZ

I. Facilitating Treatment of Hospitalized Patients Through Administrative Supervision of Psychoanalytic Interns

An interview with Michael Beck

On my recommendation, several years ago psychoanalytic students began serving internships in the state hospital unit of Central Islip where I am a treatment team leader. They have employed the updated psychoanalytic approach suggested for schizophrenic and other narcissistic disorders. This treatment utilizes transference as a primary tool. However, the transference relationship sought is a narcissistic one, constructed by means of various ego-insulating techniques. Resistances are supported until the patient feels it is safe to relinquish them. Communication is relayed regularly via nonverbal and empathetic modes, and direct interpretation is discouraged.

We expect that interns using these methods could facilitate the treatment of hospitalized schizophrenics. Supervising these interns has been an interesting and gratifying aspect of my work, not least because of the therapeutic increment to many narcissistic patients who have been restored to human contact.

To date, about 25 interns have been supervised at Central Islip. Although some begin with just one patient, all of them eventually carry from three to six patients in modern psychoanalytic therapy. Thus over a hundred patients have been reported in supervision and administrative consultation.

There are about 140 patients on the three chronic wards under my jurisdiction, two of which house males and one, females. Patients are as old as 90, and some have been in-patients for 50 years. There seems to be a rough correlation between length of residence and degree of narcissism. A ratio of one staff member for every five patients is maintained, but because the patients are so demanding, this allocation of staff is not excessive. Patients come from the metropolitan New York area —especially from Brooklyn but also from Queens, Suffolk, and Nassau counties. The hospital, situated about 50 miles from the heart of New York City, recruits staff from this wide geographic area. However, in general, the psychiatrists come from other countries and live on or near the hospital grounds.

The ambiance of a state mental hospital induces strong feelings in addition to those which one normally might have when beginning work in a new setting. To support the intern in making these special adjustments, the hospital supervision includes an orientation to the hospital itself and to the facilities of the town surrounding it. It also provides each intern with a treatment room and analytic couch.

Not only the institutional setting but the hospital staff induce feelings which are confusing. For example, staff coping mechanisms may include cheerfulness that masks hopelessness or efficiency that masks helplessness concerning the patients. Interns usually pick up these mixed messages and are uncertain as to how to deal with them.

Finally, the oft-times quite deteriorated physical appearance of the patients elicits a gamut of emotional responses in the interns, ranging from pity and nurturance to revulsion and flight. The administrative supervisor's role with interns is to support all these feelings and reactions, thus mirroring the way in which treatment is to take place. All feelings are accepted. "Why not feel hopeless?" "What's wrong with feeling confused?" "Why can't one feel repelled?"

The interns are in therapy themselves and in case supervision with a qualified psychoanalyst, a most important requirement for anyone working with profound narcissistic illnesses.

The administrative supervisor's approach is an adjunctive experience to the case supervision: the modality through which they will learn to treat patients. They gradually sense that they neither have to get rid of nor act on their feelings. Once the intern achieves a measure of comfort about sustaining many kinds of feelings, this attitude communicates to their patients.

This initial contact with the unfamiliar world of the mental institution floods the intern with feelings. In a way, the situation mirrors the process which will be going on when a patient gets in touch with similar feelings. Thus the internship provides a real situation which can help the analyst-in-training empathetically understand the patient's situation.

Although the intern must make certain commitments in terms of number of months and number of hours per week, we try to negotiate goals and preferences as much as possible, just as one might negotiate contractually with a patient. We ask the intern questions such as "How many patients would you like to begin with?" or "What kind of patient do you want to work with?" This nonauthoritarian approach is reflected later on in the intern's work with patients. No pressure is put on interns to take more patients than they feel they are ready for in terms of meeting patients and also in terms of consultation hours with staff.

Modern psychoanalysts usually wait for the patient to initiate contact before intervening. Silence is investigated with one or two neutral comments to provide minimal contact. The administrative supervisor at the hospital observes the contact functioning of the interns. They are offered either one patient or more. They are offered hospital consultations, either group or individual. Wherever possible, adjustments are made to incorporate the intern's desires. Our aim here, as with a patient, is to reinforce the intern's ego and support his defenses.

Interns are supported in another way too. Because their presence induces many feelings in the regular staff, the administrative supervisor accepts responsibility for the presence of the interns and provides opportunities for the staff to ventilate their feelings about it. Opportunity for ventilation can also facil-

itate patient care, which is to a great extent custodial. Drug treatment, in large measure, dulls the patients' feelings and makes their behavior more manageable. Psychoanalytic treatment initiates a process which results in patients getting in touch with feelings. Thus, in the short range, interns indeed create problems for regular staff, especially nurses and therapy aides, when a patient is put in touch with feelings before he can handle them. When channels are set up to air these feelings, then resistances to the work of the interns can be dealt with, and an educative process may begin which will enlist the aid of staff in the goals of therapy.

This educative process goes on in the patient/analyst/supervisory relationship too. When an intern has decided, by casual observation in the ward, or inspection of records, or discussion, which patients he would like to work with, an introduction is arranged, if possible. At that point treatment begins. The administrative supervisor provides a waiting room, and the patient is told when his appointment is. Whether or not the intern has to pick up the patient in the ward, or whether he can ask that the aid bring the patient to the waiting room, or whether the patient is able to come for his appointment on his own—all these are matters for analytic exploration.

How long a treatment session lasts is also an important matter in a hospital setting. No patient is seen more than once a week. Some patients begin with only five- or ten-minute sessions. Eventually, most are comfortable with a thirty-minute session. A few can tolerate a regular 50-minute hour. Some patients can barely withstand being in the same room with the intern; others can allow themselves to be seated, either facing or facing away from the intern. This often happens as the therapist becomes more comfortable and relaxed about having patients use the couch. Most patients learn to feel comfortable on the couch during a majority of their sessions.

The couch helps the patient understand that although he can feel and say anything he wants to during the session, he is supposed to remain physically inactive. The couch promotes analytic work but also discourages acting out.

Interns vary in their ability to communicate to an administrator, just as patients vary in their ability to communicate with an intern. Interns are encouraged to bring up any aspect of their placement with the administrative supervisor.

Interns exhibit certain rather standard resistances in placement supervisory sessions, especially at the beginning. They may not remember a session, they may have made notes but forget to bring them, they may want to take notes but neglect to bring a pen. They may quote outside authorities as a rationale for various requests they wish to make regarding their patients. They may bring up personal material which belong more appropriately in an analytic session. Applying modern psychoanalytic principles to intern consultations, these resistances are not discouraged; they may be investigated but no interpretations are made. When the relationship between hospital administrator and intern has built to the point where both are comfortable with each other, then these resistances are resolved and more progressive communication ensues.

Other types of resistances to successfully working in the hospital arise from the nature of dealing with the demands of schizophrenic patients. These patients induce anxiety, confusion, and fear but provide little immediate gratification to the intern in return. These are very deprived patients, and they cannot give what they never got. In fact, a paradoxical situation seems to arise. When the intern is successful in creating a narcissistic transference—which may take from six months to two years—the patient begins to experience the intern as someone who feels and thinks as he does. This means that if a negative attachment unfolds, the patient begins to release aggression and heaps verbal abuse on the intern, just as he does on himself. The interns require hospital help through such periods of threatened ego loss to enable them to stay with their patients. I often have the impulse to tell them what is going on. If the intern is fully cooperative, perhaps an intellectual explanation of some related psychodynamic problem may be appropriate. Or a factual question or two may supply him with enough stability so that he can persist with his patient.

To the extent that the hospital makes it possible for the intern to tolerate all feelings, then the patient will be enabled to become cooperative.

Since facilitation of patient care was a major reason for establishing psychoanalytic internships, what are some of the results? To begin with, the use of interns has been a conduit for treatment of over a hundred patients who otherwise would not have had psychodynamic therapy. Some virtually mute patients have begun to speak, and others have become interested in their surroundings. In almost all cases, it has been possible to establish a relationship and, in some cases, to establish a narcissistic transference. One sees very clearly the operation of resistances on every level, as explicated in the recent literature. It is also clear that consistent application of the modern psychoanalytic approach results in some modification of repetitious and superficial contact and in more progressive communication.

These patients can be worked with, relationships can be established with them, modern psychoanalytic principles really are appropriate, and treatment can be ongoing. One has to be satisfied with very modest progress. But in the treatment of hospitalized schizophrenics in a chronic unit, modest progress is in itself worthy of note.

II. Staff–Intern Relations

An interview with Christine Duffey

The goal of modern state mental hospitals has become one of stabilizing illness, helping a patient return to some level of functioning and returning him to the community as soon as possible. The notion seems to be that real treatment can only be done outside hospitals, that hospitals promote their own illness. A dichotomous patient population results from this philosophy —some staying one to three months or a little longer, others remaining in residence for many years.

A question which came to mind three years ago, upon being appointed director of one of nine small hospitals which comprise Creedmoor State Hospital,* was how to enable a staff of about 150 to function in more positive ways so that rather than settling for symptom stabilization, some therapeutic gain for patients might be realized within the hospital setting itself.

This large staff services various arms of the hospital. Inpatients number about 150 to 200. In addition, there are some 70 day-center patients, about 600 former patients housed in two residential homes, plus a clinic outpatient population of around

*Located in Queens County, a borough of New York City

300. These patients are served by workers deployed in day, evening and night shifts.

Staff development toward a more therapeutic goal for patients was structured around a key concept of modern psychoanalysis, i.e., resolving resistance. What resistances prevented staff from functioning so that patients received the care to which they were entitled? In the analytic situation, resistances are identified by asking a patient to talk and observing what prevents him from verbalizing freely. It was felt that a better understanding of staff resistances could be deduced by providing opportunities for them to talk about their work, and then noting what prevented them from doing so freely.

The state mental hospital system has many built-in provocations and frustrations for staff as well as patients. The tendency is for people to close off feeling when circumstances become very difficult. If all feelings are experienced directly it becomes intolerable, essentially because people believe they need to act on them.

In a way, this situation mirrors why many patients have ended up in a mental hospital: they have not been able to deal with all their feelings—in particular, the angry ones—and have internalized too many of them, thereby using exorbitant amounts of energy to keep them in check. That same hypothesis holds for staff. Channels are needed through which staff can gradually release feelings of frustration and anger (gradually in the sense that they will be able to tolerate the release without exploding and learn more acceptable methods of release.

STAFF GROUP MEETINGS

To this end, weekly team meetings were set up for each of the several inpatient and outpatient areas. Although the bulk of the program is run by therapy aides who are paraprofessionals, all levels of professionals from psychiatrists to attendants were included. In addition to the weekly team meetings, the disciplines —psychiatry, nursing, social work—met separately on a weekly or bi-monthly schedule. Sometimes it is easier for peers to acknowledge and help each other with a problem and subjects will be discussed differently than with a team group. There

were also weekly intergroup meetings with designated leaders from each area in which policy decisisions are made, including staffing changes and program changes.

This format of a number of types of groups provides flexibility in establishing productive relationships. Staff problems can be studied one to one, or via the team meeting, or the peer meeting, or the intergroup meeting.

It may take quite some time for the group to be able to devote its communications to talk about patients. When these meetings were started, there was little such communication. The need of the group members seemed to be first to feel safe with the director. This need was respected and discussions were led into neutral topic areas, away from ego-threatening ones. After a while, discussion shifted to complaints about the director and/or the hospital, about things that prevented them from functioning. The next phase of group development included complaints about each other, what kinds of things were interfering with team functioning. Eventually the talk got around to patients, what kinds of things interfered with the patients' needs being met. It was important first to identify the need, next acknowledge it in some way, and finally see who might be the best person to meet it.

The sequence of progress with this panoply of work groups has followed quite closely the sequence of progress in individual treatment with patients, or the progress of therapy groups. At first one had to deal with treatment destructive resistances, such as staff not coming, coming but not talking, coming but not staying for a whole session. The level of communication changed gradually and people began to talk about patient care. A positive side effect has been that staff has matured while patients have gotten better care.

In the beginning when team meetings were scheduled, there seemed to be many excuses for not coming. In a hospital you can always have an emergency, somebody acted out, they needed to go to a particular medical-surgical building, etc. Now, three years later, if the director cannot meet on a particular day, staff members want to know what alternative time they will be given. The bureaucracy of the state hospital system

works against consistency, follow-through and personlization. In these meetings group members have been helped to tolerate feelings generated by the system and then helped to move past it.

Improvements began when the staff believed there would be positive results from their participation, be they attendant, psychiatrist or social worker.

CONTRIBUTIONS OF INTERNS

Of importance in this program has been the contribution of psychoanalytic interns to staff functioning. These interns are candidates in the training program at the Manhattan Center for Advanced Psychoanalytic Studies, and, under *psychoanalytic* and *administrative* supervision, work with patients at the hospital to satisfy the requirements of their program for clinical experience.

The interns have had a great influence on the staff as models. Their presence in the hospital sets a different tone. When they are around, staff is regularly exposed to new ideas and a new attitude towards patients. The modern psychoanalytic internship and field placement goes beyond work with individual patients. It is important that interns learn to work with resistance of staff as well, and in cases where indicated, with resistances of patients' families.

Although in the end it is paraprofessionals who run most of the programs which have direct, day-to-day effect on patients, interns may model how to treat people in their interaction with staff both in the various meetings described and in other less structured ways. Experience indicates that this eventually filters through to appropriate interaction between patients and paraprofessional therapy aides.

EFFECT ON STAFF FUNCTIONING

When modern psychoanalytic groups and intern-staff contacts are used, staff learns that good functioning on the job depends on first identifying resistances. Once group members learn to detect more than one meaning in communications among themselves and between themselves and patients, the content as

well as the quality of interactions changes. With sophistication, staff members' responses to each others' needs are identified more readily and responses to a problem tend to have a better fit.

Such sophistication also carries over to patient management. The hospital staff is now at the point where not every infraction by a patient is treated with the same restriction. There is more flexibility. This has taken place 1) because an overall system for discipline was established where before there had been none, and 2) because, once a system was established, they were able to say, "Well, everybody's not the same and what might be best for that particular patient?" Earlier, everyone was afraid of loss of control. It was feared that the whole place would fall apart if routine was broken.

Flexibility in patient treatment is one problem. But another one is consistency in patient care. How can one assure that the same principles govern treatment by day, evening and night shifts? A system has been worked out where representatives from the three shifts meet regularly so that there is a carry over of goals as well as of ways to implement them. It does not seem to matter what is actually discussed. When staff realizes that someone is in charge who will direct the conferences and who senses what it is that interferes with functioning or with providing a service, then follow-through develops.

The same result occurs when one works to coordinate inpatient and outpatient policy. Once a week a representative from each area meets with representatives from all others and they talk about patient movement, planning for people going out and for people coming back.

The modern group emphasizes an object orientation. With the discussion steered away from the egos of staff members to something outside themselves, "the patient," the possibility of narcissistic injury to the participant is curtailed. As commitment to the task grows, the entire hospital is strengthened.

In a very simple way, each succeeding meeting is a check on whether or not a previous resistance has been resolved: Was a proposed plan actually accomplished? Before one can count on this happening with regularity, group members go through

several stages: First learning to identify angry and annoying feelings, then learning that it is safe to express them in this setting, and finally learning when to act and not to act on them. Progression through these stages has helped staff to do things for patients which they could not ordinarily have done.

The group process has also helped staff members develop a sense of identity as workers with a function. There is satisfaction when they see something good happen for a patient and a sense of identity with our unit. They are learning what is being strived for and that a setback does not mean all is lost.

There are still occasions when a patient gets hurt as the result of staff neglect or loss of patience, but in most cases there is more therapeutic activity with patients than ever before. In the beginning, staff would have parties and meet by themselves. Later they began to invite patients to some of their parties. Recently families of patients have also been invited. Another example of patient involvement: At unit meetings each area was asked to do a presentation for the other areas. In the beginning a traditional concept was used, presentation of a problem patient as a case study. Then there was a shift to presenting programs, and finally to having patients present programs.

The staff's idea of making the hospital community resemble a real community as closely as possibile had profound effects. Meetings are attended by groups of patients mixed in age, in all diagnoses and in all severities. Patients attend many kinds of specialized therapeutic activities, depending on their interests. There is a newspaper group, a cooking group, a woodworking group, a pre-discharge group, a good grooming group, a Weight Watchers' group. Patients are indeed involved now.

There is a camaraderie among staff, between staff and interns and between staff and patients in terms of relationship which is much different from what had been exhibited three years ago. Even the job descriptions of staff have changed, now that all have been working together in this way. The team recently interviewed a psychiatrist to make sure he had the potential to fit its needs. This is really a new notion.

The use of a modern psychoanalytic internship and staff

development program has resulted in an administrative position, that of hospital unit director, being turned into a powerful therapeutic lever. This approach has enabled director, staff and interns to grow in their functions. It has renewed hope for many patients.

III. Follow-up Treatment of Schizophrenics on an Out-Patient Basis

An interview with Fred Levenson

It is commonly believed that schizophrenics cannot be dealt with as outpatients unless they are vigorously pursued. Thus long-acting medication such as prolixin is viewed as an answer to the problem of treating and maintaining them in the community. Results of my work with a small number of individuals —seen first as in-patients at King's Park Psychiatric Facility and later in aftercare over a two-year period—indicate that psychoanalysis, as modified by Spotnitz *et al.* for treatment of preoedipal disorders, has motivated such patients to continue in treatment as out-patients.

Modern psychoanalytic therapy with these patients was started in the hospital, and continued over a period of two to three months. It was theorized that treatment in aftercare with the same intern would allow for a smoother transition back to the community, and a plan was worked out to incorporate this feature.

Treatment was carried out in Brooklyn on a once-a-week basis during half-hour sessions. The aftercare setting was some 50 miles from Kings Park Psychiatric Facility, where therapy had begun. About a dozen patients of both sexes, ranging in age from 20 to 60 years, were part of this program. These were

persons who had presented symptoms of promiscuity, total withdrawal, somatization, antisocial behavior, sexual inadequacy—the full range of problems a psychotic typically manifests—and the gamut of diagnoses from psychotic depression to all types of schizophrenia.

Key elements in the treatment of any schizophrenic patient are (1) establishment of the narcissistic transference, which allows the treatment to unfold, and (2) the therapist's recognition and use of the countertransference feelings induced in him by the patient, which guides the plan of treatment. These patients usually have a characterological transference from all previous physicians, psychologists or social workers who told them to change or to stop acting a certain way. Therefore, they are petrified by the idea of being forced to abandon their defenses. But when a therapist accepts these defenses, the narcissistic patient is able to form a bond between himself and his therapist which enables the treatment to progress. As this bond grows stronger, the patient eventually begins to express dissatisfaction with his life in terms of dissatisfaction with the treatment. As he begins to experience the freedom to express negative feelings verbally and learns that neither he nor the therapist has to act on feelings, he feels safe. What happens then is that even though the patient may complain about lack of progress, he is willing to stay in treatment. But there will still be certain things he cannot yet say. Occasionally the therapist will have to provide support for such resistance by letting the patient know that he really should not say things at certain moments—that if he does say them it may possibly jeopardize treatment. This reinforces the safety of the therapeutic environment and this safety is experienced as gratifying.

The patient will eventually become frustrated when the therapist reflects questions rather than answers them, explores resistance rather than gives commands, and informs the patient that he must talk about the story of his life even though he may not know where or how to begin. The lack of direction and the lack of gratification in terms of not receiving answers to inquiries are extremely frustrating for a patient. No deliberate provocation is necessary. When the patient learns to verbally express

this frustration in an analytic session, he becomes, paradoxically, firmly tied to the analyst and the analytic work.

Most patients treated in aftercare were heavily medicated. This was found to be, in large measure, ego-dystonic to the outpatient and perhaps to the in-patient as well. The individual needs his symptoms at that moment, and a reduction of symptoms only tends to force internalization of the disturbing factors, causing a greater narcissistic regression. For instance, if a paranoid who is still having delusions of persecution is placed, as an outpatient, on 400 mgs. of Thorazine or Mellaril daily, he will feel physically weak. This reinforces his conviction that there is a genuine danger out in the community, that people are out to destroy him.

In most cases, a patient will respond to treatment simply on the basis of support provided by a non-hostile person who does not tell him what to do or threaten him in any way, who allows him to have his defenses—that is, his psychotic symptoms. Without those defenses the individual panics and feels that he must get to a safe place: namely, the hospital.

Although medication tends to stabilize certain levels of anxiety, it cannot resolve the basic anxieties causing the psychosis. When one sets out to resolve resistances and to build and work through the narcissistic transference, one finds that patients have been assisted in resolving psychosis and have become capable of functioning adequately in most areas.

The usual 50-minute hour may place tremendous stress on both patient and therapist when treatment begins. Feelings and anxiety are so intense on both sides of the couch that half-hour sessions, once a week might be best. Requests for more time are explored and granted if the therapist agrees with the reasons the patient presents. I have found it is unnecessary to see a patient more than once a week for him to function adequately. When a patient asks for more sessions, I find he is asking me to assume his ego functions and provide ego strengths and boundaries that need to be developed on an intrapsychic level rather than through external forces.

The belief that a schizophrenic should not be treated on the couch is pervasive throughout the mental hygiene profes-

sion—based on the fear that this will cause a dangerous regression. However, experience based on training at the Manhattan Center for Advanced Psychoanalytic Studies has demonstrated the opposite effect: the patient may be forced into a greater and less controlled regression if the couch is *not* used. The analyst who suggests the couch usually finds that patients respond with feelings ranging from open acceptance to a fair amount of resistance, all of which are cause for exploration. For instance, the paranoid does not want to have anybody behind him while he is on the couch.

One way of dealing with a patient's resistance to the couch is to say that he can try it for a limited amount of time, perhaps five minutes, and if he feels uncomfortable after five minutes, he can return to his seat. Very rarely have patients asked to get off the couch once they have agreed to try it for a short trial period.

Patients also act quite responsibly by calling and presenting a reasonably adequate excuse for missing an appointment—usually physical illness. When a patient misses an appointment without adequate explanation, it often signals an approaching decompensation. At such a signal, the analyst has an obligation to contact the patient so that this treatment destructive resistance can be explored. When the exploration is successful, the resistance is resolved and the likelihood of rehospitalization is reduced. However, even if the patient is readmitted, the period of hospitalization is shorter, and, if the resistance is expressed upon release, the patient returns to therapy.

Occasionally, it has been beneficial to meet the nuclear family to assess what is going on in the home as well as to develop more adequate communication among family members. A patient sometimes recognizes that although he is now functioning adequately, the other family members are not. He begins to understand that what they claim is abnormal or crazy behavior is actually an adequate adjustment and that what the family might consider normal, healthy behavior is psychotic. When he realizes this, he typically will ask for assistance for his family. Whether he can motivate them to enter treatment is, of course, a more difficult aspect of the situation. But once the

patient reaches this stage, he usually wants to leave home anyway: he no longer wants to be under the domineering or overly protective wing of the nuclear family.

In my estimation, the principal goal in working with the schizophrenic is continuation of treatment. This contrasts with the goal of much of the mental hygiene community, which seems to be to *set* goals for the patient. Experience has shown that once resistances are resolved by means of modern psychoanalytic techniques, the patient begins to set quite adequate goals of his own.

The patients I have been describing have undergone many kinds of treatment, including electroconvulsive shock. Eighty percent of them have a history of recurring "breaks" and recidivism. They range in intelligence from borderline retardation to a high average I.Q. Yet all have responded to modern psychoanalytic interventions to varying extents.

There has been an intriguing recent development. For a complicated set of reasons, I treated these patients over the telephone at once-a-week sessions of approximately normal length. These phone contacts maintained most of them for the four months involved.

Two years of treating about a dozen patients using modern psychoanalytic techniques in an aftercare setting have indicated that schizophrenic patients with diverse symptomatology and severity of illness can keep appointments, use the couch, form a narcissistic transference, be maintained on a once-a-week basis, and improve their functioning. A modest investment of therapeutic time has motivated them to pursue treatment as outpatients.

NEWS AND NOTES

The widespread influence of psychoanalytic concepts and techniques throughout the mental health field has encouraged the development of numerous independent psychoanalytic training institutes in recent years.

Psychoanalysts have recognized the importance of regulating psychoanalytic training and have developed a self-regulatory body similar to those established by other responsible academic and professional institutions in the United States.

Membership and accreditation in the National Accreditation Association for Psychoanalysis is open to all psychoanalytic training facilities that meet approved standards. The association has accredited twenty-four psychoanalytic training institutes. NAAP President Selwyn Brody, M.D., reports that NAAP was established for the following purposes:

1. to agree on minimum standards in psychoanalytic education,
2. to accredit institutes that maintain these standards,
3. to certify individuals who meet the approved standards,
4. to maintain a registry of training institutes in psychoanalysis and psychoanalytic psychotherapy and make this registry available to the public,

5. to maintain a registry of analysts certified by the association and to furnish copies of this registry to the public.

One important issue involved in establishing an accreditation procedure was the need to maintain minimum standards nationwide for the practice of psychoanalysis. Now that many states are licensing professionals in psychotherapy and psychoanalysis, the association enables these professionals to have a voice in the proceedings.

By the end of 1971 the National Accreditation Association for Psychoanalysis had sent questionnaires to all existing institutes to survey standards of the profession. The following list includes all known institutes conducting programs in psychoanalysis and psychoanalytic psychotherapy. This listing is provided as a service to the reader and does not imply endorsement by this journal of any facility listed. *Those whose standards are endorsed by the NAAP are so indicated under accreditation status.* For further information on admission and training, write directly to the institute or the NAAP, 16 West 10th Street, New York, N.Y. 10011.

LISTING OF PSYCHOANALYTIC TRAINING FACILITIES IN THE UNITED STATES

ARIZONA

Southwest Association for Psychoanalysis (See listing under Colo.)

CALIFORNIA

California Graduate Institute, College of Psychological and Social Sciences
1100 Glendon Ave., Suite 1119, Los Angeles, CA 90024
Founded: 1968
Executive Director: Marvin M. Koven, Ph.D.
Accreditation: National Accreditation Association for Psya.

Institute of the Los Angeles Society for Psychoanalytic Psychology
6022 Pico Boulevard, Los Angeles, CA 90035
Founded: 1970
President: Norman Oberman, Ph.D.

C.G. Jung Institute of Los Angeles
10349 West Pico Boulevard, Los Angeles, CA 90064
Founded: 1952
President: Albert Kreinheder, Ph.D.
Accreditation: National Accreditation Association for Psychoanalysis

C.G. Jung Institute of San Francisco
2040 Gough Street, San Francisco, CA 94109
Coordinator of Studies: R. James Yandell, Ph.D., M.D.

Los Angeles Psychoanalytic Society and Institute
344 North Bedford Drive, Beverly Hills, CA 90210
Founded: 1946
Director of Education: Arthur Ourieff, M.D.
Member: American Psychoanalytic Association

San Francisco Psychoanalytic Institute
2420 Sutter St., San Francisco, CA 94115
Founded: 1942
President: Lloyd C. Patterson, M.D.
Member: American Psychoanalytic Association

Southern California Psychoanalytic Institute
9024 Olympic Boulevard, Beverly Hills, CA 90211
Founded: 1950
President: Joseph M. Natterson, M.D.
Member: American Psychoanalytic Association

Western Institute for Research and Training in Humanics (Alfred Adler Institute—San Francisco)
226 Stanford Ave., Berkeley, CA 94708
Founded: 1970
Director: Lucy K. Ackerknecht, Ph.D.
Accreditation: National Accreditation Association for Psychoanalysis

COLORADO

Denver Institute for Psychoanalysis, University of Colorado
4200 East Ninth Ave., Denver, CO 80220
Founded: 1969
Director: Herbert S. Gaskill, M.D.
Member: American Psychoanalytic Association

Southwest Association for Psychoanalysis
Box 401, Durango, CO 81301
Founded: 1965
President: Veryl Rosenbaum
Accreditation: National Accreditation Association for Psychoanalysis

CONNECTICUT

Western New England Institute for Psychoanalysis
340 Whitney Ave., New Haven, CT 06511
Founded: 1952
President: George F. Mahl, Ph.D.
Member: American Psychoanalytic Association

DISTRICT OF COLUMBIA

Washington Psychoanalytic Institute
4925 MacArthur Boulevard, N.W., Washington, D.C. 20007
Founded: 1933
Chairman, Education Committee: Clarence G. Schulz, M.D.
Member: American Psychoanalytic Association

Washington School of Psychiatry
1610 New Hampshire Ave., N.W., Washington, D.C. 20009
Founded: 1936
President: Robert A. Cohen, M.D.

FLORIDA

Psychoanalytic Department, Heed University
Monroe at Twentieth Streets, Hollywood, FL 33020
Founded: 1974
President: Marvin Hirsch, Ph.D.
Accreditation: National Accreditation Association for Psychoanalysis

ILLINOIS

Alfred Adler Institute of Chicago, Inc.
110 S. Dearborn St., Chicago, IL 60603
Founded: 1952
President: Eugene J. McClory, M.A.
Accreditation: National Accreditation Association for Psychoanalysis

Chicago Institute for Psychoanalysis
180 North Michigan Ave., Chicago, IL 60601
Founded: 1932
Director: George H. Pollock, M.D.
Member: American Psychoanalytic Association

KANSAS

Topeka Institute for Psychoanalysis
Box 829, Topeka, KA 66601
Founded: 1938
Director: Ishak Ramzy, Ph.D.
Member: American Psychoanalytic Association

LOUISIANA

New Orleans Psychoanalytic Institute, Inc.
3624 Coliseum St., New Orleans, LA 70115
Founded: 1953
Director: William C. Thompson, M.D.
Member: American Psychoanalytic Association

MARYLAND

Baltimore—District of Columbia Institute for Psychoanalysis
821 N. Charles St., Baltimore, MD 21201
Founded: 1933
Director: James F. Bing, M.D.
Member: American Psychoanalytic Association

MASSACHUSETTS

Boston Center for Psychoanalytic and Psychotherapeutic Studies, Inc.
8 Hawthorne Place, Suite 102, Boston, MA 02114
Founded: 1972
President: Jack Green, M.D.
Accreditation: National Accreditation Association for Psya.

Boston Psychoanalytic Society and Institute, Inc.
15 Commonwealth Ave., Boston, MA 02116
Founded: 1930
Chairman, Education Committee: Henry M. Fox, M.D.
Member: American Psychoanalytic Association

MICHIGAN

Michigan Psychoanalytic Institute
16310 West 12 Mile Road, No. 204, Southfield, MI 48076
Founded: 1962
President: Mordecai L. Falick, M.D.
Member: American Psychoanalytic Association

Michigan Psychoanalytic Study Group
27650 Farmington Rd., Farmington Hills, MI 48024
Founded: 1973
Vice-President: Harold Esler, Ph.D.
Accreditation: National Accreditation Association for Psya.

MISSOURI

St. Louis Psychoanalytic Institute
4524 Forest Park Ave., St. Louis, MO 63108
Founded: 1973
Director: Paul A. Dewald, M.D.
Member: American Psychoanalytic Association

NEW JERSEY

New Jersey Institute for Training in Psychoanalysis
175 Cedar Lane, Suite 2, Teaneck, NJ 07666
Founded: 1972
Co-Directors: Neil Wilson, Ph.D., Joel Bernstein, Ph.D.
Accreditation: National Accreditation Association for Psychoanalysis

NEW MEXICO

Southwest Association for Psychoanalysis (See COLO. listing)

NEW YORK

Institute of Advanced Psychological Studies, Adelphi University
Garden City, L.I., New York
Founded: 1952
Director: Gordon F. Derner

Advanced Institute for Analytic Psychotherapy
178-10 Wexford Terrace, Jamaica, NY 11432
Founded: 1958 (Jamaica Center for Psychotherapy)
Director: Joseph E. LeBoit, M.S.
Accreditation: National Accreditation Association for Psychoanalysis

Alfred Adler Institute
333 Central Park West, New York, NY 10025
Founded: 1950
Director: Helene Papanek
Accreditation: National Accreditation Association for Psychoanalysis

American Institute for Psychotherapy and Psychoanalysis
140 West 58th Street, New York, NY 10019
Director: Ross Thalheimer, Ph.D.

American Institute for Psychoanalysis of the Karen Horney Psychoanalytic Institute and Center
329 East 62nd Street, New York, NY 10021
Founded: 1941
Dean: Harry Gershman, M.D.

Columbia University Psychoanalytic Clinic for Training and Research
Psychiatric Institute, 722 West 168th Street, New York, NY 10032
Founded: 1944
Director: Aaron Karush, M.D.
Member: American Psychoanalytic Association

Institute for Psychoanalytic Training and Research
8 Grammercy Park South, New York, NY 10003
Founded: 1960
President: Norbert Freedman, Ph.D.
Accreditation: National Accreditation Association for Psychoanalysis

Institute for the Study of Psychotherapy
30 West 60th Street, New York, NY 10023
Founded: 1971
Administrative Director: Rubin Blanck
Accreditation: National Accreditation Association for Psychoanalysis

Psychoanalytic Department, International Graduate University at the American College of Switzerland
205 West End Ave., Suite 1P, New York, NY 10023
Founded: 1965
President: Nat Asherman, Ed.D.
Accreditation: National Accreditation Association for Psychoanalysis

C.G. Jung Training Center
28 East 39th Street, New York, NY 10016
Founded: 1963
President: Edward F. Edinger, M.D.
Accreditation: National Accreditation Association for Psychoanalysis

Manhattan Center for Advanced Psychoanalytic Studies
17 West 10 Street, New York, NY 10011
Founded: 1971
Director: Phyllis W. Meadow, Ph.D.
Accreditation: National Accreditation Association for Psychoanalysis

Mental Health Institute
25 West 81st Street, New York, NY 10024
Founded: 1956
Co-Directors: Alfred Jones, Ph.D., Harvey Shrier, Ph.D.
Accreditation: National Accreditation Association for Psychoanalysis

National Psychological Association for Psychoanalysis
150 West 13th Street, New York, NY 10011
Founded: 1948
President: Annette Overby, M.S.S.
Accreditation: National Accreditation Association for Psychoanalysis

New York Center for Psychoanalytic Training
9 East 89th Street, New York, NY 10028
Founded: 1963
Director: Reuben Fine, Ph.D.

New York Psychoanalytic Institute
247 East 82nd Street, New York, NY 10028
Founded: 1931
President: Arnold Eisendorfer, M.D.
Member: American Psychoanalytic Association

New York Society of Freudian Psychologists
133 East 73rd Street, New York, NY 10021
President: Jeffrey Golland, Ph.D.

New York University Postdoctoral Program in Psychoanalysis and Psychotherapy
21 Washington Place, New York, N.Y. 10003
Director: Dr. Bernard Kalinkowitz

Postgraduate Center for Mental Health
124 East 28th Street, New York, NY 10016
Founded: 1948
Director: Dr. Benjamin Fielding

State University of New York, Division of Psychoanalytic Education, Downstate Medical Center, College of Medicine at New York City
606 Winthrop Street, Brooklyn, NY 11203
Founded: 1954
Director: Alan J. Eisnitz, M.D.
Member: American Psychoanalytic Association

Training Institute for Mental Health Practitioners
40 East 30th Street, New York, NY 10016
Founded: 1968
Executive Director: Francis J. Peropat, Ph.D.
Accreditation: National Accreditation Association for Psychoanalysis

Washington Square Institute for Psychotherapy and Mental Health, Inc.
80 Fifth Ave., New York, NY 10011
Founded: 1960
Executive Director: Gerd H. Fenchel, Ph.D.
Accreditation: National Accreditation Association for Psychoanalysis

Westchester Center for the Study of Psychotherapy and Psychoanalysis
20 Sterling Ave., White Plains, NY 10606
Director: Paul Stark, Ph.D.

Westchester Institute for Training in Counseling and Psychotherapy
260 Stuyvesant Ave., Rye, New York, 10580
Dean of Administration: Lyman R. Hartley
Accreditation: Correspondent Status, National Accreditation Association for Psychoanalysis

William Alanson White Institute of Psychoanalysis
20 West 74th Street, New York, NY 10023
Founded: 1946
Director: Earl Witenberg, M.D.

NORTH CAROLINA

Psychoanalytic Training Program, University of North Carolina —Duke University
Department of Psychiatry, U. N. C. School of Medicine, 239 Old Nurses Dorm, Chapel Hill, N.C. 27514
Founded: 1961
Director: Milton L. Miller, M.D.
Member: American Psychoanalytic Association

OHIO

Cincinnati Psychoanalytic Institute
2600 Euclid Ave., Cincinnati, OH 45219
Founded: 1973
Director: John A. MacLeod, M.D.
Member: American Psychoanalytic Association

The Cleveland Psychoanalytic Institute
11328 Euclid Ave., Cleveland, OH 44106
Founded: 1960
President: David Crocker, M.D.
Member: American Psychoanalytic Association

OREGON

Klamath Mental Health Center
3800 Vandenberg Rd., Klamath Falls, OR 97601
Founded: Currently developing a program
Director: Abdul S. Dalal, Ph.D.
Accreditation: Pre-accreditation status, National Accreditation Association for Psychoanalysis

PENNSYLVANIA

Direct Psychoanalytic Center
155 East Oakland Ave., Doylestown, PA 18901
Director: John N. Rosen, M.D.

Institute of the Philadelphia Association for Psychoanalysis
15 St. Asaph's Rd., Bala Cynwyd, PA 19004
Founded: 1949
Director: Stephen Morgenstern, M.D.
Member: American Psychoanalytic Association

Philadelphia School of Psychoanalysis
417 South Juniper St., Philadelphia, PA 19147
Founded: 1971
President: Harold R. Stern, Mus.D.
Accreditation: National Accreditation Association for Psychoanalysis

Philadelphia Psychoanalytic Institute
111 North 49th Street, Philadelphia, PA 19139
Founded: 1940
Executive Director: William S. Robbins, M.D.
Member: American Psychoanalytic Association

Pittsburgh Psychoanalytic Institute, School of Medicine, University of Pittsburgh
3811 O'Hara St., Pittsburgh, PA 19261
Founded: 1961
Director: James T. McLaughlin, M.D.
Member: American Psychoanalytic Association

The Psychoanalytic Studies Institute
1235 Pine Street, Philadelphia, PA 19107
Founded: 1954
Director: Richard J. Peters, Ed.D.
Accreditation: National Accreditation Association for Psychoanalysis

Psychological Institute for Psychotherapy
250 South 17th Street, Suite 701, Philadelphia, PA 19103

WASHINGTON

Seattle Psychoanalytic Institute
4033 East Madison St., Seattle, WN 98112
Founded: 1951
Director: Gerald B. Olch, M.D.
Member: American Psychoanalytic Association

BOOK REVIEWS

EGO PSYCHOLOGY: THEORY AND PRACTICE. By Gertrude and Rubin Blanck. Foreword by: Nathaniel Ross. New York: Columbia University Press, 1974. ix + 395 pp.

The first section of this book on Freudian developmental psychology is devoted to unifying Freud's writings on the subject and those of later psychoanalytic investigators such as Hartmann, Kris, Loewenstein, Jacobson, Mahler, Spitz, Kernberg, and Kohut—referred to as "giants of theory building." Thus the Blancks fashion a conceptual base for the technical procedures that are systematically discussed and illustrated in the second section. They view these procedures as constituting a "technique of psychotherapy different in some respects from that of psychoanalysis [p. 7]."

The term psychoanalysis denotes only the classical procedure, which the Blancks forthrightly describe as "a circumscribed form of treatment designed for a particular type of patient and having a clearly defined goal [p. 1]." They do not differentiate psychoanalysis from "modern psychoanalysis"; the term is never mentioned. Nevertheless, their book is about how the classical procedure evolved into modern psychoanalysis—a

broad psychotherapeutic science based on Freudian principles and oriented to the maturation of the personalities of all patients with psychologically reversible forms of illness.

These authors, like others who adhere to the orthodox view, should not be faulted for failing to recognize what is an ongoing historical development. If alerted to the implications of semantic differences, the student can learn much of value from practitioners who operate effectively as psychotherapists, however different the frame of reference in which they write. The Blancks are obviously skillful practitioners; they not only seem highly motivated to treat patients with preoedipal problems but report good results in these cases. Moreover, the main thrust of their book is, in their words, to "help therapists who treat the large population of psychotherapy out-patients who live in the community [p. 15]." Consequently, it is important to point out the significant gaps in their knowledge and discuss some misleading impressions they convey.

Their attempts to synthesize their own clinical observations and experiences with the psychoanalytic concepts of others are often unsuccessful. Had they developed their own concepts rather than base their delineation of techniques exclusively on theories that are frequently unrelated to the therapeutic task at hand, the book would have been more enlightening.

One also encounters inexact descriptions of the relation between theory and technique: for example, "If theory is well understood, technical interventions resolve themselves—not into rules, but into logical moves which flow easily from theory [p. 15]" and "Out of this theory [psychoanalytic developmental psychology] arise the specific techniques we have described and illustrated [p. 363]." These explanations are simplistic because they obscure the vital significance of empirical observations in the choice of technique. Theory offers a general guide, but the therapist must operate on the basis of the patient's functioning in the immediate treatment situation.

Although the authors describe new techniques for dealing with preoedipal problems, they regard these problems as ego defects rather than as resistance. The book does not present a unifying concept for dealing with narcissistic transference re-

sistance or suggest specific techniques for resolving it. Neither Kohut nor Kernberg, from whom the Blancks derive their "technique of working with the more severe pathologies [p. 6]," discuss this resistance, which presumably explains the authors' failure to formulate an operational concept for dealing with it consistently in these terms. This is unfortunate, because the inability to comprehend and resolve narcissistic transference resistance blocks the cure of the severely disturbed patient.

In psychotherapy, the Blancks state, positive transference is "of greater importance than in psychoanalysis [p. 135]." This statement applies only to therapists who react with anxiety to the manifestation of negative transference because they do not know how to deal with them. And in a chapter devoted to the rationale of differentiating psychoanalysis from psychotherapy, both qualitatively and quantitatively, the following statement appears: "For some psychotherapy patients regression and fantasying are undesirable, and if patients are found to be subject to these on the couch, they are better treated sitting up [p. 129]." This is correct if the therapist is anxious or if the patient cannot tolerate the couch. Having the patient sit up is a way of joining the narcissistic patient's resistance.

A lack of understanding is suggested by the statement that "anxiety brought on rapid regression [p. 125]." Anxiety is simply an emotional signal of danger; sometimes it points to the mobilization of aggression, which may precipitate the regression.

Two chapters—one on the reconstruction of preverbal experience and the other on the use of dreams in treatment—are valuable contributions to the literature. Notwithstanding my reservations about content, I recommend the book to the student as a model for clear presentation of subject matter. Discussions of technique are interspersed with abundant clinical material, and the book is effectively organized and well written.

Hyman Spotnitz

THE ANATOMY OF HUMAN DESTRUCTIVENESS. By Erich Fromm. New York: Holt, Rinehart and Winston, 1973. 521 pp.

Fromm's book is offered as a definitive statement on the origins of the human appetite for cruelty and destruction. The author notes that six years ago, when he envisioned the book as the first volume of a comprehensive work on psychoanalytic theory, he focused on this topic because "aside from being one of the fundamental theoretical problems in psychoanalysis, the wave of destructiveness engulfing the world makes it also one of the most practically relevant ones. [p. xi]." The result is an impressively long and wide-ranging analysis of the problem in which Fromm regrettably fails to make good on his promise to provide us with a substantial new understanding of the morbid human passion for death and destruction.

In the first third of the book, Fromm reargues the old debate on nature versus nurture (or instinct versus behaviorism) and decides (as he has often done in previous works) in favor of a third position—his own brand of existentialism, in which he views humans as motivated by character-rooted passions that evolve from individual life experiences and are influenced to a large degree by the particular social system in which the individual is enmeshed.

From this vantage point, Fromm rejects appetitive instinct theories of aggression, such as the Freudian death instinct or Lorentz's phylogenetically programmed aggressive behavior, in which agressive energy inevitably accumulates to the point of explosive discharge unless drained off beforehand by appropriate stimuli. Fromm insists (as most contemporary psychoanalysts probably would) that normal aggressive behavior in humans occurs only as a response to frustration. He points out the Darwinian survival value of this inherited instinctual response that man shares with other species in the animal kingdom. And it is at this point that he arrives at his main thesis: beyond this defensive or "benign" aggression, there is a second kind of aggression, found only among humans, that he labels "malignant aggression." This kind of aggression leads man to

kill or torture for no apparent reason, other than the satisfaction he derives from the pure act of destruction. In contrast to the instinctually based defensive aggression, Fromm argues, malignant aggression is rooted in the human character, one of the passions like love, ambition, and greed.

Fromm identifies two kinds of malignant aggression: sadism and necrophilia. He then proposes generalizing the familiar concept of sadism to include nonsexual acts of mental or physical cruelty in addition to the sexual perversion. For example, he points out that Stalin had the sadistic habit of assuring people they were safe when he had already given the order for their arrest. Fromm's main point about sadism is that its essence is the thirst for control: "The core of sadism, common to all its manifestations, is the passion to have absolute and unrestricted control over a living being [p. 288]."

The second form of malignant aggression, necrophilia, is less familiar. Again, Fromm proposes that the concept be generalized beyond the sexual perversion to include "the passionate attraction to all that is dead, decayed, putrid, sickly; it is the passion to transform that which is alive into something unalive; to destroy for the sake of destruction; the exclusive interest in all that is purely mechanical. It is the passion to tear apart living structures [p. 332]."

Whereas the sadistic character's interests fall short of killing his victim (he wants to enslave, with the infliction of unbearable pain as the ultimate proof of his absolute power), the necrophilic character's primary interest is death and destruction. One obvious example of this behavior is the methodical mass murder of Jews in the Nazi gas chambers. A less obvious manifestation of necrophilia, according to Fromm, is seen in the impact of technological society. The dehumanizing effects of living in a "megamachine" society (*à la* Lewis Mumford) devoted to mechanized progress and regimented consumption leads to what Fromm calls the "cybernetic man." This kind of man shows no overt interest in human corpses and other tangible reminders of death; his necrophilia is revealed in his alienation from spontaneous human feeling, his total absorption in

the intellectual world of things, and his identification with the nonliving machines that control him.

Fromm uses extensive descriptive material—examples from case histories as well as detailed biographical studies—to delineate his conceptions of the sadistic necrophilic characters for the reader. He chooses Heinrich Himmler as his prime example of the sadistic character and provides us with an engrossing 25-page study of Himmler's personal life and character traits. However, as the necrophilic character par excellence Fromm points to Adolf Hitler and devotes 64 pages to uncovering the clues to features of Hitler's character that can be discerned from reading the many available sources of biographical information.

Fromm has gone to great effort to pull together a wide variety of clinical data of this kind to illustrate his ideas about sadism and necrophilia, and these pages are the most rewarding in the book. In contrast, his efforts to explain what is of greatest interest about these ideas to practicing psychoanalysts are disappointing. He devotes surprisingly little space to the possible origins of these two malignant character structures in the psychosexual (Fromm would prefer psychosocial) development of the human psyche. The closest he comes to such a formulation are some brief remarks in which he accepts Freud's view that sadism has its origins in the anal period of development and observes that the sadistic character "occurs in those people who are more hostile and more narcissistic than the average hoarding (anal) character [p. 348]." He then suggests that the necrophilic character occurs when the anal personality is combined with a still greater degree of hostility and narcissism, concluding that the necrophile is the most malignant form of the anal character.

Fromm himself admits, however, that this conclusion does not fit the cybernetic man form of necrophilia (presumably the most numerous type found in modern society). The cybernetic man's most prominent features are a deep sense of alienation and lack of affect. Fromm ends the discussion by noting the striking similarities between his cybernetic man and the schizo-

phrenic. However, he questions whether there is not a difference between the two because, although he views the cybernetic necrophile as acting in destructive ways, he points out that adult schizophrenics rarely become actually violent or destructive.

The reader's curiosity is left unsatisfied about the origins of both character structures. Fromm himself is unclear about whether the necrophilic character is primarily a product of the anal period or of the earlier oral period that gives rise to schizophrenia.

I would venture to clarify this confusion by suggesting that in his necrophilic character, Fromm has simply rediscovered the character of Narcissus (or the narcissistic character). Spotnitz pointed out that the myth of Narcissus is best explained by attributing Narcissus' withdrawal and self-preoccupation to defenses against murderous rage toward the object world.[1] Thus Spotnitz suggests that schizophrenia, the most severe of the narcissistic disorders, can be understood as a defense against intense infantile rage in which the rage is turned against the self, resulting in destruction of the individual's own ego and the appearance of the ego-fragmented behavior characteristic of schizophrenia.

Analysis of schizophrenic patients, in my own experience, invariably reveals the presence of this central motivating core of murderous feelings and interest in death and destruction.[2] The anal character wants to control, the narcissistic character wants to murder; and just as the anal character becomes the primary victim of his own powerful urges, so it is with the narcissist.

If we are willing to recognize this motivating force underlying the narcissistic disorders (an observation apparently not widely appreciated in analytic circles), then Fromm's necrophilic character clearly belongs in the realm of narcissism (the early

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[1]Spotnitz, H. *Modern Psychoanalysis of the Schizophrenic Patient.* N.Y. Grune & Stratton. 1969.

[2]Davis, H. L. *Short-term psychoanalytic Therapy with Hospitalized Schizophrenics. Psychoanal. Rev.* 52(4), 1965, pp. 422-448.

oral period of development) rather than in the realm of anality.

A remaining question is whether the necrophilic character (whom Fromm envisions as a nonpsychotic functioning member of the community) actually differs in any essential way from the familiar schizoid character. Although Fromm notes many similarities, he questions whether the schizoid is really destructive to others. Based on our premise that the schizoid is indeed filled with extremely strong impulses to destroy, which are held in check only by equally strong defenses, we would expect that because no psychological defense is ever completely successful, careful analysis will always show that the relations schizoids do have with others reveal many destructive actions similar to those Fromm sees in necrophilics. Thus, using Fromm's framework, we might label the schizoid a well-defended necrophilic. But from the opposite point of view, Fromm's necrophilic can be viewed as a too loosely defended schizoid.

In summary, my reaction to *The Anatomy of Human Destructiveness* is that although Fromm did not reach the conclusion himself, the material he presents reinforces the thesis that the most horrifying acts of human brutality and the most deep-seated and bizarre disturbances in human behavior share a common origin in the earliest months of human development.

Harold L. Davis

GROUP THERAPY 1974: AN OVERVIEW. Lewis R. Wolberg and Marvin L. Aronson, eds. New York: Stratton Intercontinental Medical Book Corporation, 1975. 221 pp.

This book is the second in an annual series: the first was dedicated to the late Asya Kadis, long-time director of the Group Therapy Department, Postgraduate Center for Mental Health. The present collection is dedicated to Nathan Ackerman. Ten of the eighteen papers deal with family therapy; these comprise a well-chosen selection of thoughtful contributions, opening with Donald Bloch's sensitive observations on Ackerman's first paper devoted to the family. In a theoretical contribution, Ravich traces the development of the concept of

complementarity in Ackerman's family process theory. A cogent statement by Feldsteel views the polarization of family therapy and individual therapy as a false dichotomy and calls for a flexible approach to integrating the two approaches according to the needs of the individuals and families involved. Semrad and Grunebaum offer helpful guidelines for evaluating and treating the family of the psychotic patient. Ehrenwald, blending emotional and cultural dynamics, contributes an interesting discussion about one family's psychological heritage and conflicts which were handed down through four generations. Rosenbaum delineates some of the pressures the family therapist must deal with when confronted with the clash of differing value systems within the family and demands that the therapist serve as "social arbitrator and secular priest." In the face of increasingly diffuse models of family living, Rosenbaum finds that Martin Buber's concepts provide a valuable underpinning to an approach that emphasizes the need for dialogue within the family.

The group therapy section contains a far less unified and rather uneven assortment of articles, ranging from Aronson's blending of psychoanalytic and behavior modification principles in a short-term treatment program for overcoming flying phobias to a study of group behavior of a baboon troupe by Kellerman, Buirski, and Plutchik. Durkin presents a comprehensive, knowledgable review of the current state of the American group therapy movement against the backdrop of an accurate developmental history. She discusses conflicts and problems of assimilation and integration posed by the infusion of ego psychology into the older psychoanalytic model, the experiential approach in the 1950s, the impact of the encounter wave, and the swift development of family therapy as a group modality. A too-brief survey of countertransference is rendered by Rabin, who gives appropriate emphasis to the group therapist's transference to the group as a whole and notes Ormont's contribution concerning the therapeutic potential of the objective countertransference. Mintz illustrates the use in marathon groups of several dramatic techniques drawn from psy-

chodrama and gestalt therapy. These scenarios—i.e., "The Trial," "Communication with the Dead," and "Impersonation of the Hated Object"—are presented as facilitating the attainment of emotional insight by patients who might otherwise resist classically rendered interpretations.

In a paper titled "Fight With Me in Group Therapy," Bach describes his technique of aggressive therapeutic group leadership—active participation in fights that occur between members of marathon groups. Although I appreciated Bach's recognition of the value of constructive release of aggression and was impressed by his conscientious pursuit of opportunities in which to engage group members (and co-therapists) in aggressive exchanges, I was left with the uncomfortable impression that this aggressiveness may not always be fully self-disciplined. Bach's assertion that it is not the therapist's job to protect the scapegoat is open to question. But my strongest objection concerned his proclaimed strategy that certain defenses should be attacked.

A transactional approach based on systems theory and utilizing artistic creations made by members as a basis and matrix for discussion is described by Vassilou and Vassilou, who develop the concept of the collective image as a central motif derived from the overlapping projections of individual members. Geller makes a brief statement on the contribution of the interpersonal school of psychoanalysis to analytic group psychotherapy.

This slim book fulfills its primary function of memorializing Nathan Ackerman's pioneer efforts in family therapy. However, by discussing some of his significant contributions to group psychotherapy, the authors would have achieved more balance and enhanced the group therapy section.

Leslie Rosenthal

BOOK NOTES

Unsigned Book Notes are by the Book Review Editor

A PRIMER OF CHILD PSYCHOTHERAPY. By Paul L. Adams. Boston: Little, Brown & Co., 1974.

Emphasizing "know-how applied to procedures and techniques" rather than theory of therapy, Adam's book is primarily a working manual for beginners in child psychotherapy. But fortunately much of his ideology of psychotherapy shines through. He forewarns the reader that his orientation is "interpersonal [largely Sullivanian], both behavioral and dynamic, eclectic, and a bit radical sociopolitically [p. vii]." As those introductory words suggest, the book is pungent, lucid, and somewhat idiosyncratic in tone and content. For example, Adams comments that

> we want to know the mind of the child because we cannot know it. We are impelled to fathom what we cannot fathom and to search for the devices that we have lost irretrievably. Discrete, critical moments—sudden flashes—comprised our own childhood, our *temps perdu,* and it is just these same imponderable flukes of existence which make up the childhood of our offspring and of our patients. To work with children assuredly is to live with unforeseeable and unequilibrated flukes [p. 10].

The longest section of the book concerns the conduct of therapy itself. And there is a final chapter on therapy for the adolescent, which, in its juxtaposition to the material that precedes it, highlights many of the differences between adolescent and child psychotherapy.

SEXUALITY AND PSYCHOANALYSIS. Edward T. Adelson, ed. New York: Brunner/Mazel, 1975.

This book consists of essays by 19 psychoanalysts on the ever crucial subject of interrelations between psychoanalysis and sexuality. These essays were first presented at the sixth triennial symposium of the Society of Medical Psychoanalysts, titled "Sexuality and Psychoanalysis Revisited." In his introduction, Adelson surveys—from Hippocrates to the present—the history of the concept that sexuality and mental illness are related. (Because masturbation, for the past three centuries, has more widely than not been considered a cause of severe mental disorders, his survey deals at some length with the history of that notion.) Discussing libido or sexual energy, Adelson concurs with Colby, Fairbairn, and others who reject the Freudian assumption that the psyche is a closed system ("Energy only has meaning in respect to a field of forces.") and concludes that

> Freud was right in one respect: all our symbolic operations can, in the last analysis, be traced back to a core of early childhood sensory experiences. . . . The growing child constantly identifies its somatic functions with the objects of the external world. The infant constantly analogizes external processes with hearing, swallowing, refusing, taking, getting . . . etc. This is why analysts of the various schools have about the same success rate. [p. 9].

The range of views and content among the other essays can be suggested by citing a few topics they cover: for example, influences of sex hormones on mood and behavior (Lunde), "Nativism vs. Culturalism in Gender-Identity Differentiation" (Money), psychoanalysis in relation to findings of experimental primatology (McKenney), biosocial roots of childhood sexuality

(Bieber), and effects on ego development of sexual experiences in early adolescence (Kalogerakis).

INTERPRETATION OF SCHIZOPHRENIA. 2nd edition. By Silvano Arieti. New York: Basic Books. 1974.

According to Arieti, this second edition of his massive compendium on schizophrenia has been almost completely rewritten and contains "new sections that may be useful to the beginner. These include the manifest symptomalogy of the disorder, its sociocultural and epidemiological aspects, prevention of the psychosis, and genetic and other somatic studies [p. vii]." Only an exhaustive review could presume to deal adequately with this book, which is certainly essential reading for students of modern psychoanalysis, the techniques of which were evolved from the treatment of schizophrenics. Arieti's own therapeutic approach can

> be considered as consisting of four aspects: (1) establishment of relatedness . . . (2) specific treatment of psychotic mechanisms . . . (3) psychodynamic analysis: recognition of unconscious motivation and insight into the psychological components of the disorder . . . and (4) general participation in patient's life, in some cases with the use of a therapeutic assistant or a psychiatric nurse [pp. 546-547].

This approach differs markedly from that of modern psychoanalysis in two respects: Arieti recommends that when establishing a relationship of trust with a patient, the analyst should offer a greater amount of warmth and more verbal gratification than modern analysts usually consider optimum for the development of a narcissistic transference. In psychodynamic analysis of the patient, Arieti recommends more frequent use of interpretations than modern analysts tend to practice. For example:

> The fear, the mistrust, the experiencing of others as monstrous powers and of the world at large as an unbearable pressure from which the patient wants to withdraw in or-

> der not to be crushed, are discussed at an advanced stage of treatment. . . . What we offer is not just an interpretation but also a feeling of understanding and willingness to share some views of the world and to correct others [pp. 590-591].

Those who use Spotnitzian techniques when dealing with schizophrenics should keep in mind that Arieti's presentation of his own psychotherapeutic approaches constitutes only three chapters of this 45-chapter-work—the depth and scope of which are perhaps suggested by the following comment:

> The study of schizophrenia transcends psychiatry. No other condition in human pathology permits us to delve so deeply into what is specific to human nature. [The therapist of the schizophrenic must] . . . deal with a panorama of the human condition, which includes the cardinal problems of truth and illusion, bizarreness and creativity, grandiosity and self-abnegation, loneliness and capacity for communion, . . . capacity for projecting and blaming and self-accusation, surrender to love and hate and imperviousness to those feelings [pp. vii-viii].

THE EMOTIONALLY DISTURBED, MENTALLY RETARDED: A HISTORICAL AND CONTEMPORARY PERSPECTIVE. Earl E. Balthazar and Harvey A. Stevens. Englewood Cliffs, N.J.: Prentice-Hall, 1975.

> The major theme and general purpose of this book [according to the authors] is to present a general and yet definitive description and critique of the literature of emotional adjustment in mental retardation. It represents a major effort to define, analyze, and reconstruct past and present thinking regarding the problems imposed by mental retardation and adaptive behavior; the prevalence of emotional disturbance when it is connected with retardation; the historical aspects of some of the problems associated with emotional disturbances and retardation [p. 3].

The book includes a review of a variety of psychotherapies that are used as remedial techniques with emotionally disturbed retardates. The literature related to psychoanalysis and the retarded shows the psychoanalytic system as "a descriptive

work of intellectual brilliance and psychological insight, and it provides a general source of direction in clarifying the emotional requirements of the retarded child [p. 37]." However, the authors conclude from their review of the literature that as a therapeutic technique for the retarded, psychoanalysis

> conforms to a method of long-term and complex retrospective clinical analysis. . . . Obviously, mental retardates lack the insights and intelligence to be eligible for psychoanalytic therapy . . . and the holistic quality of the psychoanalytic system has contributed to the questionable assumption that reinforcement and reward are the same with the retarded as with the normal child [pp. 37-38].

LEARNING PSYCHOTHERAPY: RATIONALE AND GROUND RULES. By Hilde Bruch. Cambridge, Mass.: Harvard University Press, 1974.

Dr. Bruch has dedicated her book to her teachers, among them Freida Fromm-Reichmann and Harry Stack Sullivan. Apparently they transmitted their interest in treating severely disturbed patients to Dr. Bruch because she devoted considerable space to the management and treatment of schizophrenics. She tries to provide an understanding of the schizophrenic patient by emphasizing that his problems differ in degree rather than kind from those of less disturbed patients. Thus she is able to convey to the reader that although many problems that patients present may seem insurmountable at first, they are not actually so and that, with diligent and careful work, the mantle of obscurity that cloaks the patient and the therapeutic process can be removed.

Dr. Bruch points out several ways this can be done. For example, when treating some patients, it is necessary to involve the family in the treatment process. She also suggests that, at times, judicious use of medication is appropriate and that factors other than the analytic process per se can have therapeutic value. The latter emphasis is particualrly welcome in the context of treating in-patients, where many other factors that impinge on the patient's day-to-day activity can, if properly

managed, be allies of treatment. Searles makes the same point when he relates that therapists tend to denigrate influences such as occupational therapy and act as though psychotherapy is carried out in a vacuum.[1] In sum, Bruch's book offers a number of practical suggestions for the management and treatment of patients and, especially if read in the context of a teaching situation, provides much material for further discussion and clarification.

Michael J. Beck

MANAGEMENT OF EMOTIONAL PROBLEMS OF CHILDREN AND ADOLESCENTS. 2nd edition. A. H. Chapman. Philadelphia: J. B. Lippincott Co., 1974.

Written for "physicians who deal in any way with children and adolescents," except as psychiatrists, this book fulfills its author's promise of being a "comprehensive but simple guide to the emotional disorders of childhood and adolescence." Indeed, Chapman's ability to convey complex concepts related to mental illness in nontechnical prose and his admixture of a number of useful techniques and ideas for counseling children and parents informally make the book a useful primer for almost anyone who is not a specialist in the mental health professions but is interested in understanding the psychogenic disorders of the first two decades of life.

THE ANNUAL OF PSYCHOANALYSIS (Vol. II/1974). Chicago Institute for Psychoanalysis. New York: International Universities Press, 1975.

This volume, edited by the Chicago Institute for Psychoanalysis, consists of 20 compelling articles organized under the general headings of psychoanalytic history, psychoanalysis and philosophy, clinical theory, clinical psychoanalysis, psychoanalytic education, and applications of psychoanalytic theory in other areas.

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[1]Searles, Harold F. *The Non-Human Environment in Normal Development and in Schizophrenia.* New York: International Universities Press. 1960.

Among the articles of special interest to practitioners and students of modern psychoanalysis is "On Narcissism: Beyond the Introduction, Highlights of Heinz Kohut's Contributions to the Psychoanalytic Treatment of Narcissistic Personality Disorders" by Paul H. Ornstein.

> [Kohut's theories] have helped us to delineate a new clinical entity from the entire mixed group of narcissistic disorders and have also clarified the metapsychology and the unanalyzability of the remaining borderline and psychotic conditions. . . . Kohut's method leads to an expansion of the psychoanalytic method without involving the use of parameters. This gives us a more secure "analytic base" from which we can extrapolate theory and technique to the treatment of borderline and psychotic conditions more usefully than it had been possible to do in the reverse direction. In addition, we now have enough compelling analytic clinical data that necessitate a revision of the classical paradigm to incorporate Kohut's findings into what might well turn out to be a contribution toward a unified theory of the psychoanalytic treatment process [p. 147].

C. G. JUNG AND THE SCIENTIFIC ATTITUDE. By Edmund D. Cohen. New York: Philosophical Library, 1975.

If you want to learn about C. G. Jung as a psychotherapist or a systematizing psychologist, this book will provide you with minimal information. Start instead with *Theories of Personality,*[1] by Hall and Lindzey. If you want a critical evaluation of Jung's scientific methodology, you will also be disappointed. But if you are interested in knowing how uncritical and unanalyzed impressions are passed on from master to disciple, this book may be instructive.

A lack of critical judgment pervades Cohen's attempt to define Jung as a scientist. Since he provides no critical basis for deciding what scientific means, he does not stick to his topic. Cohen deals with Jung's early experiments with the Word Association Test and his mapping of the psychological attitudes and types as though they are on a methodological par with his later

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[1]Hall, C. S., & Lindzey, G. *Theories of Personality.* New York: Wiley, 1957.

"experiments" with UFOs, psychokinesis, prevision, visitation by ghosts, oracular consultations of the I-Ching, and synchronicity. Jung described synchronicity as the simultaneous occurrence of certain psychic and physical events that could not be explained in terms of space, time, and causality.[2] In one favorite example, a patient tells Jung about a dream in which someone gives her a golden scarab, an impressive piece of jewelry. During her narration, Jung notices a rapping on the window. When he opens the window, a gold-green scarabaeid beetle flies into his hand. He turns and says to his patient: "Here is your scarab."

Cohen is all the more impressed by Jung's welcoming attitude toward experiences that defy scientific explanation because it represents a reversal of Jung's earlier approach. In his doctoral dissertation, Jung traced the voices and personalities that spoke through a 15-year-old psychic medium to suggestions the youth had internalized at an unconscious level. In the fuller wisdom of his maturity, however, Jung tended to view similar cases as actual spooking by autonomous, free-floating complexes of persons living or dead.

Cohen himself is no stranger to the paranormal: he was briefly telepathic at age 13, and while attending the C. G. Jung Institute he was encouraged to write this book during a consultation with the I-Ching. This reviewer too is willing to be encouraged by means of telepathic communications, spooks, or synchronistic happenstances. But until the relevant factors can be analyzed and manipulated instrumentally, they remain outside the arena of science and psychotherapeutic technique. *C. G. Jung and the Scientific Attitude* illuminates neither Jung, his scientific attitude, nor the "paranormal" phenomena that are so intriguing.

Gerald M. Lucas

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[2]Jung, C. G. & Pauli, Wolfgang. *The Interpretation and Nature of the Psyche.* New York: Bollingen Foundation, 1955.

ALTERATIONS IN DEFENSES DURING PSYCHOANALYSIS. ASPECTS OF PSYCHOANALYTIC INTERVENTION. Bernard D. Fine and Herbert F. Waldhorn, eds. Monograph VI of the Series of the Kris Study Group. New York: International Universities Press, 1975.

This volume of the Monograph Series of the Kris Study Group of the New York Psychoanalytic Institute contains the two cited papers. *Alterations in Defenses During Psychoanalysis* presents

> the principal ideas concerning the fate of defenses in the course of psychoanalysis that emerged from the work of a Section of [the Group]: What psychoanalysts call "a defense" is not a *thing.* It is an aspect of mental functioning that can be defined only by its *purpose,* in this case, to ward off a dangerous instinctual or supergo derivative. . . . The same . . . ego functions that serve instinctual gratification under one set of circumstances are used as defenses at other times. [In psychoanalysis, if effective,] . . . it is the need for a defensive posture . . . that has lessened or disappeared, not the means that are used for this purpose [pp. 20-22].

The other study, *Aspects of Psychoanalytic Intervention,* explicates interpretation and other interventions in

> three corresponding fields of observation: (1) the viewpoint of general psychological theory; (2) the viewpoint of clinical effectiveness; (3) the viewpoint of the psychoanalytic situation and process. [The third viewpoint involves the need to consider] the criteria by which the responses of the patient are judged. The focus of this study is upon those responses which are in the direction of development of the psychoanalytic process and, from this view, may be arranged in an approximate hierarchy: recognition, recall, integration, and analytic insight [pp. 91-93].

THE NATURE AND TREATMENT OF DEPRESSION. Frederic Flach and Suzanne Draghi, eds. New York: John Wiley & Sons, 1975.

In introducing this outstanding and eclectic compilation on the nature, causes, and treatment of depression, Flach and Draghi note that the purpose of the book is "to present the problem of depression in a broad and encompassing manner and to avoid the hazards of absolutism, which, although appealing as a way of seizing attention and quieting the scientist's own insecurities, serve well neither the patient nor the search for truth [p. 9]." Topics treated by the editors and other contributors include intrapersonal and interpersonal dynamics of depression; depression in children, adolescents, and the aged; the use of dyadic, group, and family psychotherapy in the treatment of depression; pharmacotherapy, convulsive therapy, and biological treatments; genetic studies of affective disorders; and endocrine factors in depressive illness.

PRACTICAL AND THEORETICAL ASPECTS OF PSYCHOANALYSIS. Revised edition. By Lawrence Kubie. New York: International Universities Press, 1975.

This book is the second revised edition of *Practical Aspects of Psychoanalysis,* which was originally published in 1936. Its intent, now as then, is "to help people recognize sound psychoanalytic procedure when they meet it. . . ." The following comments were extracted from a comprehensive review by Oscar Sternbach:

> Kubie describes himself, and rightly so, as a deviationist from Freudian psychoanalysis. His tendency to deviate, noticeable quite early, increased considerably with his growing age. However recent his theoretical deviations, by which he attempts to make psychoanalysis more modern—though making it less Freudian—his book shows many of the earmarks of a bygone era. . . . [For example,] in line with the oldest id-analysis, he holds that the unconscious is not "normal," i.e., it is pathological, taking no cognizance of the fact that even the most normal ego is largely unconscious—which must have been known at least since 1923 (Freud's *The Ego and the Id*) to Kubie too. But Kubie rejects ego-analysis as a term as well as a technique. In a curious way, he finds his scientific position compatible with an op-

> timistic and happy indeterminism, which promises that "to the extent . . . to which conscious processes govern our lives we are free. . . . Such freedom . . . is the essential core of normality . . . normality means freedom." His technical advice is, one might say, "hyper-orthodox." Among other statements, he says that experience has proved that it is not possible for the analyst to advise and guide a patient in his practical affairs without seriously undermining his value as analyst. This point of view, although it was held for years by many analysts, is quite in contrast with Freud's statement in his *Outline of Psychoanalysis* in 1940: "We serve the patient in various functions, as an authority and a substitute for his parents, as a teacher and educator. . . .[1]"—which shows that Freud, even late in life and analytic experience, was much less worried about technical "purity".

PSYCHOANALYSIS AND FEMINISM. By Juliet Mitchell. New York: Vintage Books, 1975.

This paperback edition of Mitchell's effective but—because it is not written in a style that is appropriate for a mass audience—not yet widely read book, confutes the view held by

> the greater part of the feminist movement [that] has identified Freud as the enemy. It is held that psychoanalysis claims women are inferior and that they can achieve true femininity only as wives and mothers. Psychoanalysis is seen as a justification for the status-quo, bourgeois and patriarchal, and Freud in his own person exemplifies these qualities. I would agree that popularized Freudianism must answer to this description; but the argument of this book is that a rejection of psychoanalysis and of Freud's works is fatal for feminism. However it may have been used, psychoanalysis is not a recommendation *for* a patriarchal society, but an analysis of one. . . . Feminist critics of Freud have . . . extrapolated his ideas about femininity from their context within the larger theories of psychoanalysis. [In addition, the feminist movement,] if less deliberately. . . . , has embraced the alternative radical psychologies developed by Wilhelm Reich's work on sex-

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[1]Freud, Sigmund. *An Outline of Psychoanalysis.* In Standard Edition, Vol. 23, p. 181. London: Hogarth Press, 1964.

> uality and R. D. Laing's on the family. . . . But it seems to me that we have turned things on their head by accepting Reich's and Laing's analyses and repudiating Freud's. . . . Reich's political and Laing's sociological observations provide us with a good deal of important material, but I do not believe that we can use these observations until we have freed them from the dubious theoretical and philosophical frameworks in which they are set [pp. xiii-xx]."

The book should be read, or at least sampled, by any who reject Freudian-based analysis because they "disbelieve in penis envy."

GROUP PSYCHOTHERAPIES FOR CHILDREN: A TEXTBOOK. By S. R. Slavson and Mortimer Schiffer. New York: International Universities Press, 1975.

This book by S. R. Slavson, eminent for his work in group psychotherapy with both adults and children, and Mortimer Schiffer, a practitioner of group psychotherapy with children, was published too recently to be reviewed in this issue. However, it should be pointed out that the authors distill "experiences of four decades with many thousands of children in a great number of groups of different modalities and in different situations." The book contains separate sections on activity group therapy, activity-interview group psychotherapy, play-group therapy, and the therapeutic play group—each with protocols and case histories. A review will appear in the next issue of this journal.

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NATIONAL REGISTRY OF PSYCHOANALYSTS AND PSYCHOANALYTIC PSYCHOTHERAPISTS

If you are not a member of the National Accreditation Association for Psychoanalysis, but you are a trained psychoanalyst or psychoanalytic psychotherapist, we invite you to apply for individual certification by the NAAP.

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4) Supervised psychoanalytic practice—minimum of two analytic controls totaling 100 hours.

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