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SELF PSYCHOLOGY NEWS

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Information

Masthead

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Notes

Editor's Introduction

Christine C. Kieffer, Ph.D.

I invite you to explore what seems to me to be a very rich newsletter issue: it contains synopses of key programs from the 2005 conference in Baltimore last fall

- both for the benefit of those who could not attend and also for those who would like to review the highlights. As usual, the issue contains an interview, this time with Jessica Benjamin, who, while not among those who identify themselves as Self Psychologists, offers insight and theory that can add much to the richness of our existing models. Other feature articles and op-eds included in this year's newsletter offer descriptions and commentary on conferences and programs which have been conducted in other parts of the world, and some showcase treatments that have integrated Self Psychological approaches with other forms of treatment, notably Cognitive Behavior Therapy. Other essays offer innovative programs that use Self Psychological principles to reach out to new treatment populations.

In keeping with the improvisational, co-constructed and multiple-perspective spirit that has characterized the programming of recent Psychology of the Self conferences, I would like to suggest a new feature of the Newsletter, that will make its appearance next year: A Letters to the Editor Section. But we need *your* participation in order to create this column. As you read the various articles in this year's newsletter, please take some time to consider writing back with your reactions, comments, criticisms and questions. I will try to publish as many letters as possible in the 2007 edition of the newsletter.

Notes

Notes from the President

James L. Fosshage

I am very pleased to announce that IAPSP has had an extraordinary first year. The only international professional membership association dedicated to the development and dissemination of Self Psychological ideas, IAPSP currently has over 430 members and continues to grow.

Featured accomplishments include:
a stimulating 28th Annual International Conference on The Psychology of the Self, held in Baltimore, Maryland, October 20-23, 2005, that featured contemporary developments and trends in Self Psychology; the inclusion of all past volumes of Progress in Self Psychology in the PEP CD ROM Archives; the launching of our new quarterly journal under a new name, the *International Journal for Psychoanalytic Self Psychology* , which will be included in the PEP CD ROM Archives; the establishment of the IAPSP Membership Roster , listing all of our members alphabetically and geographically, available to all professionals for referrals and networking; and the expansion of our interactive eJournal , on-line activities that include an international chat room, seminars and reading groups. The establishment of a welcoming committee at our annual conferences where senior professionals are assign to "newcomers" to introduce them to others; initiation of a major effort to make IAPSP indeed an international association - for example, plans are in the making for our annual conference in October or November of 2008 to be held outside North America; and panel papers

at our conferences will be available for purchase in the following languages, thus far: English, French, Portuguese, and Spanish (professionals have volunteered to translate the papers). The establishment of an IAPSP Committee to Promote Membership: chairs in each city, region or country will appoint a subcommittee to reach out in a major membership drive. If you are interested in participating, look below at the Committee member list and contact your chair.

We thank you for your contributions to IAPSP. We hope that you will encourage your friends to join as well.

I welcome your suggestions for IAPSP (fosshage@psychoanalysis.net).

My fellow officers, Gianni Nebbiosi, Ph.D., Treasurer, Estelle Shane, Ph.D., Secretary, and Paul Ornstein, M.D., Past President, join me in sending you our warmest wishes,

James Fosshage, Ph.D.
President

IAPSP Committee to Promote Membership

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New Zealand

Self Psychology Around the World

Self Psychology in Australia Today: A Snapshot

S. Giac Giacomantonio

Self psychology in Australia enjoys the same diversity and multiplicity of identity as it does in the United States. Not only are there representatives of each of the major sub-theories of self psychology, but there is even something of an analogous, geographical stratification of approaches.

In the U.S., self psychology was born in the heart of the psychoanalytic movement, though claims to the proper understanding of self psychology seem today to be made both by those who see it as psychoanalysis proper, and those who are as proud to be outside of orthodox psychoanalysis as they are to be self-psychologists. In Australia, self psychology seems not to have found a bona fide place in the curriculum of any institute affiliated with the International Psychoanalytical Association. Instead, self-psychological ideas have been disseminated mostly through other psychotherapy training programmes, with few individuals in the psychoanalytic establishments incorporating it in their supervision/training analyses etc.

I interviewed a number of people for this article, each of whom would be easily identified in Australia as having strong ties to self psychology. I present them organised by geography. This brief article cannot supply an exhaustive list of those of self-psychological influence in Australia, and it must be pointed out that inclusion/exclusion was to some degree an exercise in 'convenience sampling'.

SYDNEY

Russell Meares has devoted his professional career to furthering our understanding of treating the more severely disturbed patient. He trained as a psychiatrist in London, and cites as two of his greatest, initial influences, the work of his father, Ainslie Meares, and his close colleague Robert Hobson, both of whom had been devoted to studying new possibilities in the treatment of intractable psychopathology. Meares has been identified with Hobson as co-author of the "Conversational Model." For readers unfamiliar with the Conversational Model,

Meares describes it by saying that the patient "presents in a form of conversation that is a manifestation of his or her current kind of consciousness. A form of consciousness is the resultant of a particular interplay of the brain with the environment. This interplay is mediated, in terms of the social environment, by conversation. The therapeutic aim is to develop a particular kind of conversation with the patient that is necessary to the brain-state that underpins the emergence of that larger and more coherent form of consciousness William James called self."

After moving to Australia in 1969, Meares was appointed to a chair in Sydney at Westmead Hospital in 1981, and began a Masters programme for training psychiatric candidates in psychotherapy, a programme that continues to this day. At about this time he met Robert Gordon who was another key figure in the introduction of self psychology to Australia (see below), and they and a number of others established a faculty to develop and teach a psychology of the self that would integrate the various traditions of the respective backgrounds of its members. These included self psychology (Craig Powell), middle group psychoanalysis, Sullivanian perspectives, and the Conversational Model. This psychology of the self included, but was not exclusively like, the psychoanalytic one developed by Kohut and his colleagues.

From 1983, Meares led the establishment of annual meetings in Sydney and, over the next 12 years, many of those in the U.S. who were central to the developing world of self psychology (including Brandchaft, Stolorow, the Ornsteins, Goldberg, Bacal, Strozier and Lichtenberg, among others) were brought to Australia. The impact of these visiting speakers on the developing scene in Australia is difficult to overestimate, and was emphasised by many of those interviewed for the present article.

In 1989, the Master of Medicine programme at Westmead Hospital was replicated in a parallel programme that permitted non-medical candidates to take the same psychotherapeutic training afforded to registrars. The Australia and New Zealand Association for Psychotherapy (ANZAP) was born, with Meares as the foundation president. With requests from a number of other cities across Australia and New Zealand, ANZAP was to offer training in Perth, Melbourne, Canberra, Christchurch, and Townsville, demanding much of the training staff who often travelled regularly to these other centres for supervision.

Today, the ANZAP group continues its tradition of training and rigorous research into the treatment of the more fragile patient. Alongside its training in the Conversational Model, ANZAP continues to be one of the most important institutes in the country for the training of self psychology theory, and both Meares and former ANZAP President, Tessa Philips were appointed to the International Council of Psychoanalytic Self Psychology.

Meares has recently received a (much coveted) NHMRC grant to study linguistically the conversations of psychotherapeutic treatment, and has established a new laboratory for the neurobiological study of unconscious emotional processing in subjective states of trauma.

Robert Gordon is a psychiatrist in Sydney who had been attending regularly the self psychology conferences in the U.S., after being first inspired by the introductory article of Wolf and Kohut, published in 1978 in the *International Journal* . Gordon felt that he had finally found a theory that would contribute more than any other to his being able to "understand human beings"; though for Gordon, self psychology might be better thought of as a 'process', than a 'theory'. Since his initial contact with self psychology, it has remained a central theme in his writing. In his own work, he recognises the input of the many perspectives from the contemporary field today, with influences from dynamic systems theory, affect theory, the work of Mitchell, and a special place for the theory of intersubjectivity.

When he met Meares for the first time, Gordon had sensed that Meares' original work was investigating lines similar to those of some self psychologists in the U.S.; they began working together. Gordon was Head of the Department of Psychotherapy when the Masters Programme commenced at Westmead Hospital, and continued to be involved in the training programmes for many years. He described these years with a fondness and affection for his colleagues, and with a sense of admiration for the high standards of teaching and practice attained in the training programme.

Suffering from compromised health, Gordon resigned from ANZAP in 1993. A year later he and his then-wife Kerry Egan founded the Institute for Contemporary Psychotherapy (ICP), which offered a programme based heavily on self psychology. The ICP continued to train successive cohorts, including a number of students in Canberra, before dissolving in 2002 after the dissolution of the marriage between Gordon and Egan. Gordon then taught at the Australian College of Psychotherapists (the member organisation of the ICP) for a year, but since then, although continuing to supervise, he has focused mainly on his clinical practice.

Craig Powell is a psychoanalyst affiliated with the Sydney Institute of Psychoanalysis, and the New South Wales Institute of Psychoanalytic Psychotherapy. He is singular amongst those interviewed for the present article inasmuch as he is the only psychoanalyst mentioned with connections both to self psychology and to the Australian Psychoanalytical Association. Self psychology might still be thought of as an 'adjunct' theory in the curricula of the psychoanalytic training programmes in Australia, most of which programmes were heavily Kleinian when Powell immigrated after his psychoanalytic training at the Toronto Institute of Psychoanalysis. (Powell remembered with amusement how a colleague at the institute in Sydney confessed that Kohut had for many years been thought of as 'the devil'.) A self-psychological viewpoint is available to psychoanalytic candidates only if they happen to encounter one of a few teachers (either as supervisor, or leader of case conferences, etc.,) of which Powell is one.

Powell laments the ongoing lack of cooperation and harmony in Sydney between the psychoanalytic society and the individuals and institutes otherwise mentioned herein, having been himself one of the few bridges between them. His own training experiences spanned the worlds of Object Relations and self psychology, as did his training analysis with Howard Bacal, and his own work reflects this

integration.

MELBOURNE

Ronald Lee was first alerted to the work of Heinz Kohut in 1971, when he was professor of pastoral counselling at Northwestern University. A colleague had recommended him to read the new title, *The Analysis of the Self* , with the endorsement that it would change his life. Lee devoted a two-week vacation to reading the book, and says that it was only his stubbornness that helped him endure an initial reaction of utter confusion, such that he might arrive finally at an understanding he still describes as "thrilling". Lee began to pursue these new ideas by attending presentations at the Chicago Institute, and during the 1980s he attended the lectures at Cape Cod over a number of years. At these lectures he was exposed to a variety of developments of Kohut's work, most of which are represented today by the pluralism we see at our annual conferences.

In 1984, Lee returned to his native Australia, to live in Melbourne. Here he established a private practice, "Empathink", with a life-long friend and colleague, Brian James. He was dissatisfied with the options for psychotherapeutic training in Melbourne at the time, because many were not open to including self psychology, while those that were, had strayed from the tripartite emphasis on personal treatment, supervision, and didactic training. Empathink continues to offer these three pillars from a contemporary, self-psychological perspective, in a city with a strong tradition of biologically based, psychiatric treatment. Today, Lee also lectures in self psychology at the University of Melbourne's Department of Psychiatry.

For Lee, the tenets of self psychology lead inevitably to a clean break from psychoanalysis, which he feels cannot adequately contain the innovation of Kohut's work. He feels that the many theoretical perspectives we see today can be meaningfully linked or united by tracing their conceptual origins to a small number of postulates of Kohut - *Postulates of Kohut* being the subject and title of a new book he is currently writing. Lee regularly holds an annual Self Psychology Summer School in various cities in Australia, in which there is an emphasis placed on both learning classical self-psychological theory and exploring new, original contributions.

CANBERRA

In Canberra, a group of psychologists operates the local branch of the Australian Psychological Society's Psychoanalytic Interest Group, with a heavy focus on self psychology. Malise Arnstein, Sandra Kay Lauffenburger, and Carol Clark have organised a regular seminar series over the last three years, and have begun to collect a small library of books on psychotherapy and self psychology. Although they do not operate a training programme *per se* , they offer self-psychological treatment and supervision. Institutes in Sydney have offered the Canberra arm of their training programme with the assistance of this group.

The group began in 1997, when Bruce Stevens and Margaret Groube approached

Arnstein to bring Robert Gordon and Kerry Egan (from the then 'Institute of Contemporary Psychotherapy' [ICP]) to Canberra to give an introductory workshop. This soon led to a number of people taking training in Canberra from the ICP, and the beginnings of the group were born. Some of the influences still evident in the group today include the work of Kohut, Ron Lee, Nancy McWilliams, Fonagy, Brandchaft, and an emphasis on neuro-psychoanalysis.

BRISBANE

The Brisbane Psychoanalytic Self Psychology Group was founded by Giac Giacomantonio and Tony Wild, two psychoanalytic therapists interested in self psychology, and working in a town that self psychology had not yet touched. Wild and Giac. discovered their common interest by chance, while working as psychiatrist and psychologist (respectively) on the same case. They found that they had both gone outside of Brisbane to find mentors in self psychology, Wild with Ronald Lee and Giac. with Ernest Wolf and Arnold Goldberg. In addition to establishing the Brisbane Group, Wild and Giac. have sought to promote self psychology through their lecturing and supervisory work in the post-graduate training programmes of psychology and psychiatry candidates.

The Brisbane Group (with a subscription list of some 80 members) is currently devoted to bi-monthly literature readings and discussions, with additional presentations by invited psychoanalysts from time to time. The Group makes psychoanalytic texts available to members, and has donated a number of otherwise absent titles to the local Universities. No formal treatment or supervision is offered under the appellation of the Group, though Wild and Giac. offer privately both self-psychological treatment and consultation. Not having a formal teaching programme *per se* , the Brisbane Group cannot be said to have a unified opinion or official, 'sub-theoretical' allegiance, though a number in the Group could be said to be "classical" self psychologists, believing (for example) that theories like intersubjectivity and the Relational perspective lie outside the boundaries of psychoanalysis, for philosophical and conceptual reasons. Instead, the Group maintains a healthy diversity of opinions, with disagreement and debate marking the discussions of every meeting.

In Australia, psychoanalytic approaches to mental health treatment seem to have grown in popularity both in the academy, and in the private practice of psychotherapy. Accordingly, self psychology has grown in popularity amongst professionals and students in the mental health disciplines. Across the space of a couple of decades, a relatively small number of scholars brought the self-psychological approach from the U.S.. These teachings were as diverse and numerous as the individuals in question. Some were more original than others. Some were more traditional than others. But each of them has transmitted to a new generation the excitement and enthusiasm that seems always to be found in communities of self psychologists. And they all have left a legacy of inquiry, interest in dialogue, and the persistent quest for better understanding.

Acknowledgements

I wish to thank Malise Arnstein, Robert Gordon, Ronald Lee, Russell Meares, Craig Powell, and Tony Wild for their time in granting me interviews in one or another medium.

Self Psychology Around the World

Review of Joseph Lichtenberg's *Craft and spirit*

Tony Verner

Book review. Lichtenberg, J.D. (2005). *Craft & spirit: A guide to the exploratory psychotherapies* (Vol. 20 in the Psychoanalytic Inquiry Book Series). Mahwah, NJ: Analytic Press. 216 pp. US$45. ISBN 0881634336.

Craft and spirit is 'written to inform not only patients contemplating intensive psychotherapy but also experienced therapists and those in training' (p. vi). I am not sure that many patients would have the commitment to read it all the way through, but clearly this is a valuable book, especially for psychoanalytically-informed therapists. It has a strong practical focus, with the 10 chapters dealing with each of the 10 principles or guidelines of technique set out more briefly in Lichtenberg, Lachmann and Fosshage's 1996 book *The clinical exchange* . In that book, one nine-year analysis of Lichtenberg's patient, Nancy, was given comprehensive coverage, with a very useful lengthy transcription of interactions between patient and therapist. This showed us that experienced contemporary psychoanalysts use many different interventions than classical interpretation. In *Craft and spirit* there are 30 cases (of Lichtenberg's, Lachmann's and Fosshage's) actually described, but with less lengthy transcriptions. (I would be interested to know by what method the transcriptions were obtained.) There is also less focus in *Craft and spirit* on the five motivational systems enunciated by Lichtenberg and his colleagues in previous publications.

Craft and spirit is well written and a delight to read. Consonant with his theory, Lichtenberg is quite transparent about how he actually works, triumphs and stumbles included. There are some wonderful examples given of what Lichtenberg and his colleagues describe as "disciplined spontaneous engagements" on the part of the therapist, which certain more orthodox psychoanalysts would blanch at. This willingness to be flexible, innovative and pragmatic in his technique, in empathic resonance with the patient, is the hallmark of Lichtenberg. Lichtenberg is integrative in his approach, diverging in many significant ways from classical ego-psychological and even self-psychological technique and theory. In addition to these traditions, he draws from infant research, attachment theory, neurophysiology, systems theory, intersubjectivity and relational psychoanalysis. A useful list of those works which have influenced Lichtenberg's thinking is contained in the Notes section of this book. I particularly recommend the two autobiographical articles cited there, as well as Teicholz' interview of Lichtenberg in the Summer 2004 edition of *Self Psychology News* (http://www.psychologyoftheself.com/newsletter/2004/teicholz.htm).

An innovation of this book is Lichtenberg's combining under the rubric of 'exploratory, investigative or intensive psychotherapies' psychoanalysis and psychoanalytic psychotherapy. This amalgamation, he implies, is something that would not have been possible 25 years ago when he wrote his first book *The talking cure: A descriptive guide to psychoanalysis* . Both psychoanalysis and psychotherapy now both 'involve two interactive subjectivities where therapists must sense themselves, and be sensed by their patients, as fully and emotionally involved in the treatment' (p. viii). Lichtenberg sees therapists as now 'more on stage'. There is greater involvement and transparency, but this, he points out, must not be allowed to interfere with the traditional freedom of exploration on part of the patient. 'The biggest difference between analysis and psychotherapy lies not in the principles of technique used, but in the opportunity provided by the frequency of the sessions and an open-ended mutual commitment' (p. vi). (Lichtenberg does not touch upon the extensive literature of brief or time-limited psychoanalytic psychotherapy; nor, unlike Wachtel or Mardi Horowitz, the overlaps between analytic and non-analytic psychotherapies.)

Another change that Lichtenberg believes has occurred over the last 25 years is that traditional 'ideal-for-analysis patients' have proved to be extremely rare and analysis has become increasingly sensitive to personality or characterological problems and the many impediments that limit free association. This, in his view, creates a need for fresh consideration of technical guidelines. Lichtenberg, who tends not to conceptualise cases in terms of DSM-IV diagnoses, contends that most patients bring to therapy, backgrounds of insecure attachment (preoccupied, anxious-resistant, disorganised) and serious concerns about safety and being again traumatised.

Lichtenberg sees effective psychotherapy as being a balance between rule-based consistency (which provides a frame of safety for the patient) and a spontaneity on the part of the therapist which helps provide an aliveness, creativity and depth to the co-constructed narrative of the patient's life. A sense of safety, a secure base, leads to more open and direct communication, and vice versa. "Progress in therapy combines therapists being guided by their intuitively sensing the likely positive impact of an intervention and being free on occasion to risk an intervention outside the known safety zone.... the art of conducting a successful exploratory psychotherapy lies in listening, understanding, and articulating within the boundaries of a predictable intersubjective field of safety while remaining open to humour, novelty, and improvisation" (pp. 181-182). This is therapy as a highly skilled craft.

An important concept for Lichtenberg is what he calls 'a spirit of inquiry'. This is, I presume, more fully enunciated in his previous book with Lachmann & Fosshage (2002) *A spirit of inquiry* . The term is defined in the present book as "the ineffable something more than the craft and the doing of listening, understanding, and interpreting. It is the humanist trend that combines the healer's altruism with a therapist's approach to exploration through sensing into another to gain a depth of knowledge of the other, the self, and the emergent experiential world they create together" (p. xiii).

Lichtenberg's 10 guidelines for exploratory psychotherapy are:
Arrangements that establish a frame of friendliness, consistency, reliability, and an ambiance of safety
Systematic application of the empathic mode of perception - 'sensing into the mind-states of others' (and of the self)
*Discerning a patient's specific affect to appreciate his or her experience; and discerning the affect experience being sought to appreciate the patient's motivation
'The message contains the message' (this is contrasted with the view of classical psychoanalysis that the true message of the patient is always concealed). Therapist and patient open communication to its fullest revelation
Filling the narrative envelope (to better grasp the patient's narrative, the therapist asks 'who, what, where, when, and how' questions of events)
*'The wearing of attributions', i.e. the therapist accepts the reality of the patient's experience of the therapist
*Joint construction of model scenes - bringing the theatre of the mind onto the patient-therapist stage. The elaboration of one or more model scenes, metaphors or schemas integrates disparate aspects of the patient's experience, past and present
*Aversive motives (resistance, reluctance, defensiveness) are a communicative expression to be explored like any other message - what are the messages that a patient does not want the therapist or himself/herself to know?
Three ways in which therapists intervene to further the therapeutic process:
Most frequently, the therapist's interventions are based on empathic listening and are presented from the patient's point of view
Illuminating a recognisable pattern, or communicating feelings, appraisals, or impressions from the therapist's own perspective
*Disciplined spontaneous engagements
Following the sequence of interventions and the patient's responses to them to evaluate their effect.
*The techniques marked with an asterisk I find particularly useful.

Conclusion:

Lichtenberg is both a practicing psychoanalyst and psychotherapist. This is far from rare, but it is still unusual to have one of the major figures who writes regularly in the top psychoanalytic journals focusing in depth on the common reality of psychoanalytic psychotherapy practice. (Wallerstein is another major figure who immediately comes to mind. The field of self psychology has been blessed with other notable exceptions: e.g., Basch and Ringstrom). It is over 50 years since Alexander, Gill and others bravely brought the skeleton of psychoanalytic psychotherapy out of the closet into the pages of the *Journal of the American Psychoanalytic Association* (1954). Since then the bastard son, the shameful mutant, has morphed into many strapping even dominant offspring. 'Dominant' in the sense that psychotherapy, both extensive and brief, has become far more widely practised and acceptable to the vast majority of psychotherapy patients. It is evident that most of those trained as psychoanalysts are conducting relatively few 'psychoanalyses', according to traditional criteria such as frequency and purity of technique (free association, therapist abstinence/neutrality/anonymity, pure interpretation of transference or resistance, and so on). Many 'true' psychoanalyses appear to be carried out on trainee

psychoanalysts or other therapists. Despite this, what I observe in my little part of Australia, amongst the beleaguered few who read psychoanalytic texts, is a sort of benighted worship of ancestors, involving what appears to be a huge gap between what we discuss in our seminars and reading groups (disputing how many angels fit in the eye of a needle) and actual therapy practice.

Presumably there will always be a need, and an ability to pay, by some patients for psychoanalysis, traditional or contemporary. Psychoanalysis still remains by far the richest and most insightful paradigm explaining human function, dysfunction and psychological healing. It has therefore much to offer trainee therapists of today, be they psychiatrists, psychologists, family therapists or counselors. Psychoanalysis' future lies with seeking interdigitation or ecumenical dialogue (not capitulation) with the dominant paradigms in these fields, namely neurobiology, CBT, systems theory and constructivism. Psychoanalysis ignores these fields, and the attempts to resolve conflicts between them through research, at the peril of increasing marginalisation.

Joseph Lichtenberg, at an age when many are lured by the sirens of resignation, is still courageously and energetically leading the way towards more fruitful integration and the amendment of psychoanalytic theory to more closely resemble psychotherapy practice. He is an inspiration to many of us at the farther reaches of the world.

Tony Verner is a psychodynamically-informed psychologist, member of the Brisbane Psychoanalytic Self Psychology Group, who is Program Leader for relationship counselling and education in Relationships Australia Queensland, a community-based counselling organisation. He is an ex-diplomat, university administrator and art gallery owner. He also has degrees in literature, economics, administrative studies and clinical hypnosis. (tverner@relateqld.com.au).

The Gay Community

Introduction

R. Dennis Shelby

Some time ago at an analytic discussion group, I caused a bit of a stir when I offered my view that disclosing or revealing my orientation to a patient or anyone else, was not revealing a great deal about me as an individual. I was surprised at the reaction. The person leading the discussion (a heterosexual training analyst) was quite flustered and accused me of being glib. He emphatically stated that orientation was about everything: that it was about Libido! Several gay analysts reacted with alarm and anger. Yet no one could tell me why they disagreed, why orientation was about everything, or why they were so angry.

A common myth about gay and lesbian psychotherapists who specialize in working with gay and lesbian patients is that treatment is dominated by "sameness," "familiarity," or "mutual recognition." Like many observations and assumptions, it has some surface validity, but beyond readily recognizable characteristics, the idea of sameness begins to crumble. The human mind is far too complex, far too nuanced in its gross and subtle differences to assume that sameness dominates the clinical encounter when both parties are of the same orientation.

The following account of a clinical encounter illustrates the many levels of difference gay and lesbian therapists encounter in their daily work. Boris is an African-American gay man and a doctoral student. He comes from an enriched home life and has a law degree and an MSW from a prestigious university. His patient comes from a deprived, poverty-stricken family. She identifies herself as bi-sexual, is of mixed ethnic heritage, and was exposed to traumas in the course of her development that are far from Boris' life experience. But they still manage to make sense to each other. A useful transference develops and Boris accepts it and works with it.

The case write-up is a wonderful illustration of how very different the patient and therapist often are. This is often the case with the gay and lesbian clinician and their patients. Similarities are seemingly important, yet at times hard to observe. No matter how the patient and therapist identify themselves, they must still find common ground. That common ground goes deeper than social identification. But the question still remains: how important is the act of seeing a therapist of a similar orientation? It is very important for some patients, and many therapists make their living specializing in working with people of their own orientation. Despite this important degree of sameness, or alikeness, or recognition, differences remain that must be bridged. Perhaps it is the bridging function of the selfobject transferences that give each treatment its unique aspects. As usual I encourage people who agree or disagree to write, and offer their ideas to this endeavor.

The Gay Community

Defense Against the Traumatized Self and the Corresponding Challenge to the Therapist's Empathic Attunement

Boris Thomas, LCSW

This article is no longer available.

Musings to Regulate Myself

Amy Eldridge

How can you do this to me? You are disrespectful, self centered, you don't understand my life. You don't understand *me* . . .. The message goes on to list, with great indignation, injury after injury. I am portrayed as harmful and useless. By needing to change an appointment time to accommodate my travel schedule, I feel as though I am brutalizing my patient. Worse, I feel that the very essence of my being is under attack. We all know this type of call.

I construct many return messages in the wireless phone system in my head. I fight the feeling of being attacked with angry, retaliatory messages. I protect myself with defensive, self righteous messages. I restore my sense of power by threatening abandonment, which I could justify as a reasonable response to my patient's portrayal of my chronic uselessness and hurtfulness. Ultimately, I calm down, my self restored, and begin to think about the meaning of the message, the process that had provoked it, and struggle to find a therapeutic response to it. This is a familiar pattern with this patient; a woman who had suffered extreme abuse at the hands of a psychotic mother.

How do I respond? Do I take an empathic point of view; try to enter my patient's experience and respond from that perspective? I replay the message in my head, trying to hear the background tones that depict a deeply painful state as well as the foreground words angrily depicting injury. I could imagine my return message: "You are worn down from too many demands on you. By asking you to change times, I am making yet another of you. Expecting you to make the change makes you feel that I am not taking your distress into account, and worse, that I do not understand you. I seem to be simply responding to my own needs and unconcerned with you. I did not realize that this would upset you so deeply, and I am sorry." I could throw in an interpretation, about how this was experienced so repetitively in the patient's childhood, but this is best done in the context of our next session.

All of this seems true and useful. If I respond this way, I would likely, one more time, repair the rupture between us. But, this understanding does not seem complex enough to explain my range of reactions, let alone my patient's. She is regurgitating many of the injuries that she has experienced in the course of her very long and intense treatment - as if all of the past injuries are packed into this one devastating blow. Can this be best understood as a result of fragmentation? If so, then the content reflects a breakdown of a self collapsing. I wonder, though, if the angry content of her message has any symbolic meaning? I also wonder, as I have so many times before, about my experience of being surprised and momentarily destroyed by the content and the intensity of her reactions. I shift to an intersubjective position in my conversation with myself.

I recently heard Jessica Benjamin present a paper, illuminating her version of the

concept of the third. The experience of listening to her perspective is one of turning familiar concepts upside down and examining them anew. In this paper, she made reference to the process of containment, suggesting that it maintains the one person doing unto another dynamic. In her terms, this is an enactment which destroys the recognition of the separate subjectivities of analyst and patient. By containing, the therapist/analyst re-establishes herself as "good" by not reacting in harmful ways to the patient's affect. By fighting off the painful projection, the analyst leaves the patient with it. She maintains, however, that splitting the relational dynamics into subject and object does not leave room for the analytic process. In her view, harm is part of the process. I begin to think about how this idea applies to empathy.

In self psychology, we believe that maintaining an empathic perspective opens up the patient's subjectivity and allows a developmental process to be activated. We, too, believe that harm is part of the process in that we recognize the inherent injuries involved in the therapeutic process and the cycle of rupture and repair. By entering the patient's subjectivity, the therapist is able to offer a response to the injury which helps restore the patient's self and dissipate fragmentation. The therapist's sense of injury is not addressed; the therapist's subjectivity is often put aside in order to understand the patient. Theoretically, this emphasis on understanding the patient's perspective would ameliorate the injury felt by the therapist. When it does not, and the therapist responds in this fashion anyway, we suspect that a pathological accommodation to the patient is at play.

By maintaining a focus on the patient's subjectivity, we are intentionally excluding the subjectivity of the analyst from the process. This has led many self psychologists to move to an intersubjective perspective. Returning to Benjamin, I wonder if the subjectivity of either party can be excluded without creating an enactment of object subjugated to subject. In self psychology, the enactment is believed to be necessary to analyze the patient. And, we have vast experience with the restorative and curative power of this perspective. But, does subjugation of the analyst's subjectivity limit the analytic process in unanticipated ways? Does it limit my power, specifically, to address the destructive process at play with my patient's negation of my "analytic goodness" (Benjamin, 1999, p. 202)?

How, then, do I understand and respond to my patient? I firmly believe that I must address the injury before I can address the rest. When fragmented after feeling so injured, she can only resort to protecting herself; albeit with an angry attack. To respond directly to it would only prolong and solidify the state of affairs in which she feels deeply injured and misunderstood. So, I, at this point can only protect my self from feeling destroyed by talking with myself about it. I leave a version of the message that I imagined. In our next session, I encourage my patient to tell me about her experience of the request to change appointments. She reluctantly reveals that she felt left alone to die. She hates feeling that she needs me to live. Now we are in her experience together and I have to bear the feelings of being this awful, of being the subject of her hatred. But, with both our selves momentarily restored, we can talk about it instead of enacting it.

Empathy provides an opening and a process that optimally allows both subjectivities in the room. Unless the patient has achieved a state in which her subjectivity is upheld and understood, the therapist cannot be experienced as anything but an object. The perspective of self psychology, which encourages the sequestering of the analyst's subjectivity in order to be experienced as a self object, provides the opportunity for the eventual recognition of both subjectivities. But, without recognizing the enactment, full understanding of the patient is not possible. I think about the enactment, its meaning, and about restoring each of us in order to resume the reflective process. I feel that this complicated process of empathic emersion and my analysis of the enactment eventually brings me into my patient's subjectivity without losing my own.

Feature Articles

Prevention of Insecure Disorganized Attachment: and maybe the Ambivalent and Avoidant as well

Irene Harwood, MSW, Ph.D., Psy. D.

While writing my psychoanalytic thesis on *Trauma, Attachment and Neurobiology* many questions arose for me about how the different individuals responded to their particular trauma. I wondered how different attachment configurations and caretakers responsivity would have affected their ability to respond and deal with the trauma differently.

After many years of attending Beatrice Beebe's presentations I started applying what I have learned from her, other infant researchers, and attachment specialists in my practice. I started working with pregnant and new mothers before and after they gave birth. As someone working intersubjectively in individual and group for many years, I also wanted to focus on the first dyad in life in a group setting (Harwood, 1986, 1995, 1998) with the focus on prevention of the intergenerational transmission of trauma.

Through my UCLA appointment, I was able find a community setting to develop a prevention program for pregnant and new mothers called PIDA - *Prevention of Insecure Disorganized Attachment* . All of these women were from the Spanish speaking community and had undergone some form of trauma. Trauma literature suggests that without intervention, trauma gets transmitted through several generations. Thus, while continuing my regular practice I also wanted to reach into the community, give back, and try to make a difference.

To summarize some findings from trauma literature: adults who have suffered severe trauma, especially as young children, are likely to develop unresolved insecure disorganized attachment styles as manifested by 1) introversion, 2) unassertiveness, 3) feelings of exploitation, 4) self-consciousness and lack of self

confidence, 5) more negative than positive feelings about themselves, 6) signs and symptoms of anxiety, depression, hostility and violence, 7) self defeating behavior and greater reporting of physical illness, and 8) fluctuations between interpersonal neediness and withdrawing (Shaver & Clark, 1994). They are also likely to suffer from posttraumatic stress disorder and dissociation (van der Kolk, et al., 1985, 1996). Victims of trauma tend to either reenact their own experience of trauma with their own children or others or never move out of experiencing themselves as victims. In the latter situation, they are unable to leave abusive and violent relationships and therefore also expose their own offspring to the intergenerational transmission of trauma. In my practice, both in psychoanalytic and psychotherapy cases, I also have become aware how traumatized individuals often reenact what has been done to them when the trauma has been disassociated.

The trauma, attachment, infant research, and neurobiology literature (Beebe, 2000, 2003; Fonagy, 1996, 2000, 2001: Heinicke et al., 1999, 2001; Jaffe at., al, 2001; Main, 2000: Pally, 2003, Tronick, 2004, Schore, 2003a, b) suggest that patterns of attachment develop by the end of the fourth month of life and are consolidated by the end of the first year. Most synaptic connections are immature at birth and are open to be shaped by experience. If infants are not responded to in an affectively attuned manner, many of their brain cells in the orbital frontal cortex are thought to die by the end of the first year of life. In addition, if these infants are also traumatized, they are likely to develop an insecure disorganized attachment. These same infants are in danger of not developing the capacity for understanding the state of another from facial impressions, the basis of empathy.

In the last three years, I have started and conducted two groups for pregnant and new mothers. From the first group, I learned that in order to make an impact one should start with pregnant women at least during their last trimester. From both of these groups I learned that psycho-educational methods must be supplemented with specific metaphors that each mother can relate to in order not to do to her infant what has been done to her.

These groups need to go through several phases:

The first phase of the group is psycho-educational. It provides information about infant development and facilitates for the new mothers the sharing of their experiences. It is also the stage where the ambiance of safety, confidentiality and trust is established.

In the second phase, as the babies are born and brought into group, the mothers can start applying what they have learned in the psycho educational stage as well as reworking what has been stored in their own body memories from their own first years of life. At four months, a specific attachment - secure; insecure ambivalent, insecure avoidant or insecure disorganized starts forming and, if not disrupted, will consolidate at age one. It is also during the first four months of the baby's life that intervention and facilitation for a secure attachment has to take place. This is the prime time for prevention of negative establishing patterns between mothers and babies.

An example of an intervention with a depressed mother and baby

Supporting Beebe (2003) and Lachmann's (2004) observations that one way that babies cope with the depressed mother is by imitating her affect, in our first group, baby Beth, at three months, closely watched her mother's sad and unsmiling face. She looked continuously sad just like her mother.

Since mothers are pleased when I show interest in their babies and pick them up, I knew an intervention was timely. I extended my arms and invited Beth into them. After picking her up, I waited until Beth established eye contact with me and then I started gently, but barely, smiling at her. As she responded, and we took turns, I increased the width of my smile and the sparkle in my eyes, similarly to Beebe's (2003) interventions demonstrated in her research videos. I slightly increased my affect as I spoke softly to her, attending to vocal rhythm. Beth responded with a full, pleased, and related smile.

After having established a joyous dyadic regulation with Beth, I noticed that her mother was now looking at her daughter with full interest and attention. I quickly placed Beth, who by now had a full smile on her face, into her mother's lap. Her mother, Silvia, had not yet, to my observation and her admission, received such a response from her daughter, but, seeing a smile on her daughter's face, she was able to shift from her own depressive feelings and return a delighted smile to Beth. Quite pleased with what I was able to accomplish, I whispered my newly discovered mantra: "My mama's smile is the most beautiful mirror in the world." A "heightened affective moment" was born (Beebe, 2003).

Silvia could not stop smiling at her baby and Beth was delightfully smiling back. The group joined in by validating with smiles and great warmth this newly established connection between mother and child. I had confidence, at that point, that this was the beginning of ongoing, positive, affective dyadic regulation and a secure attachment relationship for Silvia and Beth, unless disrupted by a significant trauma. Indeed, this warm affective dance continued between Silvia and her daughter during the next few group sessions. During her fourth and fifth months, Beth was also able to respond to the different mothers' interest, words and smiles and sit happily in their laps for a considerable time. After a while, she would turn toward her mother, stretch out her arms and Silvia would happily pick her up. Beth would put her hand on her mother's breast, a form of self-regulation, and at times turn towards Silvia's breast and vocalize her needs. There was a relaxed sense of "being at home base." At this early time, babies can establish differing intersubjective dyadic regulations and differing attachment configurations with different people, all encoded in implicit memory.

Group interactions

In the second stage of these groups, when a mother is having difficulties, she is encouraged by the example of others to talk about her feelings. The other mothers in the group also have a chance to sympathize and empathize. Thus, each mother does not feel so unique in her response. I also specifically encourage observation of their babies during the week and ask them to bring in for discussion the

observed new psycho-emotional and physical developments.

Since it is difficult for each mother to observe herself and her baby in the dyad, I ask a different mother in the group to describe what she observes about the baby across from her, including the gaze, vocalization, body tone, hand gestures, touch, ongoing regulation, de-regulation, rupture and repair, and hightened affective moments. I then ask for any other observations from the entire group. Throughout I validate attunement and responsiveness by each mother to others, to her own baby, and to participating in the group.

I ask the group what the baby is trying to communicate, when I see reaction to impingement. Not being caught up in their own mind-body set, mothers who cannot see something with their own baby, often can see it demonstrated by another mother and baby. Even mothers who dissociate at times can observe and tune-in to others. It takes some mothers once, and others many, many times, to change how they approach their own babies. Even with awareness, during times of stress, the previously traumatized mother unconsciously and automatically reenacts her own traumatizations.

Teaching Mentalization through empathic metaphors

It is at the times that an impingement or lack of attunement, or blaming of the baby occurred that I learned how to utilize metaphors to help the mothers start attuning to the self-state or communication of their infant. For Fonagy, mentalization is the ability to attune to the mental state of the infant.

Thus, when I observe a miss-attunement to the communication that the baby is offering, or when the mother is enacting something that has nothing to do with the baby's needs, I try to find an equivalent metaphor that the mother(s) can relate to from past experience. It is when I give an example of a situation that the mother can identify with and find some humor in, that I find that she can start empathizing with her baby's state of mind.

For example, if a mother is trying to feed the baby and the baby is gaze averting, I ask (tongue-in-cheek) something like: "Let's see how many of you have been in a situation when you went to your mother-in-law's and you were not hungry, but she insisted that you eat what she made and tried putting it in your mouth? How did it feel?" The response was a hearty laugh. From this point on, most of the mothers would *offer* food, rather than insist that the child eat. When a mother forgets and insists that a child eat, another mother might laugh and say: "Remember mother-in-law."

Thus, more and more, I became aware that helping mothers acquire the capacity to mentalize through such psycho-educational means as modeling and describing what the babies appear to be expressing by their gaze, vocalizations, affects, hand gestures, touch and body postures were not as effective as utilizing empathic metaphors.

In another situation, baby Beth, 7 months, was sitting happily exploring and

playing with colorful toys. The mothers were having light refreshments. All of a sudden, Silvia, for no apparent reason, picked up her daughter without warning and placed her on her back. Beth protested this impingement by crying loudly. Silvia complained to everyone: "Look, she is again making war!" I wondered aloud if we could imagine Beth's experience. I asked the women: "Imagine someone more than twice your size, while you are enjoying your refreshments, picking you up without warning from your sitting position and laying you down on the floor. How would you feel?" Most of them, in a chorus, including Silvia, responded, "We would make war, too!"

I have also utilized metaphors and empathic introspection to help the mothers move out from their baby's face and space, when they were smothering their babies with kisses or overwhelming with tickling, and failing to attend to their babies' nonverbal communication. I asked them to imagine, or remember, how they feel when they are in the midst of something important and pleasant and are interrupted by their husbands' kissing and tickling them in a manner that soon becomes overwhelming. The description of such a scenario brought knowing smiles and laughter as well.

In essence, I learned how to help these mothers mentalize their babies' subjective experiences by first empathically immersing myself in experiences that they could imagine or may have experienced, and then playfully, through the use of metaphor, translate these for them. As we know, we unconsciously repeat with others what has been done to us. People who have experienced traumatic impingements tend to unconsciously repeat those experiences with others. By being empathically playful with the mothers, I encourage the beginning of self-reflection between their own memories and experiences and those of their babies.

In the Prevention of Insecure Disorganized Attachment (PIDA) groups, with the start of each group, we are beginning the process of breaking the intergenerational transmission of trauma.

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Feature Articles

Report on the Bali Conference: Varieties of Dissociation

Herb Rabin and Judith Rustin

We are pleased to be asked to report on the Dissociation Conference held in Ubud, Bali, January 2006. In summary, for us, reasonably intrepid travelers, it was a truly "once in a lifetime experience!" Throughout the four days of the Conference and since our return home, this sentiment has been echoed and amplified by each conference participant with whom we've talked.

Time wise, our experience was reversed from that of most of the conference participants. Because of professional commitments we left Bali immediately following the conference, but arrived a week before its start. We began our Bali immersion at the serenely, exquisite Alila Manggis, sister hotel of the Alila Ubud, the conference hotel. Arriving from a two day stay in Taipei, Tawain, a grey and dreary city, we were immediately transformed in "state" by the translucent light of Bali shimmering through the sky, creating a sense of wonder and beauty. The advertising propaganda was true. Bali seemed like a worldly paradise! At the Alila Manggis, located on the moderately underdeveloped east coast of Bali our altered state of consciousness was cemented by the understated responsiveness of the staff of this five star hotel and the ancient Hindu spirituality that permeates place and person. We spent the first two days soaking up a quiet, calm serenity after a very long trip and, as for most of us, a hectic professional life.

By the end of the second day we were ready to venture forth from this relaxed cocoon and immerse ourselves in the local color of this third world country. We ventured out by signing up for interesting treks. Our first trek meant getting up at 4:30 AM to climb a mountain to greet the sunrise. The trek involved passage through the monkey temple; we were adorned by our guide with sari and sash in order that we might pass through the temple. This was the beginning of our education on temples, respect and obeisance to the Gods and a beginning taste of the ancient Hindu philosophy. Once through the monkey temple we were immediately surrounded by monkeys, who followed us through the rest of the trek. It was a rigorous climb in that it was an almost vertical climb uphill, albeit on wide steps. One of us (Judith) did not think she would make it; she did. And the view at the top, watching the sun rise over the Indian Ocean, even on a cloudy day was magnificent. It whetted our appetites for more.

Therefore, we let ourselves be talked into a trek for the next day by the guide who assured us that the climb was not as steep and would end in the ancient village of Tanganana, known for a unique double weaving process of fabric famous throughout the world. The guide neglected to tell us that although the climb up was more gentle, the pathways up were extremely narrow surrounded by deep irrigation ditches on either side. In addition, we would need to cross brooks and rivulets on narrow, low slung bridges made of bamboo and that the descent down to the ancient village was a very steep, long narrow path covered with wet stones. We learned the true meaning of the word trek (arduous), not to be confused with hike! Herb fell twice, slightly injuring his arm but more so his physical pride. Our guide was sensitive and helped him navigate the descent. Judith's good balance based upon years of ballet training enabled her to traverse the descent and rocks without falling. The one hour descent was exhausting but the exposure to the real life of the Balinese was indeed fascinating and once safe and sound back at the hotel, ultimately worth all the hard work. Trekking through the rice fields, we were again mesmerized by the beauty of the light as it was reflected in the green of the abundant rice fields. The interplay of blue (sky) and green (rice fields) was breathtakingly exquisite. We observed the communal nature of this society, for example, the co-operation on irrigation so that it occurs in a step down fashion, i.e. those furthest from the water source get it first and so on up the mountain. We watched the Balinese women work in almost perfect synchrony beating the rice stalks to release the grains. We were privy to a young family bathing naked in the river while washing their clothes and we saw men and women lovingly washing their cows in the river "to keep them fresh"; this was a powerful reminder that cows are sacred in a Hindu society.

On this trek we also had the first hints that all is NOT wonderful in paradise. For example, we realized we had been talked into this trek by our guide partly out of his desperation for our business. This sense of hunger and depression triggered by the downturn in tourism became clearer as we shopped in the local town of Candidasa. We learned from our various guides that the economy, so dependent on the tourist industry had been recovering from the 2002 bombings; the second bombing in October, 2005, demolished the recovery, sending the economy plummeting. We felt deeply for this gentle peace loving people essentially

victimized by terrorists. When we moved to the Alila Ubud for the conference (Ubud being the center of tourism in Bali) the economic downturn and its impact on the people became even more apparent. Despite the undercurrent of economic hunger and depression, the "face" of the people remained loving, helpful and beyond gracious.

We gladly did our parts to help the local economy and ourselves in the process. Bali is both a physical and shopper's paradise. Beautiful, handmade items abound at a fraction the cost in the U.S. We, as did many of our colleagues, hired an Alila concierge who took us to top quality studios where we were able to both see the craftsmen at work and purchase unique and authentic items, by our standards at significantly reduced prices.

The conference began with a welcome dinner and a presentation by Rucina Ballinger, a published ethnologist, an American married with children, living in Bali with her Balinese husband. Her presentation focused on the balance of harmony within the culture, which she personally ascribes to with her family while at the same time maintaining an upfront dose of skepticism. This open tension between the fundamentally different and seemingly incompatible life philosophies (East and West) captured our own sense of uncertainty about "the correctness of one's life view" and forced us to confront some of our own unquestioned belief systems. For example, she focused on the use of healers who employ controlled methods of dissociation to treat individual and social ills with beneficial effects. From what we had seen, with the exception of the economic desperation due to contextual circumstances, the Balinese people seemed pretty content.

Similarly, hearing from Luh Ketut Suryani, M.D. a Balinese Psychiatrist educated in the U.S., as to how she works with a patient, using the importance of forgiveness to foster re-connection and working with patients in their larger tribal groups provided a window into a radically different view of therapeutic action and the working through process.

The papers presented were all very interesting, but more importantly unusually well paired. Each unit, morning and afternoon was organized around a specific theme. Obviously dissociation was the overarching theme, but the first papers dealt with dissociation in the patients' experience, the second morning was organized around dissociation expressed in specific symptoms, i.e. Anorexia/ Bulimia, Hair-pulling and Addictions. The third day was organized around the Analyst's response to the patient and its impact on the treatment, followed by the "forgetting" of the power elite in Institutions, so that their dissociated responses allow them to perpetuate the same mini trauma on those who follow. The last afternoon was organized around working with dreams and dissociated patients.

Attendance of participants at all sessions was very high. And, whether it was the quality of the papers, the fact that we were a shared sub group within this very strange culture or some other inexplicable factor, over the three days, the conference took on the "feel" of an on-going seminar. Interchanges with the presenter were lively and engaging and increasingly, the group participants became more open and interactive with each other.

The closing banquet, held at an amazing complex organized to protect the Balinese environment was a fitting close to the conference. The accommodations were beautiful, the food delicious, the hostess gracious and generous and the Balinese dancing provided a full taste of the local culture and color. We were sorry to have missed the post conference tours to see "a healer" in action and to have high tea with the priest. All reports from colleagues (see Addendum) reveal these were unusual and special experiences arranged by Meghan Pappenheim who now makes Bali her home.

Finally, it is always impossible to specifically delineate what makes an experience "special." The whole is usually greater than the sum of its parts. But, there is no doubt that Harriet Pappenheim and her daughter Meghan can be singled out as the catalysts that helped shape the experience in such a positive direction for all. Harriet introduced each paper, orchestrated the discussion and despite working every moment, maintained good humor throughout. Meghan, unflappable, seamlessly attended to everyone's travel needs and provided access to the special experiences that gave us that extra taste of Balinese culture, up close and personal. We thank them both for all their efforts. And, from all the feedback we've gotten from other conference participants, we think our thanks to them echo the sentiment of the group.

ADDENDUM: The Friday Post-Conference Tour, by Beth Meehan

Our enchanting post-conference tour was arranged by Meghan Pappenheim. First we had lunch at the Royal Compound in Tabanan with the charming 76-year-old king of the region. We were treated to Balinese dancing accompanied by traditional gamelan music. Next we met with spiritual healers whom the king had invited for the occasion. We learned about mental health treatment in Bali and how mental illness is understood as a spiritual disease. When someone in the (extended family) compound becomes ill they assess that something in the compound is not spiritually right. Spiritual practices are examined. If addressing spiritual practice fails to heal the individual person a healer may be consulted. Only in the case of very severe, socially disruptive behavior is a person brought to the mental hospital in Bengli. Our tour guides and the healers insisted that most of the time disturbed behavior is resolved by traditional means.

After an excellent Balinese lunch, for which a suckling pig was roasted, we drove to Taman Sari Bali Cottages, a cultural community and eco-tourism center. Village dancers greeted us. They were beautiful girls, 6-12 years old, wearing traditional dress, strewing rose petals in our path, and performing traditional dances.

In this enchanting spot, with rice terraces behind us the experience was almost surreal. After high tea we witnessed a healing ceremony. We chose a medically ill person to be the subject. The healing ritual involved channeling by the family member who was deemed the most spiritual. I was impressed by how the holy woman physically expressed symptoms that I knew to be associated with the patient's illness. She did this even though the symptoms were not readily

observable. Having a wish for faith, I found the Balinese culture to be both beautiful and haunting. All of us, including those who maintain their "western skepticism," were profoundly touched by these gentle, open, people who conduct their everyday lives with such enormous integrity.

Kidstuff

Contributions from Analytic Work with Children and Adolescents

From the Editors

Jackie Gotthold and Rosalind Chaplin Kindler

Regular readers of this column will note the new title for this section on child work in the Newsletter. We decided that since we have always followed a developmental approach to our work with children, so it should be with the child segment of the newsletter. Thus came the decision that it was time to allow the children's section to emerge from the "corner", spread its wings, explore a wider arena of experience, and try a new identity as an independent centre of initiative. It's been heartbreaking for we co-editors to have to let go of our own selfobject needs and wishes to keep our children's section close, safely tucked up in the corner under our care, but we have every confidence in its capacity to successfully differentiate and find its way independently around the Newsletter, connecting competently with our readers.

The two articles that we present appear to be 'child' articles, yet when considered in a wider lens they point toward wider reaching applications. Roger Segalla summarizes Amy Joelson's paper, "A Girl, Her Mother and The Analyst: A Study of Self and Interactive Regulation," which was presented at this past year's International Conference on the Psychology of the Self. He outlines some of the contemporary conceptual points that Ms. Joelson applies to a child treatment case that involves the mother in a session. The complexities of "shifting dyadic configurations" in terms of self and interactive regulation in the treatment process are noted by Ms. Joelson. Roger Segalla suggests that this conceptualization is applicable to triadic work such as in couples treatment.

In the second article, Amy Eldridge presents us with a self psychological understanding of the ever complex and daunting task of the analyst's work with parents of child patients. She, too, notes a dynamic and interactive model whereby the selfstate of the parents is affected by the response of the child, just as the development of the child is affected by the parents' selfstate. Again, we can see how the work with children can serve as an ideal vantage point to explore the complexities of the treatment process.

We hope these articles expand your horizons.

Contributions from Analytic Work with Children and Adolescents

The Parent-Child Relationship

Amy Eldridge, PhD

The parent-child relationship is like a marriage; it is ripe with possibilities and fraught with difficulties. Working with parents from the perspective of self psychology requires an understanding of the complexities of this relationship. Ideally, parenting is an opportunity for growth, as the parent's self expands in response to the child. I quote Miriam Elson (1984), who wrote so eloquently about parenthood from the perspective of self psychology:

It is not that parents, recognizing the experiences of their own childhood, seek to undo such experiences in their children; such an approach would in effect, intrude the parent's needs. It is that the parents are now empathically in tune with childhood needs. When they are in tune with the child as a center of perception and initiative, parents can exercise the guiding and confirming relationship such needs dictate. In process there is implicit humorous sadness in relinquishing a goal anticipated for one's child, some increase in wisdom in recognizing and supporting the direction of the child's goals, some acceptance tinged with sadness of one's own transience in relinquishing the position of centrality in the child's life. At work here is a simultaneous process in child and parents, a double helix of the formation deepening, and elaborating of narcissism in the child and the further transformation of narcissism in parents.

Erika Schmidt and I (1990) introduced the concept of the parental self, which develops in response to and in interaction with the expectation, birth and growth of children. The ideas are similar in asserting that, in parenthood, the self-state of the parent is deeply affected by the response of the child, and in reverse, the child's development is deeply affected by the response of the parent. The parent child relationship provides each member with needed self object functions.

When a child fails to provide selfobject functions, through anomalies of development, or because of the particulars and/or massiveness of the parents needs, they are at risk for developing the kinds of symptoms that bring parents to seek help. Too often children are depended on to restore a fragile parent's self - especially in the absence of more appropriate selfobject experiences, as when family of origin or marital issues are at play. When these children not only fail as selfobjects but become problems in their own right, parents are so lost in their own distress that they cannot respond reasonably to their children.

How then does a therapist form an alliance with parents in this state? One understands many therapists' wishes to bypass parents and just work with the

child. The challenge is enormous, and the answers are not easy. Isolated issues in healthier relationships are obviously easier to respond to. These parents are often relieved to find help and understanding. They then can utilize the therapist's elucidation of the child's issues to enlarge their empathic capacities.

In contrast, when a child's symptoms are embedded in a troubled family, troubled parent and/or troubled marriage, they are just the tip of the iceberg. Parents often hope that the therapist can address the symptoms without addressing the problem. However, addressing the symptom is double edged, as to do so risks evoking intense shame reactions in parents. Parents comes to the therapist hoping for help and defensively resisting it, for it confirms their sense of failure for the therapist to be involved and to help (Hoffman, 1984). Parents' efforts to manage their vulnerability, made worse as they struggle in their role as parent, may lead to the sorts of behaviors that we find to be difficult.

I offer the following suggestions. First, meet with parents on their terms. All too often, I have found that there is good reason why one parent is excluded from the consultation. While excluding does not ultimately help, I have found that honoring the request has more often been helpful than not. Only when the reasons for exclusion are understood, can they be dealt with. And, that takes time. Second, address the parent as a colleague who is consulting you. Respect and sensitivity are paramount. This is like a topical balm for the parents' sense of deficiency. While not deeply restorative, it is an attitude that simply helps. Finally, listen for the breakdown in the parent-child relationship, ie, the selfobject failures between parent and child (Leone, 2001). There are often multiple failures that underlie a parent's request for help. Recognizing that the parent feels both failed and like a failure is the beginning of an alliance.

Within the first sessions, developing some understanding of the parents is essential. One must enter the parents' subjective experience to understand how disturbed they feel by their child's behavior; remembering that the child is likely being experienced in ways skewed by transference. It is important to really appreciate parents' sense that their child has failed them, even when the therapist feels that the parents have failed the child. The feelings of hurt and harm that parents feel in response to the child are very real and must be understood in order for treatment to proceed. I have found that if I respond to the parents' distress initially, I will later be in a position to help them understand their child's distress.

When it is not possible to develop this level of empathy with parents the treatment process is much more precarious. In some cases, parents may be dispassionate and detached in order to avoid the vulnerability of experiencing the child as a selfobject. I have written of child neglect as a symptom of a parent who sacrifices closeness to the child in order to avoid painful emotional states (Eldridge, A & Finnican, M, 1985).

Parents who have been subjected to trauma in their own childhood are likely to approach parenting with a combination of rigidity, vulnerability and poorly organized internal states. In these cases, the therapist has the difficult task of reaching a parent whose subjectivity is filled with painful affects and whose self is

extremely fragile. Even exquisite sensitivity on the therapist's part may fail to foster an alliance. Therapists then face the dilemma of trying to give some meaningful relational experience to the child in whatever time allotted or choosing not to see the child and risk possible interruption. I usually choose the former, as sometimes it works and this is then very helpful to the child.

A decision must be made about whom to see. Optimally, this decision is made on an assessment of what configuration will best restore the parent-child relationship: restoration of the parent, the child, the parental alliance, or some combination. Often, this decision is influenced by the parent's state. The parent may insist that you only see the child, or that you never see the child. When parents insist on a particular plan, I have found it best to follow it. The parent-child system is the patient; following the parent's lead is like the process of free association. If allowed, greater understanding will be promoted. To counter often engages the parent's defenses before an alliance can be made. A non-linear dynamic systems perspective suggests that, even if the therapist has conviction about how the therapeutic process should proceed, it will proceed in unpredictable ways.

While difficult, work with parents presents the opportunity to therapists to create dramatic change within the system. When the child is seen and a parental alliance is in place, the therapist is both able to help the child directly and to assist parents in developing empathy for their child. To do so, the therapist must, based on sustained empathic emersion into the parent's experience, interpret the parent's response to the child's behavior. Then, the therapist can help the parent understand that the meaning of the child's behavior is different than the parent attributes to it. With greater understanding and a less fragile self state, the parent is more likely to respond in helpful ways to the child. Over time, and as therapy proceeds, the child is usually more able to respond positively to the parent.

Kidstuff

Contributions from Analytic Work with Children and Adolescents

"A Girl, Her Mother, and Her Analyst: A Study Of Self And Interactive Regulation In Child Treatment" - summary of paper given by Amy Joelson, LCSW at the 2005 Self Psychology Meeting in Baltimore

Roger J. Segalla, Jr., PhD

In the last five years, writers and theorists with a relational or self psychological orientation to psychoanalysis have contributed to a profoundly important understanding of the ways in which self and mutual regulation impact on the

analytic treatment process. Infant observational studies (Beebe & Lachmann, 2002) have provided a model for conceptualizing the moment-to-moment affective interaction between the analyst and her patient and translating this understanding into clinical opportunities to deepen the connection and facilitate therapeutic change. Despite this progress, exploration of the operations of self and mutual regulatory interactions in a triad, especially those operating within the analysis of a child, remain relatively uninvestigated. Amy Joelson's paper: "A Girl, Her Mother, and Her Analyst: A Study Of Self And Interactive Regulation In Child Treatment," provides a unique opportunity to explore these concepts in the context of four year old girl's analysis. Ms. Joelson's very stimulating paper was presented this October to the International Conference on The Psychology of The Self and was followed by a discussion by Dr. Irene Harwood.

Using two "heightened affective moments" (Beebe & Lachmann, 2002), Ms. Joelson described how, after responding to the child's demand that her mother join them in the consultation room, this new child-mother-analyst triad engaged in what would become a fascinating complexity of self and mutual regulatory processes. This triadic analysis clearly provided the child with the safety necessary to express the distress she was experiencing in the midst of her parent's difficult separation. Ms. Joelson's ability to both playfully engage with the child and monitor the regulatory processes unfolding in the room allowed this child to communicate the meaning behind her frequent tantrums and apparent agitation. Sensing she had a partner (Ms. Joelson) that would allow her to safely demonstrate her distress in a way that would not irreparably damage her already fragile mother, this precocious three year old set about "staging" scenarios that depicted feelings (anxiety, despair, anger) that would have otherwise been too dangerous and too complex to communicate verbally. Ms. Joelson's presence between mother and child provided a critically important emotional buffer that allowed this mother and child to play more directly while the more difficult even unspeakable feelings were placed within and held by Ms. Joelson. By pushing away any self-consciousness, or any need to control the process, Ms Joelson allowed herself to be playfully transformed into a frog, a bunny, and a princess. These transformations provided this distressed child the opportunity to work through some very difficult feelings while maintaining her attachment her mother.

Ms. Joelson decision to respond to the child's demand that her mother participate in their session could not have been easy or without second thoughts. What evolved was not a psychoanalytic form of family therapy but a profoundly more complicated process that actually involved a complexity of shifting dyadic configurations (child-analyst, analyst-mother, and child-mother). As an analyst that feels fully occupied trying to attend to the words, actions, and feeling states of a single dyad, I was enormously impressed by Ms. Joelson's ability to stay attuned to the moment to moment events in each of these dyads without becoming so enmeshed (or overwhelmed) that she lost her observational platform. She seemed to do this, at least in part, by implicitly trusting that this sometimes bossy, overbearing three year old had something very important she needed to communicate to her distressed and overwhelmed mother. On her own, this child could only express her distress through the blunt instrument of tantrums. While maintaining a connection, largely unspoken with the mother, Ms. Joelson allowed

this child to use her (sometimes quite roughly) as a modulated instrument to demonstrate her unmodulated fear for herself and for her mother. Beyond this critically important communication, the play Ms. Joelson engaged in helped this child connect to and work through feeling states (anger, grief, fear, etc.) that on her own must have felt like unformulated affective storms. By herself she could not have sorted through these feeling states without choosing sides in the unwinnable dilemma created by the reality that her two primary objects were at war.

The first "heightened affective moment" occurred right after Isabel (the child) demanded that her mother join them in the session. Ms. Joelson's decision to allow the mother into the consultation room allowed Isabel to express her profound distress following the previous day's unexpected arrival of Isabel's father and her mother refusal to allow him entry into the home. After Ms. Joelson let a doll slip out of her hand, Isabel screamed at her analyst "you let my daddy go," "you let him slip away." As this interaction continued to play out Ms. Joelson recognized that the mother was silently crying, leaving Ms. Joelson torn between the need to attend to child and the need to attend to the mother. What followed was shifting regulatory process in which Ms. Joelson allowed the child to use her as the object of her fury, this enabled her to down-regulate enough to express feelings that had only been expressed as tantrums the day before. The mother's crying was soon followed by a period of interactive regulation that marked the emergence of an elaborately structured triangular transference that became critical to exploring the disruptive dynamics generated in Isabel's family.

In the second "heightened affective moment" which Ms. Joelson labels, "The Mother Laughs," marked the beginning of a period of transformation in the triad. The play between Isabel and her analyst (who threw off her self-consciousness to become a hungry frog) changed the affective tone in the room (signaled by the mother's laughter) and released the triad from the tension created by trauma unfolding symbolically in the transference/countertransference. Ms. Joelson used this transformation and the spontaneous emergence of "Princess Lily and Bunny" to communicate more directly with Isabel, and shape the play so that she (Ms. Joelson) could guide Isabel through previously unsolvable dilemmas, like being mad at people you love.

Ms. Joelson's paper demonstrates in two richly illustrated scenarios the application of relational concepts of self and mutual regulation, three way social referencing, and moments of meeting. These concepts that have been used to describe psychoanalytic dyads can also be usefully employed to guide our understanding of complex dynamics of a psychoanalytic triads. The paper also demonstrates the use of concepts like spontaneity, interactive "sloppiness" and "wearing the attribution." These are techniques, which can serve to open up the analytic space and allow an unfolding of critical dynamic tensions. The insights this paper provides into triadic process also lend invaluable guidance for those of us who use a psychoanalytic model to treat couples. While this summary of Amy Joelson's paper "A Girl, Her Mother, and Her Analyst: A Study Of Self And Interactive Regulation In Child Treatment" is too short to do the paper real justice, I hope the

reader will recognize the contributions this engaging paper makes to our understanding of self and mutual regulatory concepts when applied to triads.

Authors' Corner

An Interview with Jessica Benjamin

Christine C. Kieffer, Ph.D.

Coming soon.

Authors' Corner

Kohut Memorial Lecture Honoree: Joseph Lichtenberg, M.D.

Shelley Doctors, Ph.D.

Joseph Lichtenberg, M.D., the first elected president of the International Council of Psychoanalytic Self Psychology and an enthusiastic proponent of the International Association for Psychoanalytic Self Psychology (IAPSP), had the honor of delivering the Kohut Memorial Lecture at the Psychology of the Self Conference held in Baltimore, Md., in October 2005. This event follows the Saturday Luncheon and is typically attended by everyone at the conference, as those who do not opt for a formal noontime meal are nonetheless welcomed into the Ballroom for the lecture.

Ernest Wolf, M.D., a former Kohut Memorial Lecturer and Dr. Lichtenberg's friend since medical school, provided a warm and light-hearted introduction, recalling the circumstances before the creation of Self Psychology which threw together the two future world-class analysts; medical students were asked to choose partners to dissect a cadaver and they chose each other! Not only did this lead to a life-long friendship, but it was fortuitous for the dissemination of Self Psychology. Later, hearing about Self Psychology from his friend Ernie, then residing in Chicago, Joe became persuaded early on and was, I think, one of the first east coast analysts to become a Kohutian loyalist. Joe found Self Psychology and Self Psychology found one of its leading proponents, for Joe went on to have an astoundingly successful and prolific psychoanalytic career. Via his 10 books, over 50 articles, countless national and international lectures, and at the Institute for Contemporary Psychoanalysis and Psychotherapy (ICP&P) in Washington, D.C., and the many other institutes where he has taught and supervised, thousands of clinicians have been inspired by Joe's writings and teachings to discover and practice Self Psychology.

Joe spoke extemporaneously for 45 minutes and treated the audience to an overview of psychoanalytic discoveries and trends from its inception to the present, with an eye toward gleaning, "What Lasts and What Fades", the subject of his talk. According to Lichtenberg, "what lasts" in psychoanalysis is a general consensus among practitioners that there is "a way of doing things", although "what fades" may involve some specific ideas about what must or mustn't be done; while a consensus may always exist, what is agreed upon may change.

Dr. Lichtenberg began his explication of "What Lasts and What Fades" by considering psychoanalytic listening, noting that psychoanalysis came into being because patients (from Anna O. to Miss F.) demanded that their well-meaning doctors (Breuer and Kohut) put aside their own ideas and *listen* to them. In the case of Kohut and Miss F., listening with fewer preconceptions led not only to a truer understanding of Miss F., but to one of the foundational precepts of Self Psychology - the importance of understanding the patient from within the patient's point of view and the beneficial impact on the patient of such communicated understanding. So *listening* has lasted, though what changes is "how to listen and what to listen for."

Lichtenberg went on to say that analysts, even when listening, are nonetheless always making "guesstimates" to *explain* what they are hearing. "Theoretician-analysts" (Lichtenberg's phrase) abstract from their patients' data to general principles that may illuminate the human condition. Though Freud's earliest ideas about what he heard from patients concerned trauma and "strangulated affects" (emotions that were not accessible to them), he moved away from this brilliant early insight (and the factual truth of trauma) in favor of experience distant concepts drawn from the science of his time. Lichtenberg referred to Freud's theory of psychic energy as a "wrong guess" and suggested that Kohut's own early "guess" - that data relevant to Self Psychology derived solely from the clinical experience - was Kohut's reaction to Freud's "wrong guess" - Freud's incorporation of scientific models of other disciplines. It was as if Kohut had said, "Get all of these borrowings from physics out of here - it's what's going on in this room!" Lichtenberg noted that as early as 1980, at the Boston Self Psychology conference, he, Michael Basch, and Daniel Stern were nonetheless claiming that there was information in the new field of infant research that was hugely relevant to clinical work. Kohut's earliest dictum (1959) can be said to have lasted - self psychologists still privilege what can be understood through empathy and introspection - but the absolute prohibition in regard to knowledge imported from ancillary scientific studies has faded and infant research now informs the psychoanalytic understanding of human interaction.

Lichtenberg next addressed the theoretical frame utilized to organize psychoanalytic data, beginning with Kohut's use of the concept of structure, borrowed from the ego psychology of the '40s and '50s. He spoke of Kohut's movement away from the macro structures of id, ego and superego to the idea of "self structures" and how the language of self and selfobject (which continues to have relevance) shifted to more experiential language. Then, just as the explanatory power of "structure" began to seem too constricting in comparison to

the immediacy of self experience and the detailed understanding (made possible by Self Psychology) of how it shifts, the language of experience came to be seen as insufficient in comparison to the language of systems. Thus the emphasis on "structure" appears to be fading as the concept of non-linear systems is on the ascendancy. (Additionally, non-linear systems theory allows us to connect with other sciences in a broader way, as disciplines such as neurophysiology utilize the non-linear systems frame.)

Though the title of Joe's talk might have suggested a historical review and evaluation of changes in psychoanalytic terminology and concepts, Joe, characteristically, was more interested in preparing for the future yet-to-come than in rehashing the past. Throughout his career, sidestepping dogma, Joe has used his lively intelligence to discern the heart and soul of clinical matters. His latest contribution, introduced in this talk, is an attempt to make sense of the very many languages that have waxed and waned in psychoanalysis. Joe envisions a generic psychoanalysis, a living breathing enterprise that withstands the battles created by competing explanatory systems. This generic psychoanalysis, nonetheless, contains formative elements. Lichtenberg offered 5 easily comprehensible terms he feels describe what happens in this generic psychoanalysis - **I**nfluence, **I**nference, **i**ntention, **c**ommunication, and **r**egulation. He then proceeded to demonstrate how these elements, abstracted from the entire psychoanalytic corpus, describe the key features of the psychoanalytic situation. **I**nfluence, for example, operates within an individual, as the individual's past affects his current functioning, and **i**nfluence operates within dyads (in both directions), and is a factor in larger non-linear systems. **I**nference, operating explicitly and implicitly is an ever-present aspect of human interaction and constantly **i**nfluences all thinking, feeling, and action. The term " **i**ntention" opens the door to a consideration of motivation, a subject dear to the heart of the creator of Motivational Systems Theory. Those listening especially carefully heard Joe add a new idea to his comprehensive comments on **i**ntentions/motivations. To Bolby's assertion that the need for safety is bedrock in human existence, and to Kohut's contention that our most profound motivation is the desire for selfobject experience, Joe Lichtenberg added the concept of informational exchange - the interactive need to know and be known. "Informational exchange," as Lichtenberg described it, is implicit in many other motivations, from affiliative needs to physiological regulation but seems sufficiently important to be recognized as a key human need.

Those of us who have listened to Joe over the years know that teaching is Joe's passion and were enthralled by the interconnections he was developing. Speaking of communication and **r**egulation brought him squarely to affect, affect toleration, modulation, and regulation and affective communication, resonance, and attunement. It was fitting that Joe brought this dazzling, wide-ranging talk to an end with a charming anecdote that said tons about affect resonance, attunement, and communication, and illustrated, once again, Kohut's powerful personal impact.

At the Boston conference in 1980, apparently Joe was quite anxious about his presentation, as he knew he had been outside Kohut's original circle. Just before he was to speak, Kohut (we can **i**nfer), sensed the **i**nfluence of Joe's anxiety on Joe's daughter Ann, whose resonance with that state was evidently communicated

to Kohut, sitting nearby. Kohut leaned over to her, intent on calming her and said, communicating and regulating, "Don't worry. Your daddy will be all right."

What lasts will certainly be Kohut's influence, his life work, recorded in books, journal articles, discussions, lectures and letters. And, what will never fade is the memory of the warmth and kindness with which he embodied his views and personally transmitted them to others. What lasts, Lichtenberg might say, is psychoanalysis, an enormously powerful, living, breathing enterprise. What fades, and what *ought* to fade are attempts to explain its workings that unnaturally delimit the richness of human experience, narrowing our thinking about human growth and development. I believe Joe's identification of these interlocking features of psychoanalysis will last and will move us toward further useful investigation of (sic) "how analysis cures". Thank you Joe, for a brilliant romp - "Everything you wanted to know about psychoanalysis..." and for your own lasting contributions, your warmth, intelligence and human touch!

Panels

Twenty-eighth Annual Conference: Developing Clinical Momentum

PANEL I
A Focus on Transference
Leslie Smith

How is clinical momentum advanced through the transference? This was the focus of Panel I. We heard from presenters Marian Tolpin and Linda Marino, and discussants Evelyn Schwaber and Estelle Shane. Chair Jill Gardner launched the panel with a lovely introduction and moderated with finesse.

Marian Tolpin and Linda Marino together presented Marino's treatment of patient Colleen. Examining pivotal moments in this ongoing analysis, Tolpin demonstrated her central points: 1) In original development, as well as in treatment, forward momentum or the lack of it is a function of the particular dynamic system made up of self-object experiences between child and parents, and later between patient and analyst; 2) Momentum in the treatment creates a "new edition" reviving the patient's thwarted developmental process; and 3) Forward momentum in treatment is bi-directional in nature. It involves a back and forth between "trailing-edge" experiences that threaten self-cohesion and "leading-edge" experiences that invite self-righting and restoration.

Tolpin showed us how Marino's steady empathic approach conveyed understanding, acceptance and recognition of Colleen's experience. In this

analytic context, Colleen began to formulate new dreams. The new dreams evidenced the patient's emerging experience of a "safe, resting place", in which she felt increasingly stable and resourceful. Of equal importance were moments of disruption between Marino and her patient. These ruptures created trailing-edge experiences of disappointment, fury, and of "things falling apart." In the working-through process, the ruptures and repairs would contribute to forward movement in the analysis.

The presentation was entitled "The Revival of Normal Development." This title captures Tolpin's concept of therapeutic action, which occurs through "reanimating the tendrils of thwarted developmental strivings" and renewing growth in the forward-edge transference as it is reconstructed.

Discussant Evelyn Schwaber brought her own perspective and challenge. Schwaber understands transference as reflecting perceptions rooted in the patient's historical experiences. She emphasized the importance of listening so as to discover meaning rather than to infer or impose it. She seemed frustrated by aspects of the clinical presentation, specifically by the absence of material evidencing moments of discovery of the patient's own meanings. As she revisited the "pivotal moments" presented, Schwaber repeatedly asked, "How does Dr. Marino know [this]? How does the patient see it? How do we know?" Schwaber questioned, "Is the theory, or the patient guiding the understanding of the patient?" Those familiar with Schwaber's early papers on empathy recognize her familiar insistence on the importance of consistently striving to understand how the patient sees things, without making any assumptions.

Estelle Shane opened her discussion by inviting us to think about how change occurs and how development is understood, both in general, in analysis, and in this particular clinical material. Bringing to bear a dynamic systems perspective, she explained that "change in analysis frequently depends on a state shift in the patient provoked by an unanticipated incident, a spontaneous action, or an experience of surprise, a perturbation in the system out of which something new emerges." Shane stressed how this "something new" must be added to our understanding of development or growth in analysis. She argued that change involves not only the revival of stunted development, or the renewal of growth, but it involves perturbations in the system. In perturbation, there is the emergence of something new, "something that has never happened before, and that therefore can not be reconstructed, but is attributable only to a novel occurrence." Returning to the clinical presentation, Shane identified Colleen's *new* experiences and related *new* capacities and *new* sense of possibilities.

My own experience of the panel was somehow less than cohesive. I appreciated the clinical presentation by Marian Tolpin and Linda Marino as it helped me to grasp more fully the important self-psychological-forward-edge perspective of Marian Tolpin. Evelyn Schwaber raised valuable fundamental questions about how we listen to our patients. And Estelle Shane introduced me to a developmental systems perspective, illuminating a new way to think about growth and change in analysis. Though Tolpin and the discussants each used the clinical material as a springboard, it was difficult for me to experience the panel

presentation as a meaningful whole. Instead I experienced it as a collection of valuable, though disconnected parts, somehow lacking in the cohesiveness and flow of the subsequent panels. It made me wonder how future panels could be organized as a more cohesive whole.

Panels

Twenty-eighth Annual Conference: Developing Clinical Momentum

PANEL II
A Focus on Relationship/Enactment
Carla Leone, Ph.D.

The mood in the room was alive and eager as we gathered for the second panel of the 2005 conference, "Developing Clinical Momentum with a Focus on Relationship/Enactment." Based on our past experiences with chair Rod Bodansky of Germany, case presenter Gianni Nebbiosi of Italy and discussants Hazel Ipp of Toronto and Jackie Gotthold of New York, we anticipated a stimulating and enjoyable afternoon - and were not disappointed.

Case presentation: "Diana: Prince of the Moment" was the title of Gianni's presentation, incorporating a phrase his patient Diana had used to describe her son. We were quickly drawn into Diana's compelling and painful story - and into the one she and her analyst were able to write together - as told by a master clinician and master storyteller.

Although both stories had occurred thousands of miles away, in another country, in another language, I soon felt I was there, in Gianni's consulting room, hearing and watching them unfold. From Diana's opening request, "Excuse me, Doctor, but I want clear answers from you," as she understandably debated whether or not to begin a third analysis, Gianni's detailed descriptions brought the story to life. I - and I think everyone present - felt saddened and sickened as we learned that Diana's first analysis, with a male analyst, had included numerous mis-attuned responses to her loving feelings for him and had ultimately led to a two year sexual relationship with the (married) analyst after the treatment ended. We cringed internally in a different way as we heard of Diana's second analysis with a female analyst, whose outrage at the first one's behavior and extreme imposition of her own agenda resulted in Diana gradually losing touch with her own experience - a process which Diana felt ultimately led her to marry a man she did not love.

With this analytic history, as well as her painful and troubled childhood history, Diana came to her analysis with Gianni. We heard of Diana's love of poetry and her poetic-ness, qualities she shares with her analyst. Their analytic connection was forged in several moving moments of meeting when Gianni was able to use this shared ability to convey his deep understanding of his patient's experience.

We learned also of Diana's serious and composed demeanor, her suspiciousness of playfulness in anyone other than her son, and her frequent request from the beginning of treatment that Gianni "not move his face so much". Gianni described his varying reactions to this request and his eventual feeling of frustration and constriction, as he felt required to have a "politically correct attitude."

With this dynamic in the background, we reach the climax of the story. There is a month-long vacation break in the treatment, during which Gianni loses weight and grows a beard. Diana eventually confronts him in the smug tone of someone who has uncovered a bluff, "you may look young, but I know the truth - you are old!" And then comes the "prince" of a moment. In response, Gianni breaks into a big smile and collapses on his desk, saying, "You got me! But please deliver the coup de grace, I am still alive," as he lies there smiling up at her.

Feeling that the English language he had been speaking in did not adequately capture this moment, Gianni dramatically reenacted it for us in Italian, to our delight. He then described his patient's initial response ("Are you nuts? You are an analyst, not a clown!") and explained how their mutual processing of the incident led to new childhood memories that helped them both understand why Diana's playfulness had been so waylaid. Gianni then concluded with the words of a poem by Pasolini which had resonated deeply for Diana when he quoted them to her at one point: "Death is not/ in not being able to communicate/ but in no longer being able to be understood."

First discussion: Being the first discussant to follow this moving and entertaining presentation was no easy task, but Hazel Ipp was up to it. She began by using the Italian word " *sprezzaturra* " to describe Gianni. Roughly translated as "easy lightness", the term refers to a noble courtier's ability to do a variety of arduous tasks with apparent ease. It was a new term to me, one I was delighted to learn and which certainly did seem to fit Gianni.

Hazel's discussion, "Changing Faces and the Faces of Change," began by conceptualizing Diana as a survivor of multiple relational traumas. She saw trauma as having disrupted Diana's attachment system and having interfered with the development of her capacity for mutual relatedness, recognition of multiple subjectivities, capacity to experience emotion freely and ability to play. For Diana, as with many trauma survivors, Hazel suggested, relationships involve either exploitation or control, doer or done-to. This led Diana to conscript her therapist to act in the very ways that she most needed him not to act: constrained and inhibited, like her.

Invoking Stern's concepts of the inherent "sloppiness" of relating, "Winnicott's squiggling interplay of two subjectivities", and Paul Russell's concept of relating as the "negotiation of affect", Hazel conceptualized Diana's relational difficulties and therapeutic needs for a different way of relating. She saw the dramatic "You're old - you got me" interaction between Diana and Gianni as the beginning of this new mode of relating, the dramatic beginning of their more mutual "shared feeling voyage."

She then moved to discussing the incident as a dramatic enactment: an example of Ogden's "interpretive action" or cognitive psychology's "representation in the enactive mode." Enactment, Hazel reminded us, is the most basic level of representing experience, the mode closest to the body, the attachment system, and procedural memory. She introduced the concept of "poetic action" - a form of analytic enactment that carries a "creative performative message that artfully condenses the momentarily formulated and the . . . unformulated." Citing the Pizers, she suggested that poetic action links primary and secondary process, and notes that analyst and patient can return to poetic action, as we do with a poem, for "further refinement and mining of meaning." Like *sprezzaturra* , poetic action was another new term I was pleased to learn and which, again, certainly seemed to apply to Gianni's work with Diana.

Second discussion: Next came Jackie Gotthold's discussion, which focused on the question of whether the term enactment adds anything to our understanding of the clinical situation. After thanking Gianni for sharing his work and noting that he makes "just the right amount of faces" for her taste, Jackie began with the words to the song "I'm a believer." Emphasizing that "theory matters", especially when we examine terms like enactment, she started by detailing what she believes in: the theoretical positions of Stolorow and his colleagues, as well as the developments in nonlinear systems theory, infant research, and work of the Boston Process of Change Study Group. She believes, in particular, that the latter group's contribution of terms like implicit relational knowing, now moments, and moments of meeting has added a specificity and clarity to our ability to articulate the "something more" in clinical process.

She turned next to the implications of these beliefs for the question of the usefulness of the term enactment. She described the clinical process as having a co-created rhythmic quality of peaks and valleys, crescendos and diminuendos, with the peaks or heightened affective or more dramatic moments embedded in and inevitably emerging from the less intense moments. She repeatedly questioned the benefit of isolating particular heightened moments by describing them as enactments rather than viewing them as more embedded in the ongoing flow of what came before and after them. All components of the treatment - perturbations large and small - move the treatment along, she reminded us.

Jackie then examined Gianni's clinical material in light of this view. Beginning with the first session, and moving through other important moments of the treatment, she highlighted the many ways Gianni had conveyed to Diana his deep understanding of her experience: through his movement, gaze, playful use of Diana's own words, silence, timing, and so on. Drawing on her work with children, Jackie reminded us that communicating understanding can occur through play, action, verbalization or silence, and questioned why we refer to some moments of conveyed understanding as interpretations and others as enactments. To her, Gianni's playful collapse and response to Diana was an interpretation that occurred through both action and words.

Gianni had left us with the words of the poet Pasolini; Jackie closed with the lyrics of the song she began with, by Neil Diamond: "Then I saw her face/ Now

I'm a believer/ Not a trace/ Of doubt in my mind." A brief but lively discussion followed, which included Marion Tolpin's comment that Freud was more playful than later writers have chosen to convey.

As for me - I'm a believer in panels like this one.

Twenty-eighth Annual Conference: Developing Clinical Momentum

PANEL III
A Focus on Dramatic Moments and Improvisation

Leonard Bearne, Psy. D.

(Please note that due to issues of confidentiality this Panel was not recorded. This report will therefore focus on the theoretical issues raised in the discussions and presentation and will omit any details about the patient except those absolutely necessary to clarify the points addressed herein. This is done with the knowledge of, and in consultation with, Dr. Alan Kindler. I would like to thank all the participants for their cooperation in making their material available to me for purposes of this report.)

To begin, I would like to say how rich I found all three panels to be, unified as they were by the theme of the conference - Developing Clinical Momentum. The focus of Panel 3 was on Dramatic Moments and Improvisation. The Panel was Chaired by Bernard Brickman, M.D., the main paper was by Alan Kindler, M.D., and the discussants were Philip Ringstrom, Ph.D., Psy.D., and Daniel Stern, M.D.

Over 25 years ago a documentary appeared, entitled "No Maps on My Taps." The title is taken from the great tap dancer Chuck Green ("I got no maps . . . on my taps . . .") and as noted by one reviewer, it is about ". . . great dancing that is so "in the moment" there is no residue, and hence "no maps." This phrase conjures the spontaneous, unplanned expression of rhythm that is what makes this form so exciting to watch and so invigorating to perform. In this it contrasts with the choreographed steps with which most of us are familiar. Let us be clear that to be able to improvise in this way requires years of disciplined, dedicated practice of fundamentals until those fundamentals become so natural that they can be subsumed into the unplanned, unscripted expression of this form of dance.

Yet improvisation is not simply that which we do automatically once a level of technical mastery has been achieved. Just because a dancer has done the requisite years of practice, there is no guarantee that s/he will ever be able to improvise. Why is that? To improvise requires a leap beyond mastery or perhaps a willingness to *be* in a particular way, which has a separate path for coming into being. I will return to these ideas in a moment but first I would like to discuss the

three presentations.

In the main presentation, "Improvisation and Spontaneity in Psychoanalysis" Dr. Alan Kindler has provided us with a case that courageously allows us to share in his thinking and responses in the midst of the treatment of a successful, yet emotionally constricted middle-aged woman. This report of his case comes four years into a largely 5x/week analysis.

Dr. Kindler begins his presentation by discussing the question of improvisation in analysis and suggesting that it may well be something we do all the time. He cites many authors (Nachmanovitch, Knoblach, Ringstrom, Chaplin-Kindler, Lachmann, Lichtenberg, Meares, Gabbard, Stern et al) who are all considering the role of the improvisational in psychoanalysis. Foci of interest for these analysts have included the prevalence of improvisation in treatment, its desirability, how this type of spontaneity may have been discouraged in the early years of psychoanalysis, how it is part of the implicit relational context of analysis, how it needs to be used carefully, and how it can be seen in the context of traditional modes of interpretation.

What Dr. Kindler stresses as a pivotal point in this case is the way in which, by calling attention to some little decorative animals on his desk that had been rearranged without his knowledge, by a four year old the previous day, he was able to introduce the idea of "play" into the analytic relationship. By referring to the rearranging of the animals, a personal, spontaneous act by the child, Dr. Kindler is able to make it easier for his patient to consider his idea that *they* play, something the patient says she would not have been able to do even at the age of four.

In their next session, following the weekend break, his patient is unable to speak about her feelings. As they sit in silence, Dr. Kindler expressed,

"out loud my musings during the silence. I told her about the fantasy I had in response to the child's game, that we would have a game in which, for a few minutes, she would say whatever comes into her mind without any responsibility for what she was doing."

The patient takes to this idea and soon they are engaged in a discussion about the other doctors, whose offices the patient walks by to get to Dr. Kindler's door and how they appear to be not yet in, while Dr. Kindler is already at work. She thinks this means that her analyst is more successful and this feels good to her. Her musings are then interrupted by the thought that hearing this might be a burden for Dr. Kindler. They are able, however, to resume their discussion about the corridor of "losers," a phrase introduced by Dr. Kindler in the spirit of the mutual play and which she accepts.

The patient is able to talk about several other topics and before finishing the session states that she hopes that they can play again, though she is not sure that she will be able to repeat it the next day. She is in tears as she notes how totally unfamiliar this is for her. Dr. Kindler tells us that her tears are a,

"response to the fact that I had suggested the game to her, that it had allowed her to do something she had never done before, and (and this was most difficult to say) that it had seemed important to me."

Over the next several sessions they are able to "play" together, though this play alternates with periods when her sense of burdensomeness and worry re-emerges. Nevertheless, as Dr. Kindler notes, "it did seem to be a transition point to novel ways of being together." They had created a "play space," something new in the patient's world.

While this clinical vignette is stimulating on its own, it really serves to illustrate the larger point of Dr. Kindler's paper. He states,

"Contemporary psychoanalytic theory (Boston Group, Lichtenberg, Ringstrom, Bacal) seems to suggest that improvisation and spontaneity are intrinsic to the analytic dialogue and contribute significantly to the therapeutic process at all times. These developments seem to point in the direction of a model of psychoanalytic participation that includes an acceptance of, and a more careful consideration of, the improvisational dimension of responsiveness. Perhaps this will occupy more of our attention as we continue to develop our skills in the art of psychoanalysis while maintaining our allegiance to the science."

This idea, that psychoanalysis needs to pay more attention to the improvisational dimension of responsiveness, is taken up by Dr. Philip Ringstrom in his discussion of Alan Kindler's presentation. Dr. Ringstrom begins with a quote from D. W. Winnicott:

"If the therapist cannot play, then he is not suitable to work. If the patient cannot play then something needs to be done to enable the patient to become able to play after which psychoanalysis may begin."

In Dr. Kindler's presentation, the emphasis seems to be on the latter part of this quote (if the patient cannot play . . .). But Dr. Ringstrom seems most interested in the earlier part of the quote (if the therapist cannot play . . .). He says, "Accordingly, I am proposing that working improvisationally should be regarded as an evolutionary leap in revising our thinking about the very process of free association," proposing what he calls "bi-directional free association" by which he means " becoming improvisational . . . drawing *both* parties' free associational process into the analytic play space."

Dr. Ringstrom is talking about an interactive process. He distinguishes this improvisation from psychoanalytic spontaneity and suggests that while spontaneity, "involves acting from a natural feeling, one expressed without constraint, effort or reflection, occurring through internal causes," improvisation,

"certainly involves spontaneity, but more importantly it plays off of and with patterns that are linear and non-linear, verbal and non-verbal, allowing contexts of experiencing to influence their development,"

however, it, "requires playing with something that arises between two or more people." "Thus, working improvisationally involves ensemble work, wherein both parties play off of and with one another's spontaneous gestures."

The other discussant, Dr. Daniel Stern, focused on spontaneity in the infant-mother dyad. He presented a beautiful rendition of the "I'm gonna get you" game noting the breaking of the child's expectations through the unpredictability of the timing of the care-takers responses, leading to a joyful experience on the part of the infant. He stressed that this joyful experience, that he called positive excitement, is something you cannot induce in yourself. He also stressed the need to be able to tolerate this experience and pointed out that this seemed to be problematic for the patient in Dr. Kindler's case. He said he would want to ask her about her experience of over-excitement and the dangers of that for her.

There are a number of interesting points raised in this panel. As Dr. Bernard Brickman, the Panel's moderator noted, the classical "tilt" toward content has had the effect of lending itself too easily to a kind of analytic deadness. He sees spontaneity and improvisation, in their emphasis on process as providing a corrective to this deadening tendency. I would like to note Dr. Brickman's recognition of the tension between a potentially deadening focus on content and the potentially liberating focus on process and return to the beginning of this report.

The idea of "no maps on my taps" seems to me to suggest an attitude that allows for a wider range of possibilities for what can occur in our treatment rooms. Some readers may be reminded of Bion's puckish dictum that analysts should have neither memory nor desire. However, it may well conjure up for others the specter of a kind of "wild" analysis where anything goes. Can we walk this line between the Scylla of analytic deadness and the Charybdis of wild analysis? If we are to walk this line there are several issues we must bear in mind.

Many of our most revered teachers, such as Heinz Kohut, broke the analytic rules at some point to give us new insight into our ways of being with patients. Yet they were well versed in the traditional understandings, often, as Dr. Kohut was himself, being seen as paradigms of those practices. In encouraging the emergence of a new analytic focus - and it seems to me that Drs. Kindler and Ringstrom as well as several of the authors they cite are doing just that - we need to be mindful that for the use of spontaneity to be not "wild" we must find ways to ensure that our training leaves candidates grounded in an understanding of practice and theory that allows them to feel comfortable in improvisation. One small caution may suffice. There are patients I have known who would not have reacted favorably to the kind of intervention that Dr. Kindler used so masterfully. This kind of systemic "perturbation" should not be enshrined. Indeed, the very notion of spontaneity indicates that in every situation something unique is happening. And our responses need to be unique as well. Spontaneous quiet, anyone?

The tap dancers I referred to at the beginning of this report had repeated, thousands of times, the basic rhythmic patterns that made up the vernacular of that

style of dance. They knew the territory. Once that knowledge was established (in our modern terms as procedural memory) they were free to explore, secure in their own bodily abilities. Likewise, we must ensure that our training leaves our candidates, and ourselves, equally well grounded.

That being said, I also noted at the beginning of this report that some talented and well-trained dancers (or musicians, or analysts) never seem to be able to improvise. I asked why that was? If there is a Scylla of deadness and a Charybdis of wildness that we must walk between as a profession, there is likewise one we must walk individually. The importance of this panel lies in its legitimizing, for us as individuals and for us as a profession, the notion of spontaneity in analysis. Without such validation by serious analysts, teachers and supervisors, it will be hard to overcome our anxieties about being judged, about appearing "wild", about breaking the rules. About, in the end, being spontaneous.

Panels

Twenty-eighth Annual Conference: Developing Clinical Momentum

Summary of the Paper Sessions

Frank M. Lachmann, Ph.D.

The quality, depth and breadth of the paper sessions is the direct result of the dedicated work of the readers who refereed the papers. We received more than twice as many papers as we could accept, a sign that self psychology is alive and well among candidates and faculty in training institutes, among therapists in private practices and clinics and in academic settings in the U.S., Canada, Europe and the Far East. Choosing among so many worthwhile contributions is a difficult task and I want to thank the readers for providing us with such a varied and high-level group of papers. The readers were: Peter Buirski, Jackie Gotthold, Arthur Gray, Ruth Gruenthal, Sandra Hirschberg, Andy Karp, Peter Kaufman, Pauline Pinto, Dori Sorter, and Judy Teicholz.

Briefly, I will give you my impressions of the paper sessions as I surveyed them. I will not be mentioning the presenters by name, but rather offering a gloss of some of the topics and ideas.

Kohut's writings presented us with the big picture. He wrote in grand, often metapsychological terms, placing self psychology into the context of, and at the center of, psychoanalytic treatment and theory. He laid out an ambitious plan. The paper sessions at these meetings take up the details of that plan, plus. The "plus" refers to issues that were not so central to the psychoanalytic enterprise at the time

Kohut was writing, but are of concern to us now. I will begin with the pluses.

In the psychoanalytic marketplace and in the competition for candidates at training institutes, self psychology is under pressure from relational theories in many quarters. The clinical material presented at the relational conferences is dramatic and engaging just as was true for Kohut when he offered his case presentations. They, too, were dramatic, novel, and so experience-near that they spoke to analysts and patients alike, and they spoke especially to analysts who were themselves undergoing their own analysis. Self psychology is now encountering the same - shall I call it threat or challenge?

One set of papers at this meeting addressed that challenge: shall we hold fast to the centrality of empathic understanding or expand our therapeutic repertoire to include the analyst's authenticity, spontaneity, playfulness, creativity, and humor? Several authors addressed the dilemma of the authenticity of the analyst. Rather than considering authenticity as a virtue and an end in itself, as some psychoanalytic practitioners do, self psychologists have their own unique take on authenticity, that is, an authenticity balanced by self-restraint and self-reflection. We do not confront our patients by telling them how they have enraged us, threatened us, or tried to seduce us. Rather, we carry on an internal dialogue in which we balance the desire for authenticity with an adherence to the "technical" principles of "wearing the attribution" of the qualities the patient ascribes to the therapist: for example, balancing the patient's belief that the analyst is in love with him, with the analyst's values, ethics and ideals. A self-imposed task for the analyst is to remain genuinely, personally engaged, while interacting professionally with the patient.

What self psychologists try to avoid is a retreat behind so-called proper analytic behavior. According to the papers presented, authenticity is a highly specific, co-created dimension of the analyst-patient interaction that is constantly subjected to self-examination and cannot be transported to any other patient or situation. Every treatment thus becomes unique, challenging, and damned difficult.

That brings me to a second plus. Once we leave the paved path of traditional psychoanalytic treatment, it is easy to trip. What if in the course of a difficult treatment with a suicidal patient, the patient requires being touched and hugged as evidence that the analyst really does exist? Or, a suicidal patient requires a home visit by the therapist who wants to make sure the patient is still alive and wants to prevent a catastrophe? What if the child's emotionally labile mother stays in the therapy room during sessions? What if you discover that you and your patient have friends in common and, to prevent a meeting from taking place, confidentiality has to be broken? What all these "what ifs" have in common is that none were addressed by the paper-presenters in a "by-the-book" manner. They all prompted the therapist to take a look both inward and outward to search for a "tailor-made" rather than "off-the-shelf" solution. The description of these challenges and struggles, by both patients and therapists has been, and still is, the essence and value of the paper sessions.

However, a caution was also introduced with respect to some of these heroic

treatments. Specifically, to what extent are these measures a consequence of the therapist's countertransference interfering with the development of "self-care" in the patient?

The plus also refers to the so-called "difficult-to-treat" cases. These are patients who have been increasingly included among those treated by self psychologists. Their treatments have been presented at our plenary meetings and paper sessions. Yet these were the patients about whom Kohut had doubts about their accessibility to his empathy and introspection. One aspect of making these difficult-to-treat patients more accessible has been the recognition of similarities in humanity between these patients and ourselves, a theme that several papers shared. For example, although the life circumstances between a transvestite man and his female therapist could not have been more different, the therapist recognized that his story was also hers. She recognized that they both struggled to speak of gender in a voice uniquely their own. But sometimes the difficulty resides not so much in the patient but, in the case of children, in the family: parents who do not believe in therapy, demand that you fix their child quickly, and then summarily pull their child out of treatment as soon as some progress has been made. It is easy and counterproductive to let one's resentment toward the parents color what may eventually be in the best interests of the child.

Some of the papers addressed the challenge of relational thinking and classical analysis head-on. A paper about hope and dread, challenged the view that patient and analyst must first tolerate, then understand, and pass through a situation of dire straits before coming out the other side. Rather, from a self psychological perspective a different view is offered: heightened affective moments provide the essential ingredient necessary for achieving a balance between hope and dread that enables change to occur. Thus, dread is not a necessary precursor to hope.

Furthermore, the general psychoanalytic assumption that partnered relationships, lifetime pair-bondings are the likeliest guarantee of human happiness is questioned. Here, too, Kohut opened the door when he unhooked narcissism and object relationships, positing two separate lines of development.

Even the Oedipus Complex was challenged in that it was recontextualized with an emphasis on the father's abusive power and the struggle with one's mortality. And while we are at it, the whole authoritarian, privileged status according to analytic interpretation was challenged by post-Cartesian, postmodern epistemology. Finally, a view of "enactments" was presented that challenged the hierarchical view of one person interpreting another's deep motivations.

In the process of their struggles, self psychologists reported encountering their own areas of strain. They searched for ways to address their own experiences of dissociation. Following the path of introspection, clues as to the subjective experience of dissociation or its influence on the treatment process were sought. Following another path of exploring one's own reveries as they occurred spontaneously in the treatment process was examined as to their contribution toward understanding the patient's material.

Case presentations that illustrate the centrality of a self psychological perspective have always been the backbone of the paper sessions. As in the past, a defining characteristic of self-pathology has been the difficulty of patients' to experience themselves as in touch with their feelings. It is what is often discussed under the diagnosis of dissociation, a problem that received considerable attention directly and indirectly, from the side of its presence in the patient's treatment and its presence in the therapist. In treatment, a multimodal approach of individual, conjoint and family therapy addressed the dissociated life of an adolescent who preferred cyberspace to life in high school.

One aspect of being a self psychologist is the extent to which we examine our own experience in the treatment process. Several papers focused on the joint experience of therapist and patient in benefiting from the treatment experience. This was illustrated in a range of treatments from the dramatic, for example, treating men who had developed a style of being overly concerned with pleasing their partners at enormous expense to themselves. Treatments were carefully detailed so that we could follow the intricate path the therapist pursued in understanding their patients and themselves.

The treatment process itself was subjected to direct and indirect attention in these papers. The complexity of multiple modalities, combining individual and group treatment was examined with respect to problems that can emerge when these modalities are combined. Extending and refining Kohut's understanding and explaining model, papers and workshops that focused on making interventions specific in the service of optimizing the positive experience of the patient. That model was further expanded through discussions of enactments. Enactments were understood as occurring as part of and at specific unexpected moments in the moment-to-moment living together of the analytic dyad.

And the treatment process was also addressed with respect to complex problems raised by supervision. Even self psychologically informed supervision that emphasizes the mutuality of the process may touch on the competition, within the supervisor, between wanting to be open and self-revealing and working in a manner that would best maximize the supervisee's ability to learn.

My final survey concerns those papers and workshops that extend Kohut's ideas beyond the borders of psychoanalysis. Kohut led the way in the field of applied psychoanalysis in his papers on literature and music. The paper sessions this year included papers by analysts who have additional areas of expertise. We heard papers on the relationship between self psychology and art, dance, religion, philosophy and literature. What an impressive list of applications.

With respect to religion, Christianity and Judaism were represented. God was discussed as a collective selfobject, aiming toward an empathic and non-pathological attachment of one's attachment to personification, and some measure of peace with an intellectual disbelief in a personal, supernatural God.

With respect to dance, a case study of a depressed, suicidal woman illustrated the twinship that developed through the combined rhythms of dance and therapy,

providing an opportunity to repair an early mind/body split, another variant of dissociation.

With respect to art, a case study illustrated the therapist's attention to a patient's nascent artistic creative strivings, leading specifically to a process of increased self-delineation.

With respect to literature, we ranged from the file, *The Piano* , to the greatest epic of all time, *Don Quixote* . What both of these works have in common is their celebration of the human spirit and that is in the best spirit of self psychology.

Panels

Twenty-eighth Annual Conference: Developing Clinical Momentum

Keynote Presentations Summary

John Riker

James Fosshage began his address with the question of, "how does analysis bring about change?" He iterated that the old answer involved offering interpretations that were backed by the objective epistemological authority of the analyst, but that self psychologically informed analysts were working out a new answer: it is the relational interaction of analyst and analysand that brings about change. The key to an effective relational interaction is the presence of the analyst's empathy, which he defined as an other-centered perspective that opens up what it feels like to be another person and offers the possibility for a reflective perspective on the self of the other. Within the relational model, transference is re-defined from a previous model that understood it as a displacement of the patient's feelings from earlier objects onto the analyst to a new model in which transference is understood as the presence of an unconscious organizational structure that produces expectancies, selective attention, and attributions of meaning.

Within this transference relational matrix, the patient can experience a selfobject pull - hope - stimulating a yearning for growth. This hope threatens the dominant organization structure but opens up the possibility of living beyond its confining rigidities. The patient has two strong interactive tendencies, one which leans towards repeating the familiar and one which is a nascent striving to achieve a new organizing structure, one which opens up possibilities, allows for differential responses to difference, and re-vitalizes life.

Fosshage then added a new way of "languaging" this change: it is the production of a novel implicit procedural memory. Implicit procedural memory is a memory

that instructs us on 'how' to do something. What is being learned in analysis is how to relate to another human being and oneself in such a way as to be loving and better able to receive love, where love is understood as the ability to affirm the worth and singularity of one's own being and the being of others.

Fosshage's description of analytic love recalled to me Heidegger's notion of authentic care. Authentic care involves a "leaping ahead" in which one helps and allows the strengths and inherent possibilities of the other emerge to solve her problems, whereas inauthentic care is a "leaping in," an attempt to solve the problems of the other without enhancing her ability to be a source of strength and vitality in herself.

(A full transcript of James Fosshage's keynote address is available on Psychology of the Self Online .)

Daniel Stern followed Fosshage's address with a talk on the key features of the shift from an intrapsychic kind of analysis to an interpersonal, intersubjective, and relational kind of analysis. He described six key shifts: (1) A two-person field is inherently unpredictable. A dyadic relationship is 'sloppy', full of mistakes, and always in need of repair, but it allows for the possibility of something new to emerge that can not be predicted. This kind of shift can only be understood with a dynamic systems theory. (2) Relational analysis works at the level of implicit and procedural knowledge, shifting unconscious expectations about what constitutes a meaningful and caring human interaction. (3) Intersubjective theory reverberates with neuroscience's discovery of mirror neurons that sit next to motor neurons and which fire when the motor neurons of another fire. Mirror neurons allow babies to connect at a bodily level to the subjectivity of a mother. (4) The fundamental psychological unit that carries meaning is an intention. Both babies and adults scan others to detect their intentions and have "intention-detecting centers in the brain. Grasping an intention means that one can organize essential data about what others are doing and are likely to do. (5) Relational analysis understands that talking with another person, presenting facial gestures, etc., are all actions. Everything is an enactment. An interpretation is not just a set of words trying to accurately describe a person's psyche, but can also be experienced as an attack, an act of love, an attempt to control, etc. (6) Relational analysis is the attempt to turn something upside down. It is in the interaction in which old ways of being in the world (to use a Heideggerian phrase) are transformed into a new way of being in the world in which both the world is seen as having new possibilities and the patient experiences herself as having the strength and vitality to seek these new forms of experience.

In sum, the conference began with two quite stunning lectures, each of which proposed that the heart of therapeutic action was the dynamic relationship between patient and analyst, an empathic relationship that can move the patient from organizational structures bent on repeating the past with its traumas and limitations to one in which new vital possibilities arise, especially possibilities for allowing others to be seen as who they are rather than reducing them to variables in one's scheme of repeated expectations. In this transformation one can see that while analysis does not use moral judgment as a way of producing change, it is an

inherently ethical enterprise, for it opens up the possibility of treating others as ends in themselves rather than as a mere means to confirm past expectations.

Op-ed

Welcoming Program Launched

Maria Slowiaczek

There are probably as many different reactions to entering a bustling beehive of 500ish professionals as there are actual attendees at large conferences. While some like nothing better than to "dive right in," others have said they wished the process were easier for them. At the annual Psychology of the Self conference (held in Baltimore in October 2005), IAPSP initiated a program to welcome newcomers, to facilitate their "comfort-in-the-group". Intended to enhance participation in and enjoyment of the meeting, the effort was initially suggested by Dr. Maria Slowiaczek who, along with Dr. Shelley Doctors, implemented the fledgling effort. The program was created to help newcomers get to know others socially, which we think can make for a more user-friendly experience, especially at mealtimes and coffee breaks when it can appear that everyone is meeting and greeting colleagues and old friends and acquaintances.

Conference attendees who wished to participate were paired with experienced self psychologists who volunteered to "meet and greet" two newcomers. Prior to the conference, the experienced volunteer contacted each of two newcomers, (individuals who indicated they wished to participate in the "Welcoming Program"), initiating a dialogue and offering to respond to questions. In many cases this led to phone contact as well. For most, this resulted in a plan to meet early in the conference, which we learned was key to a successful encounter. Further, pairing two newcomers with each volunteer acquainted each newcomer with at least one new friend who shared something of their actual experience.

Fifteen "welcomers" participated along with thirty "newcomers". Many chose to meet at the Thursday night reception. Some chose to have lunch or dinner together, to sit together at panels, or to meet at coffee breaks. We had arranged for Welcoming Program participants to sit together at the Kohut Memorial Luncheon, which for most was a further opportunity to meet people motivated to meet them and get to know them. Although we tried to create a "group" to attend the Saturday evening reception together, our last-minute effort was less successful than the better thought out luncheon tables had been.

After the conference, to learn more about what had happened and to better plan for future years, participants were sent questionnaires. In the main, newcomers and welcomers alike were glad to have participated. Most newcomers felt grateful for

the program and reported that the conference atmosphere felt inclusive and friendly; when they were able to make significant contact with new friends, their sense of belonging and their sense of having profited from the entire experience was enhanced. As this year's "welcomers" were all members of the International Council, many newcomers said they were surprised and happy that distinguished members of the Self Psychology community had been so available to them. The "welcomers" enjoyed the experience and many indicated they had benefited from the opportunity to meet new colleagues.

We learned that opportunities for sustained conversation were the most useful for all concerned, though it isn't yet clear to us how we will build on this understanding. The conference is jam-packed and many people who might otherwise participate may feel the tug of other competing professional and social obligations. So how will we build on a promising initiative?

We're hard at work trying to expand and improve our first effort. For the 2006 conference in Chicago, the Welcoming Program will be announced in the printed brochure as well as on the website, which should result in more participants. We are wondering about a "Logo" to help participants find each other in crowded rooms, and trying to see whether there is some time during the conference when participants could meet as a group. It would probably be helpful to have a group attending the Saturday night reception together, for that appears to be intimidating to otherwise spunky folks.

If you have ideas about how to improve this new initiative, please write to us. Additionally, we invite those who have attended several self psychology conferences and who wish to welcome newcomers into the fold to contact us directly. We don't define "newcomers" - anyone who might like to be personally greeted prior to the conference and at the conference is invited to participate. Many of this year's participants had attended previously and yet felt this experience enhanced their conference attendance. For all comments, suggestions, and inquiries about the program, please contact Maria Slowiaczek or Shelley Doctors .

Op-ed

Is There a Place for Cognitive-Behavioral Therapy in Psychoanalytic Therapy?

Susen Kay, Psy.D.

Recently my institute has generated an online discussion thread expressing great concern about the increasing emphasis on cognitive-behavioral therapy throughout the medical and psychological communities. Not much, if anything, is written in the psychoanalytic literature about the use of these techniques, although I believe that the general tone, when there is discussion, is one of disparagement and disdain. I wish to offer an alternative opinion: that these techniques can be

integrated and, further, might be helpful when coupled with a psychoanalytic approach.

I want to thank the editors of this newsletter for encouraging discussion and controversy and I want to encourage you the readers, to respond with your thoughts.

The following case example is intended to show how cognitive-behavioral techniques helped the patient to develop a beginning awareness of his personal subjectivity, while the concurrent psychoanalytic process, expanded and deepened that awareness.

Hank, an average-looking 30 year old male patient, came to me because he was having panic attacks. How did he know he was having panic attacks? His heart would start racing, he would feel light-headed and it would be difficult for him to breath. Notice that these are all physical symptoms (he had no awareness of any anxiety, except that in the midst of the attack, he did admit that he was afraid for his health and his life). Questions about his internal states usually resulted in a one-word answer, "fine." If pressed he would respond with a list of tasks or activities, but never any "feeling" words.

Coming as no surprise, Hank researched his symptoms on the web. He concluded he had panic attacks and the best advice on the web was to get medication and then cognitive behavioral therapy. He went to his internist to get medication and he came to me because I was listed on a website as specializing in anxiety disorders. I started working with Hank once a week while we moved him to a psychiatrist to get his medication adjusted.

A very telling example of Hank's life concerned how he made his career decision. When he was to graduate from high school, his parents told him he had to go to college and decide on a career. His older sister was dating someone who was a program developer in the computer industry and he decided that it seemed like a good choice so that's what he did. Questions about how he felt at the time elicited nothing. Of course, it is very meaningful to me that his parents didn't prepare him for college, leaving him alone to decide what to do.

Frankly, I have never worked so hard with any patient. I would ask him how he was feeling and it quickly became clear he had no concept of feelings. He would answer with his usual "fine," even when I could sense small differences in his states; sometimes happy, sometimes stressed. Pursuing it further would result in an evaluation of the number of panic attacks he'd had that week and their intensity.

We could diagnose Hank as "alexithymic" and we could postulate that during childhood his emotions were not validated, mirrored or acknowledged, so therefore he has no awareness, knowledge or words for them.

I started reflecting back to him what I guessed was his internal state; happy at the purchase of a new truck, frustration at the process of debugging a computer program, helplessness and anger at the occurrence of a panic attack, hopefulness

as he tried a new medication. My statements and guesses about his internal state would often be met with another monosyllabic response, usually in agreement. If I didn't ask for a response, he would just stare back at me blankly. Occasionally he would initiate a response with a sentence or two, an association, and I would inwardly rejoice and demonstrate interest.

Hank's psychiatrist gave him a cognitive-behavioral manual along with worksheets to fill out at each panic attack (there were several attacks every week). As his work became more stressful because of deadlines, I continued to try to develop his awareness of these stresses. Having programmed computers myself, I was able to walk through the process with him and identify various instances of frustrations and anger to help him identify these feelings. It was slow and hard work.

I asked him to bring in his cognitive-behavioral manual and forms. We went over his answers. I noticed that all his panic symptoms were still expressed somatically and he was not aware of any anxiety leading up to the panic attacks. I pointed out patterns, asked about his internal state before the attacks, what was it like to fill out the forms, etc. Often, I brought the discussion back to my guess of his feeling state, which might elicit a blank stare or sometimes an affirmative nod. I would ask about the deadlines at work, the increased workload, and his reactions. When I inquired, he would usually agree that, yes, he did feel frustrated, angry, or whatever. I asked him whether our discussions were helpful to him and he answered "yes," although he couldn't say how or why.

I dreaded his sessions, sought consultation, worked to develop his curiosity about what, exactly, was happening to him, and kept trying to find something of this process that would interest him, simultaneously, wondering what inhibited him from being curious and interested. He noticed that although the medication had decreased his symptoms, he still experienced symptoms. I identified his discouragement. In his usual manner, he flatly agreed and waited for me to say the next thing. I expressed his thought and hope that the medication would solve his panic problems and again repeated that maybe more was going on, that his emotions were involved as well.

Over the course of months of this type of work, Hank slowly became aware of some slight feelings of anxiety. Based on the forms he filled out, we concluded that Hank had the panic attacks when he managed to ignore these anxious feelings. He thought he was distracting himself, but together we decided that he was cutting himself off from his feelings and that panic would result. This was progress I thought. He was tentatively admitting that how he managed his feelings might be affecting his panic attacks.

As his work deadlines passed, Hank still continued to have several panicky periods a week. He learned to manage these through deep breathing and keep them from escalating into full panic attacks. He became resigned to them and drew some measure of confidence that he could control the panic. Hank kept coming and I attributed this to his slightly obsessive tendencies at managing his anxiety. The website had said to get therapy and he was getting it! At 5 months of treatment he asked to come every other week and I readily agreed, inwardly both

relieved and guilty.

After two more months, I went to greet him in the waiting room as usual. He had his cognitive-behavioral manual with him and he smiled at me and bounded into the room! He was excited! He said that he just read a chapter that expressed what he and I had been talking about for all these months. The chapter he read was about *making assumptions and jumping to conclusions* . He talked hurriedly and excitedly, telling me his discoveries. He had noticed that when he went into a store, he avoided the salesman. Why should he avoid the salesman, he questioned. As I picked up his question and inquired more, he explored. He realized that he was "uncomfortable" talking to the salesman if he wasn't intending to buy something, instead, only wanting to get information. This was a new dimension of his concept of his world; it wasn't just the flat perspective of "doing whatever he did" but that he had a deeper dimension of feeling and awareness of connections between his thoughts, feelings, and his reactions.

And then he had another thought. He noticed that when he drove, he was anxious about getting off at his exit, changing lanes several miles beforehand, afraid that others would not let him move over. He noticed that he made this "assumption" and also realized that there was no practical basis for it. Why would he have this fear, he asked me? I was so excited for him! He had become aware that his subjective world affected his choices and actions. This was big news!!! Noticing that he was engaging in these behaviors was the result of both the psychodynamic and the cognitive-behavioral work, but asking the "why", I believe, was the result of our psychoanalytic work.

The cognitive-behavioral techniques were a tangible, concrete methodology and gave him something to do when he had attacks. The specific questions helped Hank to direct his attention to his subjective state and to identify what he was specifically thinking at the time of the attack and just prior to the attack. They helped him identify patterns, even if they were only concrete physical patterns. My psychoanalytic approach was to explicate the specific feelings associated with his thoughts and validate their significance. I was doing my best to identify and mirror his subjective world within an implicit attitude of curiosity and exploration. His breakthrough occurred in the contexts of both the cognitive-behavioral assignments and the psychoanalytic treatment.

Hank no longer uses the cognitive-behavioral manual, coming to a point that he said was repetitive and not helpful anymore. I believe that the manual, forms and techniques were helpful in several ways when joined with my psychoanalytic approach.

First, Hank was relieved of the specific fear that his panic attack was solely a physical problem, although this took some cognitive work. For example, while he was in the process of an attack, "feeling" his heart race, he needed to remind himself that it was not like his racing heart when he jogged. In explicitly explaining the process of the attacks, Hank moved from the fear that he had something physically wrong with him to an acceptance that they were part of a larger complex process involving his thoughts, feelings, and body sensations that

carried important meanings for him in specific relational contexts, even if he couldn't understand his emotions in context for a long time.

Second, the cognitive-behavioral questions focused him on his subjective state, asking pointed questions about his thoughts. Implicitly they held, as I did, that there was something other than a physical cause. I worked with Hank to identify his feeling states associated with his thoughts. Hank noticed that filling out the forms seemed to relieve some of the panic. I explained that answering the questions on the CBT forms helped him reflect back on the panic process, stopping his panicky thoughts. I was to use this example of reflecting on his actions and thoughts many times and slowly he was able to see himself and his actions from a different perspective.

When he was able to make the leap to recognize that his behavior was "not rational," but was connected to his assumptions, convictions, and feelings he experienced in different self states within a variety of relational contexts, he was able to bring these experiences and awarenesses to me. My reaction served as another, new validating experience for him that supported his own self-regulation. He needed to have a validating "other", a mirroring "other" that would accept and help him name and understand his states and their contexts.

In conclusion I believe that the cognitive-behavioral approach reassured him he was "doing something" while beginning to point him internally towards his own subjectivity. The analytic approach focused implicitly and explicitly on a deeper subjectivity that, after many months of exploring many different situations and many specific examples, he was finally able to experience.

Op-ed

Surviving Collective Trauma: Between Loss and Renewal

Harriet Pappenheim, Emanuel Shapiro and Jean Owen

On Saturday, January 7, 2006 the Association for Psychoanalytic Self Psychology in New York City presented an all-day conference entitled "Surviving Collective Trauma: Between Loss and Renewal." As opposed to the usual focus on early individual trauma, this conference was focused on trauma as experienced within the family, community or nation. In the words of Harriet Pappenheim, LCSW, a member of the APSP Program Committee and a primary organizer of the conference, "APSP considered this subject of urgent importance since it is no secret to us in New York that there is another 9/11 disaster waiting to happen. If it

does, mental health practitioners throughout our city will be part of the community's first line of defense in helping the traumatized. APSP felt it would help to prepare for such a future event by hearing from people who have worked with people severely traumatized by terror attacks."

Our featured presenter was Dr. Esther Cohen, who has done 30 years of clinical work with victims of war and terror in Israel. Dr. Cohen was a vibrant speaker, with the amazing ability to look straight into the heart of darkness, while always looking to encourage the tendrils of hope and renewal. Dr. Cohen's first presentation was "Changing Through Trauma: Multi-Modal Therapeutic Interventions with Survivors of Terror." Dr. Cohen began with an illuminating explication of the paradoxical ways of living that Israelis have learned to deal with chronic trauma: high vigilance combined with business as usual; intense celebrating and enjoyment as well as recklessness; caring and altruism as well as interpersonal aggressiveness, black humor and open public expression of sadness.

Her therapeutic focus was on resilience building, and on the appreciation of the incredible adaptability and growth of human beings, implying both respect for the defensive and coping mechanisms they employ. She spoke of preplanned protective measures like developing and strengthening communication and support networks. She stressed the importance of preserving continuities, such as keeping families together in their homes, crisis intervention, when possible, by familiar figures like teachers and counselors. She thinks that this priority was ignored here in the response to 9/11 and Katrina. Functional continuity is also important: the ability to remain active and helpful, continuing to fulfill one's usual roles. The therapeutic challenge is how to combine empathic understanding with the expectation for coping and continuity.

Dr. Cohen then presented a multi-modal framework for conceptualizing preventive and therapeutic interventions which takes into account belief systems, affective systems, cognitive systems, physiological systems, behavioral systems, reflective systems and narrative systems. How can the traumatic experience become part of one's life story?

Dr. Cohen's second presentation, "Soothing the Wounds of Trauma with Young Children and their Caregivers," was based on a research project in Israel. Play sessions with children from four to seven who had been exposed to the violence of terrorism (and a control group who had not been exposed) were videotaped, some of which were shown to the audience. The study found that, contrary to general belief, very young children are not immune to the effects of trauma. In the play sessions it was found that while the children typically reenacted the painful aspects of their experience, some showed unusual resilience and managed to soothe themselves successfully, for example with protective and care-taking activities. Others lacked self soothing mechanisms and some were so overwhelmed by anxiety and pain that they could not use play to process their experience. Parents were given the videotapes and follow-up work was done to help them understand and deal with their children's problems. If indicated, children were referred for therapy.

The discussant was the noted self psychologist Dr. Anna Ornstein, herself a survivor of the last century's greatest terror attack, the Holocaust. Dr. Ornstein was the perfect commentator as she, too, has always looked for the tendrils of hope and renewal in her work with victims of extreme trauma.

The afternoon featured a prestigious group of trauma specialists, organized by Emanuel Shapiro, PhD, reporting on their work during the aftermath of 9/11. Drs. Cohen and Ornstein joined the panel. Meg Kalman-O'Connor, LCSW, BCD, described her work as a counselor with a disaster medical team which enters disaster sites to provide medical relief to survivors. Richard Beck, LCSW, BCD, discussed how trauma impact requires the therapist to identify, manage and understand complex relational dynamics. Suzanne Lachmann, Psy.D, who counseled firefighters, fascinated the audience with her journey from her first days when her prospective clients left the room when she entered, to her full acceptance into their ranks. Jeffrey Kleinberg, PhD, an organizational counselor, found that by absorbing the trauma of their constituents, many organizations experienced ongoing pervasive stress that resulted in functional regression with a tendency toward insecurity, defensiveness, isolation, burnout, and attrition. Finally, Michael Andronico, PhD, led a widows' group involved with strengthening the widows' defenses to enable them to bear the powerful feelings of loss. Telling the stories of their lives and losses and having them witnessed was a reparative ritual involving the "healing of memories." The five presentations provided a perspective on the varying types of trauma work that can be provided following a major disaster.

To order audio tapes of this conference send a check for $20 to APSP - 215 E. 79th Street, Apt 13C, New York, NY 10021.