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THIS ISSUE

Henry Schwartz

There are developments since the last issue that deserve mention.

Most obviously, this issue is longer and has a new binding. The added length is due to the inclusion of the exchange between Sonnenberg and Cooper from the APM scientific meeting of November, 2005; new sections edited by Wendy Katz, and by Vivian Pender; an interview; a poem; and a letter to the editor. At the same time, it should be noted that the sections on education and on culture are expected to return with the next issue, and that the section on inter-institute issues is gone and unlikely to return. The demise of the latter, unfortunately, says more than I can. Our new binding is more typical for journals of greater length, but we hope that even if we are unable to sustain this length it will remain. It gives the Bulletin the feel of a journal rather than a pamphlet.

I leave it to the section editors to introduce the new sections and any developments within our ongoing sections. Since the interview is introduced in its section, that leaves only the poem for explanation here. As for the letter, its authors Berger, Cabiniss, Feldman, and Schein, deserve appreciative acknowledgement for initiating what we hope will be the first of many more letters from our community. When there are oversights in the Bulletin, as this letter makes clear, we rely on others to point them out. When there are errors, corrections from the community become of even greater importance. And when there is more to be said, whether due to interest or disagreement, our letters section is here.

So, why a poem? The poem appears for pleasure and aesthetic relief. (As Freud strolled with "Katharina——" in the Hohe Tauern, even they must have rested at times to enjoy the view.) It is not intended to have any particular psychoanalytic application, nor does it emerge from a psychoanalytic source. Retallack is a professional poet (there are a few) who was kind enough to permit publication gratis. More art will be sought for future issues and will be included if we have the good fortune to obtain permission for publication.

LETTERS TO THE EDITOR

To the Editor,

We were delighted to see the new "candidates" section of the Bulletin and applaud the decision to write about the important issue of recruitment. However, since the article did not mention recruitment initiatives that we are undertaking here at Columbia, we thought that we would make the readership aware of them.

1. Our monthly "Why Psychoanalysis?" dinner/discussion group, run by Jonah Schein and Deborah Cabaniss, has been running since September 2005. This group is open to all psychologists and psychiatrists who are considering psychoanalytic training and want to learn more about it. Each month a candidate or graduate analyst presents clinical material and we discuss a related paper. We have had approximately 15 participants per month from a variety of training programs.

2. We are indebted to the candidates for two important recruiting initiatives. The first was a very well attended "candidate only" open house, held in January, at which candidates answered questions about the program. The second is the idea for an optional "informational interview" with a candidate that applicants will be able to select as part of the application process

3. For the first time, we are actively trying to forge a bridge to the psychology community. Bob Glick, Steven Roose, and Brenda Berger met in the fall with the directors of several psychology PhD programs to explore ways to create a bridge between the Center and their programs. One exciting result of that meeting was our active pursuit of creating an externship program at the Center for psychology PhD candidates—this is being spearheaded by Brenda Berger

4. Michael Feldman is pursuing new ways to think about recruitment of child fellows.

We welcome any new ideas from all faculty and candidates.

Sincerely,
Brenda Berger
Deborah Cabaniss
Michael Feldman
Jonah Schein

EARLY CAREER ISSUES

Introduction

Wendy Katz, section editor

When asked to edit this section on "new analysts," I spent some time considering what issues might be specific to those of us who are just emerging from training. What is on the minds of recent graduates? I put this question to others in this category, from Columbia as well as other institutes, with the plan to bring to this section the reflections of this group on topics such as: involvement in institutional politics, practice-building, balancing life as an analyst with young family life, integrating other disciplinary identities with being an analyst, and whatever else might come to the collective mind. While awaiting responses to this inquiry, I decided to put pen to paper to reflect on an aspect of graduation that felt momentous to me: life after supervision.

Alone At Last: New Analyst and Patient When Supervision Ends

Wendy Katz

In addition to being the main instrument of our clinical training, supervision is a familiar ritual to us as therapists and analysts; it is a practice that defines us professionally and bonds us to our peers and teachers. On starting analytic school and returning to supervision, I felt like an eager fish jumping back into water. The weekly process of presenting notes, discussing my understanding of the case, and benefiting from the company, reassurance, wisdom and guidance of a senior clinician was not only an educational experience but also a reaffirmation of professional identity and belonging.

After five years of tremendous learning in supervision about how to listen, intervene, and make an analysis grow, it seemed unimaginable that I would practice analysis on my own. In every meeting with every supervisor, something was pointed out to me in the sessions that I had failed to hear or understand. I comforted myself by thinking that I had probably heard things in the material that my supervisor would have missed, but truth to tell, I didn't really believe this. Before I knew it, graduation was upon me, and a decision had to be made. In consultation with my supervisors, I decided to do what seemed to be usual: to end regular meetings with three of my four supervisors. I was aware of both anxiety about working on my own, and a strong desire to try doing it "by myself."

In the extensive literature on the supervisory relationship, which addresses numerous pedagogical, theoretical and ethical questions, there is surprisingly little about *ending* supervision (Dewald,1981, is a notable exception). This may be partly because the discontinuation of supervision of an ongoing case due to a candidate's graduation is not a *termination* in the sense in which we use the word to describe a phase of analysis; it signifies nothing about the conclusion of an organic process. Further, it seems to be assumed that since the new graduate typically continues or seeks *some* supervision, the ending of any particular one is not a change worthy of note. In a paper on the development of the new analyst's identity, Rosenbloom (1992) observes that graduation is accompanied by inevitable losses, and he cites the loss of the training analyst, and the loss of the institute setting, but fails to

mention that of the supervisor! It is as if only the fact of supervision itself matters, not the particular supervisory relationship. Yet this idea conflicts with the commonly held belief that identifications with individual supervisors form an important part of the analyst's work ego.

Since the literature on supervision offered little in the way of "what to expect" about ending, my apprehensions grew into a decision to pursue some focused self-observation. What follows is a selective description of some interesting experiences I have noticed in my brief couple of months of unsupervised analytic work. Since the ink has barely dried on my certificate, this description will not provide much in the way of wisdom acquired in looking back from a distance; instead I offer it as a kind of dispatch from the front lines. I hope that it will stimulate others to reflect on and to share their own experiences of this transition, which can go relatively unmarked.

I had been alertly listening for the meanings that my graduation might have to my patients, as they reacted to receiving a form letter from the Admissions Service, informing them that they and I were on our own now, and that Columbia took no more responsibility for their care. My patients produced a range of responses, mostly negative: surprise that Columbia had ever considered itself to be involved; envy of my accomplishment; fear that I no longer needed them; betrayal (I had moved ahead without them); disappointment that they could no longer identify with me (or devalue me) as a student; and anxiety or guilt about the fee.

But as I listened for their reactions to the end of a supervisor's involvement in their treatment, I heard less than I had expected. I had certainly thought all along about how my supervisors were present in more or less metabolized form in each analysis, as I conducted myself with conscious or unconscious intent to please and emulate them, or to prove them right or wrong, and in the way that I felt myself gradually internalizing valued aspects of them. I was aware that the very facts of my status as a candidate, the existence of a supervisor and the context of the training program made the case different in important ways from what it would otherwise be, affecting both the patient's transference and my countertransference. In contrast to the findings in some of the literature on cases under supervision, I had not seen evidence of my patients having specific transferences to my supervisors. I took it for granted that they had some awareness of the supervisor in my treatment of them, but my patients seemed to express this mostly in depersonified terms—for example, as ideas about my attachment to a

theory, my adherence to some rules, or my contact with a vague group of "doctors" who might hear about them. In retrospect, it seemed to me likely that I had defensively failed to probe these thoughts carefully enough to reveal more specific fantasies.

My thoughts turned to my own reactions. As I contemplated breaking the external tie with my supervisors, I realized that in my mind, each of my patients was tightly linked to the supervisor who had guided me through the case. Each pair formed a unit in my mind, and I felt a funny surprise when I reflected on the fact that these two people did not actually know each other, or have any relationship outside of my imagination. Each one seemed to think of himself as working with just me; yet my experience was quite different, as my relationship with each one was built in part on aspects of my relationship with the other. I reflected on my role as a conduit between the two, actively conveying my sense of the patient to the supervisor, and presumably more passively conveying my sense of the supervisor to the patient, through my attempts to put into action what I was being taught. Experiences of presenting my work to others in the presence of the supervisor, and of hearing the supervisor engaged in discussion with others about my patient, had further reinforced the feeling of this patient "belonging" with that supervisor. In fact, I noticed that in talking with classmates I often referred to my patients as "My patient with Dr. X," or even "Dr. X's patient." This way of talking about them, I now reflected, suggested fantasies about me and the supervisor as the parents of the patient, or me as a kind of foster parent to the supervisor's child. Furthermore, there was a way that the unit "patient-supervisor," the two individuals together holding power over my professional progress, and sometimes responding almost in a chorus of disapproval to my technical errors, seemed at times to exclude me, as the parental couple does the child. A supervisor who was critical of my taking time off for religious observance seemed uncannily allied with the patient, who delivered frequent tirades about the irrationality of religion. More than once I found myself responding, somewhat grumpily, to a supervisor's critical evaluation of my technique with, "That's just what the patient said to me!"

It seemed then that the ending of supervision would involve not only the continuation and reworking of always ambivalent supervisory identifications (Smith, 2001), but also some type of internal transformation of the threesome. I speculated that from the point of view of the new analyst, the post-supervision period may involve both mourn-

ing the loss of a special relationship, and *also* a reorganization of the new analyst's inner relation to the analysand and to the particular analysis as a result of this loss. Our literature is replete with illuminating anecdotes about the workings of the analyst's transferences to, and identifications with supervisors, but less rich when it comes to considering the unique qualities of each trio and how the patient whose analysis was supervised might be included in the analyst's inner relation to the supervisor. Certainly, aspects of the relationships, both actual and imagined, among the three members of the supervisory triad, have received attention, for example in discussions of the "parallel process" phenomenon, the "learning alliance," and the transferences of both the candidate and the patient to the supervisor (Fleming & Benedek, 1964; Wallerstein, 1981; Barron, 2003). The supervisee is typically seen as occupying the intermediate point on a line (see Skolnikoff, 1997) with separate attachments to each of the other two figures. But just as the relationship between supervisor and analyst takes on meaning in the mind of the patient, so each dyad must find representation in the mind of the third participant, making a more apt diagram of the situation something like a pyramid, or a set of interlocking triangles.

Gediman and Wolkenfeld (1980) address this triadic structure in a more complex way, stating that "in marked contrast to other authors, we believe [the candidate's] centrality to parallelism is more apparent than real." Their paper focuses on the "parallelism phenomenon" and the multidirectional *enactment* of identifications in supervision and treatment. But they note in their discussion of the underpinnings of these enactments, that in the matrix of the supervision/supervised analysis, all three parties "rely heavily on imagination, fantasy and cognitive-affective apprehension generally to fill in the knowledge gap... [and] these 'daydreams' . . . might be viewed as transitional phenomena which are 'self-created' to some extent by the three participants and which *bond them together* (emphasis added)."

As I looked within, I saw that my main "daydream" in connection with ending supervision was one in which this bond was being broken, with my supervisor exiting the room, leaving me alone with the patient. I understand this fantasy as reflective of a multitude of ambivalent feelings about separating from the supervisor. The exploration of these feelings is not something I wish to undertake here, but it should be obvious that such an exploration would be relevant to understanding the state of mind in which the unsupervised work was begun.

I wondered how this feeling of being suddenly all alone with

the patients would be felt within the treatments. Would the patients notice my feeling of freedom? Would their transferences reflect the loss? Would they sense my vacillations between anxious uncertainty and gleeful overconfidence? Would the situation be experienced as a danger by the patients, as one of my supervisors seemed sure it would? Perhaps so, in more ways than one: a few months before I announced my graduation, the patient I presented to that supervisor dreamt of being lost with an incompetent female taxi driver who did not know her way around, and had to call to the dispatcher for directions. Soon after I announced it, he had a sexually exciting and anxiety provoking dream of being permitted to be alone and "unsupervised" in my glamorous house, also his grandmother's house.

In the newly unsupervised cases, I missed the regular guidance, and found myself thinking often of my supervisors and of specific things they had said. But I also found myself experimenting with technical approaches different from those my supervisors had advocated, and enjoying this. I had had two supervisors of markedly different orientations and styles, and part of my experimenting involved imagining what each supervisor would do with the patient he had not supervised, and then trying this out. In other words, it involved mentally pulling apart and reconstructing the dyads.

I also saw that, without being very aware of it, I had really felt that much of the responsibility for the technique and the content of interpretations, and therefore for the outcome of the work, belonged to the supervisor. Now that I was on my own, I was aware of having to bear feelings of guilt more often, instead of looking to a supervisor for absolution or reassurance. I joined with a friend who had recently graduated from another institute to talk weekly about our cases, and discovered I had plenty to offer. My analytic cases began to seem less cordoned off from the therapy cases; for example, I became aware of certain similarities between an analysand and a much more disturbed psychotherapy patient, an insight that helped me to work more creatively with both.

I noticed a subtle shift in my feelings with my patients — I felt more *intimate* with them. I wondered if the fantasy of being alone with them perhaps derived in part from the sharp decrease in talking *about* them, a reduction of the third-person perspective, and a resulting deeper immersion in the oscillation between first and second-person ways of relating to them. I had the impression that along with this shift in my feelings, my patients seemed to show an increased sense of secu-

rity in my involvement with them. This manifested less in the content of their material than in a shift in their way of talking. I heard them as talking *to* me much more, they seemed to address me more spontaneously, and as a more familiar figure. This is more an impression than a finding, of course, and I cannot say for sure whether this sense in fact represents a change in them, or simply in my experience of them, especially since I have not directly addressed it with either patient.

Overall, my impression was that my patients' experience of this change was hazy. Perhaps for patients, the end of supervision is not distinct from the fact of the analyst's graduation, especially if supervisor transferences have not been prominent. I did not hear much in the material that seemed clearly connected, although two patients seemed to express rather sudden shifts toward more autonomy in their treatments; for example, in a conviction that they should and could do more for themselves, by initiating reflections on a dream rather than waiting for me to guide them, or by observing in themselves some sign of resistance that previously they would have allowed me to point out to them. Was this a result of a change in my interpretive focus, based on my own greater feeling of independence? One patient expressed the thought that he ought to pay me more, with a sense that I was rather self-effacing and unlikely to ask for what I deserved, that he would have to take care of me by deciding on a fee. He began to open the door himself at the end of the hour, rather than hanging back and waiting for me to do it, as had been his way. I wondered if the sense of having to protect me and take over a task for me emerged more strongly because he knew that I did not have an expert guiding me anymore. The individual meanings to my patients of these shifts in their experiences are the most important thing of course, but that discussion is beyond the scope of this essay.

This fantasy of being "alone at last" with the patient may appear to be a contradiction or a defensive denial of those writings that point to the analyst's identifications with past supervisors—the "voices" in the consulting room that Smith discusses. But since the voices (like all internalizations—see Schafer, 1972) are, after all, imagined presences, the notion of an imagined *absence* seems to me an entirely compatible idea. Both are experiences within the analyst's mind of the relationship with the supervisor, different facets of the experience of the transition. I believe that this "absence" element is one of many possible features, one that took on particular importance for me early in the transition period. In my case, it was a fantasy that was linked to a feel-

ing of increased intimacy with the patients, and as such it seemed to have a beneficial effect on the work.

I have offered these reflections from my own very fresh experience, with the assumption that while the transition away from supervision has a general shape, it presents unique challenges and discoveries for each new analyst. While I do not propose anything like a theory or a prescription about ending supervision, I hope that this chart of my course through the immediate post-supervision territory, together with other people's maps, will enable something interesting and useful to be found.

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POLITICAL AFFAIRS

Vivian B. Pender, section editor

This section will feature articles written by psychoanalysts who have academic or experiential knowledge of political affairs. It will invite authors to discuss the interplay of psychoanalysis and politics. Application of psychoanalytic theory to local, national, and international government will be featured. It begins with an article about the United Nations.

United Nations and the Commission on the Status of Women

Vivian B. Pender

NOTES FROM THE FIELD

As an Executive Committee Member of the NGO Committee on the Status of Women, and living in Western civilization, it is difficult to apply the usual psychoanalytic standards to cultures in which child development, object relations, intersubjectivity, even what we think of as the self, have entirely different meanings. There are many countries that flagrantly abuse human rights, making concepts like empathy appear irrelevant. It is this milieu that challenges psychoanalysis most blatantly from the international political community. And when raw aggression and brutal violence are socially sanctioned, the physically weaker, women and children are most at risk.

Still we may ask: Are socio-political categories of any use to psychoanalysis? Can psychoanalysts function in the political world and remain psychoanalytic? Do psychoanalysts have anything to contribute to political institutions? How do we bridge academic theory with field-work (the 'trenches')? How do we apply our understanding of individual development to public health models? Addressing these questions, the United Nations offers a forum for beginning thoughts. But first, some background.

The year 2006 marked the fiftieth anniversary of the Commission on the Status of Women, a functional commission of the United Nations. In its early years the Commission was designated as a subcommittee of the Commission on Human Rights, but women's advocates argued that an independent commission was essential—that there must be a separate place on the UN agenda devoted entirely to examining the status and progress of women worldwide. Mandated to prepare reports and make recommendations, the Commission has functioned to promote women's rights in educational, political, civil, social, and health fields. Although the UN charter's Universal Declaration of Human Rights called for "equal rights for men and women," the Commission has drawn attention to the fact that they have not been realized. It was instrumental in establishing the UN Decade for women and International Women's Day. Forty-five members are appointed to the Commission for a four-year term by governments from

African, Asian, Eastern and Western European states, Caribbean and Latin American states. The Commission meets yearly for a ten-day working conference.

Beginning in 1975 in Mexico City, the first world conference coincided with the UN Decade for Women and served to remind the international community that discrimination against women persisted in much of the world. The goals of the conference were established: achievement of full gender equality, elimination of gender discrimination, integration and full participation of women in development, and an increased contribution by women in the strengthening of world peace. As Bella Abzug said: "Women do not want to be mainstreamed into a polluted stream. We want to clean the stream and transform it into a fresh and flowing body; one that moves in a new direction—a world at peace, that respects human rights for all, renders economic justice and provides a sound and healthy environment." (1) A major premise grew from this conference that development of a country was not possible without full participation of women. Guidelines were offered to governments.

The second major conference was held in Copenhagen in 1980. A discrepancy was found between established legal rights and women's ability to exercise these rights. Included in the findings were insufficient political will; lack of sufficient involvement of men in improving women's role in society; lack of recognition of the value of women's contributions to society; shortage of women in decision-making positions; insufficient services such as co-operatives, day-care centers and credit facilities to support the role of women in national life; lack of awareness among women about the opportunities available to them.

The third major conference in Nairobi in 1985 provided a blueprint for the future of women until the end of the century. New ground was broken when it declared that all issues were women's issues. Women's participation in all aspects of social and political affairs was considered legitimate and necessary. Every sphere of human activity was understood to involve women, and women were essential in all spheres. The idea that women (and humans) must be valued rather than envied as potential resources was new to many.

In 1995 the fourth world conference was held in Beijing and 40,000 people attended. A platform for action was established that specified areas of critical concern, solutions for which were considered crucial for women's advancement. These were: women and poverty, education and training of women, women and health, violence against women, women and armed conflict, women and the economy,

women in power and decision-making. Charlotte Bunch stated: "The Beijing Platform for Action is one of the most comprehensive articulations of government's commitments to the human rights of women and girls. It is based on the growing understanding in the 1990s that women's rights are human rights and its detailed proposals give concrete meaning to that phrase—outlining what human rights commitments to women would mean in the critical areas of concern from the right to education, health and reproductive rights to the right to live free of violence and poverty." (1)

The Committee on the Status of Women (CSW), a non-governmental organization established in 1972, is a coalition of representatives from almost 200 organizations that are specifically interested in promoting women's rights. Based in New York, Vienna and Geneva, it provides support for the Commission on the Status of Women. Its mandate is to foster dialogue, build international consensus, promote sound government policies for women globally, through advocacy and partnership with governments. CSW is made up of volunteers who give many unpaid hours per year and work for all of the activities. In addition to supporting the Commission's activities, the CSW organizes monthly meetings with UN and government speakers. The CSW hosts an annual luncheon for women who make a difference to honor women ambassadors at the UN. (There are currently 19 women ambassadors out of a total of 171 positions.) The CSW maintains a global listserv and website. It also provides an internship program for young people, mostly graduate students, to learn about the CSW and the UN. In New York, fifty to sixty people attend the monthly thematic meetings. Several months ago the invited guest was the Ambassador from Tunisia to the UN in preparation for a conference on information technology in developing countries. Most countries in Africa have limited infrastructure to support computer communications; electricity and passable roads are still a dream for many. In the past, women would have been excluded from these discussions and plans.

In 2006, the theme of the fiftieth anniversary of the Commission on the Status of Women was violence against women and girls. With support from the Wellesley Centers for Women and the New York County Lawyers Association, over 500 women from approximately 30 countries participated. Various research studies of the causes of violence were presented. It was agreed that abuse and neglect at different stages in a child's development contributed significantly to violence. The role of the media was also considered. Other contributing factors were ex-

plored: patriarchal systems, social systems that might lead to domestic violence, sexual exploitation and trafficking of women, vulnerable groups such as older, widowed, lesbian, migrant or disabled women. General health, reproductive health and mental health were additional factors discussed. A year ago we heard from women in Africa where millions of children are orphaned by the HIV/AIDS epidemic. These women organized a foster-parent program and were actively identifying and placing children in homes. This year women were trying to locate sources for HIV medications to bring back to their local clinics.

A woman from Iran recounted her experience of domestic violence; when she was seven-months pregnant, her husband pushed her from their moving car because he suspected infidelity. In some religious groups, a married woman who either doesn't properly cover herself, or is seen with a man who is not a relative, or works outside of the home is thought to bring dishonor to the family. She may be banished from the community or ritually stoned to death, The Iranian woman hid from authorities because otherwise she would have been killed as the object of an "honor crime." She is now in the United States seeking asylum. Volkan (2) demonstrated in a 2002 study that family structure, even if discriminatory, helped to maintain role boundaries that ensure some protection from abuse and domestic violence. An example of applied psychoanalytic theory, the study used clinical interviews with victims and perpetrators and found that childhood neglect or abuse at certain ages, particularly during adolescence, resulted in overly aggressive and impulsive adults.

Some women were educated in other countries and then returned to their home country. A Sudanese woman who had enough education, financial support and energy to get to the conference, with donated scholarship money, told us first-hand of the devastation, especially the mass rapes as a means of genocide perpetrated on the women and girls. There were too many corpses to count and the living refugees feel forgotten by the rest of the world. Recommendations stemming from the conference are currently being drafted and position papers on the various topics will be posted on the CSW website. They will be used in the future as potential guidelines for governments.

Required in thinking about these problems from a psychoanalytic viewpoint is:

1. A psychoanalytic formulation of the problem;
2. Development of working partnerships;
3. Discovery and creation of analytic experience in the field;

4. Application of public health models;
5. Identification of challenges;
6. Lessons learned and future directions.

A universal problem is that of resources. In the various forms of food, water, health, pleasure, possessions, and power, women are perceived as potentially independent sources. Even if resources are abundantly available, desire and envy would still exist. Wherever there is lack of structure, because of war or natural disaster, regression predominates. It is this understanding that may enable psychoanalysts to develop working alliances with people in governments. Psychological health includes stable identifications, freedom from fear and trauma. Due to our current media and information technology, widespread witnessing of disasters around the globe is now possible. We may see in the near future increased rates of stress, anxiety and depression on a global scale.

Although progress in these areas is slow, the United Nations constitutes a most valuable resource in that it provides a peaceful arena for continued discussion and negotiation. Upcoming events will focus on the rights of the child, the HIV/AIDS crisis, migrant women, and the 51st Commission on the Status of Women. For more information please view the UN website [www.un.org] . Please note that for events listed at the Church Center, a UN pass is not required. For events at the UN, a day-pass will be required. Psychoanalysts are invited to attend.

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PSYCHOANALYSIS AND PSYCHIATRY

Fredric N. Busch, section editor

Addressing Ongoing Problems Accepting Medication In Psychoanalysis

Fredric N. Busch

I would like to thank Larry Sandberg for his help in delineating the issues about combined treatment discussed in this article.

While the acceptance and use of medication in psychoanalytic and psychodynamic psychotherapeutic treatments has increased (Donovan and Roose, 1995; Roose and Stern, 1995), there has been limited effort to integrate pharmacotherapy with psychoanalysis either theoretically, clinically, or educationally. Very few papers have emerged that have focused on synthesizing pharmacological and psychoanalytic models. In fact, Roose and Johannet (1998) conclude "...to effectively combine medication and psychoanalysis requires that the clinician, be it analyst or psychopharmacologist, have two separate, nonintegrated theoretical systems" (p. 620). In case presentations at psychoanalytic colloquia, analysts often note that an analysand was on medication but say little about what the medication was or how the treatment was affected by it. Gwynn and Roose (submitted) discuss how medication interventions have not been adequately charted in analytic case write-ups by candidates at the Columbia Psychoanalytic Center. In spite of the increasing importance and frequency of medication intervention, many psychoanalytic institutes do not have a required course on integrating psychoanalysis and psychopharmacology.

The Gwynn and Roose data is particularly notable, given that it involved systematic assessment of charts of candidates' training cases. Charts were reviewed if the cases started during the time period September 1992 to 1995, if the patient had been diagnosed with an Axis I mood or anxiety disorder at initial consultation, and/or if the patient was treated with psychotropic medication. Amongst the authors' find-

ings (Cabaniss and Roose, 2005) were the following: "Documentation of medication treatment including assessment of response and side effects was inadequate in the overwhelming number of charts and absent in many" (p. 3); "Many charts had no evidence that medication was ever discussed with the patient during the analysis or that the analyst ever reviewed the current treatment" (p. 3); "Only a few charts indicated that the candidate had made decisions about medication based on appropriate data and had effectively differentiated the process of making medication decisions for the analytic process" (p. 3). Cabaniss and Roose, reviewing these data, conclude: "Thus the charts themselves may reflect the relegation of medication to a secondary, or even forgotten treatment, in comparison to psychoanalysis (p. 3)." Although it could be argued that these charts are for the purpose of psychoanalytic education, this view suggests that medication and its impact are not relevant to this process.

How can we understand the limited efforts to acknowledge and explore combined treatments? One source is the felt need to protect immersion in psychoanalysis from a variety of intrusions: insurance limitations, the growth of other psychotherapies, economic concerns of practicing psychoanalysts, a zeitgeist that devalues long term mind based interventions, and research. Time spent on medication use, either in a case write-up, analytic course, or case presentation, is another distraction from our focus on the dynamic operations of the mind.

Another aspect of the problem is our ongoing countertransference to medication use based on internally persistent concerns that psychopharmacology disrupts "real" analysis. Despite acknowledging that analytic models excluding medication interventions were ill founded, many of us have strong memories of supervisors who advocated withholding medication on the basis that it would interfere with, rather than deepen, the analytic process. During the course of my psychiatric and psychoanalytic training (mid 80's to early 90's), I was encouraged by supervisors to withhold medication from a patient with major depressive disorder in one case and from a dysthymic patient in another. In the first instance I was able to observe the natural course of an episode of major depression. In the latter case the supervisor averred: "it would be good if he (the patient) became depressed." Looking back I do not see how these decisions were either therapeutic or aided the analytic process.

The impact of supervisory and institutional biases of psychoanalytic training on candidates is backed up by another study. Caligor et

al. (2003) reviewed charts of analysands of psychoanalytic candidates that were referred via the Columbia clinic and compared them to private patients who were converted from psychodynamic psychotherapy to psychoanalysis. Despite a similar rate of Axis I disorders, 56% of converted cases were on medication compared to only 6% of clinic cases. In patients with Axis I disorders, the numbers were 81% (converted) vs. 0% (clinic). One likely contributor to these results is the concern candidates had about starting with an analytic case "contaminated" by medication.

The lack of focus on this area has left many questions unanswered. How can we best conceptualize the integration between psychoanalysis and psychopharmacology? How should the therapist raise the topic of medication? Should the psychoanalyst refer medication treatment to a psychopharmacologist? Should the psychodynamic psychotherapist routinely assess medication in a structured way? When is the appropriate point in the session to bring up the status of medication, its effects and side effects? Are there instances where medication interventions actually do interfere with psychoanalysis? How is termination of a psychoanalysis affected by a patient's ongoing need for medication? How do we better integrate medication into our educational system and case reports? While not providing any definitive answers, this article provides a framework for thinking about these issues.

THEORETICAL MODELS

Models for understanding the theoretical integration of psychoanalysis and psychopharmacology have evolved to some degree. Prior "two illness" models, which considered the patient as suffering from either a biological illness or a psychological disorder, or both independently, have been replaced by interactional models that look at how mind and brain affect each other in producing illness. Such models, often conceptualized as metaphors, provide a basis for understanding the interaction between biological and psychological factors and the varying roles of medication and psychoanalytic interventions. Examples include the magnet and iron filings model (Gabbard 1992) and the "top down, bottom up" viewpoint.

In Gabbard's (1992) formulation, the "magnet" is thought of as a biological diathesis that shapes the patient's psychological experience, including fantasies and conflicts. For example, a patient's anxiety disorder can lead her to experience conflicted wishes as even more threatening, as feelings of danger will be intensified. Alternatively, a

patient's psychological conflicts can act as a magnet in recruiting a particular biological susceptibility, e.g., a threat experienced from a particular conflict could overactivate the brain's anxiety center, triggering an anxiety disorder.

The top-down bottom-up model refers to pathways through which the clinician can influence the contributions of mind (top-down) and brain (bottom-up) to psychiatric illness. The top-down approach would be primarily via psychotherapy, including psychoanalytic treatments, improving cognitive appraisal and control over affects and their causal properties. The bottom-up approach occurs mainly through medication, with a presumed direct effect on subcortical or midbrain biological processes that are involved in psychiatric disorders. However, the psychoanalytic and psychopharmacological interventions do not necessarily split neatly in affecting top down and bottom up pathways. The non-verbal and verbal components of psychotherapy may affect brain mechanisms in a way that eases psychological conflict, a "bottom-up" approach. For example, the analyst's calm presence can create a shift in the brain's anxiety system, easing the danger felt from forbidden wishes. Similarly, the supportive efforts in providing medication, including psychoeducation, can have a top down impact in which information the patient takes in through cortical centers affects their anxiety system.

From the clinical standpoint, the use of concepts of bimodal relatedness (Sandberg, 1998) and shifting gears (Cabaniss, 1998) aid the clinician in moving between psychoanalytic exploration and the assessment of phenomenology that is important for psychopharmacological evaluation. The therapist thinks about the patient's symptoms employing an analytic model and then shifts to a consideration of the symptoms as possibly being of biological origin. In an additional step the clinician evaluates the interaction between the psychoanalytic and "biological," between mind and brain. For example, if the patient presents with increased guilt related to sexual fantasies in the transference, the analyst considers the possibility that the emergence into consciousness or the content of these fantasies may have triggered guilt. Depending on the intensity of the guilt, and the presence or absence of other symptoms, the analyst would consider the possibility that there has been an exacerbation of the patient's biologically based depression. Finally, both an intensification of conflict and depression could be precipitating the negative affect state.

Although these models are clearly preliminary, they do suggest ways in which these theories and treatments can be integrated. Ongoing psychoanalytic and neurobiological exploration will hopefully yield more powerful and clinically useful models in the future.

MEDICATION EVALUATION AND MONITORING

Combining psychoanalysis and medication presents certain treatment challenges. In terms of approach, the analytic model calls for an open ended, free associative interaction in which the analyst comments on the patient's productions. Psychopharmacological treatment tends to focus on systematic assessment of symptoms, dosages, and side effects, and the treating psychiatrist is directive and prescriptive. In comparison to a psychopharmacological treatment, often occurring on a monthly basis, psychodynamic psychotherapy and psychoanalysis provide the opportunity to evaluate the patient's symptoms and medication responsiveness frequently. However, psychoanalytic approaches do not necessarily include systematic psychopharmacological evaluations, and such assessments may be disruptive to the treatment. How can the psychoanalytically oriented clinician address these dilemmas?

One possibility, which will not be explored in depth in this paper, is to consign medication assessment and treatment to a psychopharmacologist. Depending on the analyst's credentials (psychiatrist or other mental health professional), this is either an option or a necessity. However, a referral to a psychopharmacologist does not fully resolve the potential problems of medication monitoring. The psychoanalyst should still be alert to cues of the reemergence or persistence of a mood or anxiety disorder and may need to do a preliminary assessment in order to determine whether a patient may want to contact the psychopharmacologist for further evaluation. In addition, an awareness of side effects is important in addressing the patient's reactions to medication.

Another option is to employ whatever interventions are needed for medication evaluation without being overly wary about the impact on the analysis. Psychoanalysts may be too concerned about certain nonanalytic interventions. Does the use of such a parameter as psychopharmacological assessment necessarily adversely affect analytic exploration? While clinical lore suggests that it might, clinical lore also called for avoiding the use of medication. We really do not have a clear idea about the degree to which occasional interventions that are

"nonanalytic" disrupt an analytic process. The question is particularly relevant when the analysis is not adequately affecting symptoms that are interfering with the analysis. This topic requires ongoing clinical consideration and research.

Disruption of the analytic process or no, the medicating psychoanalyst must appropriately evaluate the patient's medication response. The analyst should incorporate a systematic evaluation that occurs on a regular basis, as would be done in a psychopharmacological treatment. Although this may be experienced as anathema, it is the most effective means of assessing symptom level, side effects and dosages. Just as in a psychopharmacological treatment, this can be done infrequently (approximately once every one to three months) once a patient is stabilized on medication. However, psychoanalysts will tend to "forget" to implement this assessment, especially as they engage in a deepening analysis with the patient.

The use of analytic tools and knowledge can aid in balancing medication and therapy. The analyst should consider the countertransfeence and transference issues active at the point of medication intervention and assessment. Is the therapist or patient attempting to avoid frightening affects or fantasies? How is the patient experiencing the therapist in the role of prescribing physician? Understanding the affective reactions to and fantasies about medication, including fears of loss of control or humiliation, can greatly aid in maintaining a patient's compliance. Adjustments can be made in interventions according to what is happening in the treatment. A "scheduled" medication evaluation can be delayed for a time if the patient appears euthymic and the analysis is at an important juncture. The therapist can wait to ask questions about medication until later in the session if the patient initially brings up a dream or a comment about the analyst.

In addition to the systematic assessment, the analyst can be alert to other signs of the presence of a disorder, such as verbal or physical expressions indicating the presence of negative affects. However, the therapist may also become overconfident in using these criteria and in most instances they cannot substitute for systematic evaluations. In one instance of a patient prone to recurrent depression, I was aware that the patient had been under stress, but assumed she was not depressed due to an absence of some of the typical facial and vocal expressions she usually displayed at these times. At the end of the session she raised the topic: "I've been feeling more down recently." In the

next session I systematically assessed her for depressive symptoms and explored why she raised the topic at the end of the session.

Looking again at the case of the patient who presented with guilt about erotic transference fantasies, I suggested that the analyst be alert to the possibility that a biological diathesis may be contributing to an intensification of guilt. While exploring the nature of the fantasies and the perceived threat, the analyst should also listen for the presence of other depressive symptoms, such as increase self-criticism, pessimism, disrupted concentration, a "down" facial expression or mannerisms that have been associated with an exacerbation of anxiety or depression.

At this point the analyst may or may not choose to more systematically assess for the presence of depressive symptomatology. From the analytic standpoint, the analyst should be considering whether countertransference is leading to a focus on phenomenology because he or she feels uncomfortable with the patient's erotic transference. Alternatively, does the analyst not want to assess the phenomenology based on a countertransference notion that they are not being a good analyst because they will be moving away from exploring sexual fantasies? From the pharmacological standpoint, the analyst considers other data: has the patient appeared down over several sessions, is there an expression of intense guilt not only about the fantasies but about other aspects of the patient's fantasies or behavior, is it the early winter when the patient tends to get depressed?

Although the approaches discussed above can helpful in conducting combined treatment, we still have no definitive data on how to best manage these treatments, and it is likely that different psychoanalysts are better suited to certain approaches than others. Thus it is valuable not only to discuss these approaches in greater depth in the context of training, but also for individual analysts to explore what kinds of interventions work best for them and their patients.

EDUCATION

At this point it is important to accept that medication is a valuable tool in the armamentarium of the treating therapist. Patients need to be evaluated for disorders that may respond to medication treatment and often will be prescribed one or more psychotropic medications. Therapists must address the complex issues of how to best think about these treatments theoretically, and how to manage the

combined treatments technically and clinically. Given the frequency of these combined treatments, and the lack of clear answers to these problems, a course on combined treatment is a necessity in analytic training. Process classes should include a discussion of medication interventions and their impact.

Case write-ups should be reconfigured to include information about the psychopharmacological aspects of treatments. Case notes should include the dose, impact and side effects of medication, as well as the basis for medication adjustments. Transference and countertransference reactions to medications should be elucidated. Candidates should be encouraged to think about the impact of medication on the patient's conflicts, object representations, anxiety levels, transference, etc. As candidates work with these issues in analytic training, they should be encouraged to consider these factors as they pursue analytic work, psychodynamic psychotherapy and psychopharmacology in their own practices.

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CANDIDATE ISSUES

Ben Davidman, section editor

Conversion and the Candidate

Ben Davidman

What is today common practice, the conversion of patients from psychotherapy to psychoanalysis was, until quite recently, discouraged or even prohibited. This has radically shifted, in part due to shifting theoretical perspectives, in part due to the changing realities of the analytically oriented clinician's practice. Like many formerly taboo practices, conversion is now openly embraced, though not without lingering anxieties and uncertainties which are manifest in the inhibition of theorization and teaching of this essential skill. The religious overtones of the term conversion are especially appropriate for the psychoanalytic candidate who, without prior experience with the method, must recommend the treatment based on faith. In this article, I will review the changing perspectives on conversion, discuss the specific challenges facing the candidate in converting a patient to analysis, and provide recommendations for addressing these challenges in psychoanalytic education.

It seems surprising, at least to candidates, that conversion could ever have been held in such disrepute. One related motivating factor behind this may have been the generally dismissive attitudes that were prevalent within the analytic community toward all therapies that were not psychoanalytically oriented. Freud (1919) wrote, "It is very probable, too, that the large-scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion." It was clear that therapy was, in contrast, second rate. Glover (1931) provided a theoretical basis for this opinion, arguing that all psychotherapy relied upon suggestion, the power of which derived from the transference authority of the therapist. Psychoanalysis, on the other hand, operated through the analysis of all elements to their genetic and dynamic roots and was therefore thought to be free of suggestive influence.

Before the issue of conversion could be addressed directly, there was still much difference of opinion about the differences between psychotherapy and psychoanalysis. The American Psychoanalytic Association sponsored four major panel discussions concerning this distinction between 1952 and 1954. Competing viewpoints were presented for the relationship between psychotherapy and psychoanalysis. Some felt that the two were separate and distinct entities (Rangell, 1954), (Bibring, 1954), (Gill, 1954), which could be differentiated by the lack of the appearance and resolution of the transference neurosis in psychotherapy. Others proposed that the treatments existed on a continuum, and could not be easily distinguished in terms of goals or techniques (Fromm-Reichman 1954), (Alexander & French, 1946). This debate was complicated by the charge that the latter group presented psychotherapeutic technique as though it was analytic, and so did not truly practice psychoanalysis.

Perhaps more than any other factor, changing realities of analytic practices contributed to shifting opinions on conversion. In 1981, Shapiro, et. al. reported, "A sizable group of graduated members are conducting relatively few psychoanalyses. Twenty-two percent reported that patients in the survey week in April 1976 made up 10 percent or less of their private office patients; 19 percent reported that they then had only one patient in analysis or none at all." As analytic patients have become scarce, conversion has become the most viable method of obtaining analytic patients. In 1987, the American Psychoanalytic Association sponsored a panel on conversion of psychotherapy to psychoanalysis, signaling the growing acceptance of the practice.

Theoretically, the resistance to conversion centered on the potential problems involved with the maintenance of anonymity. Freud had stressed the importance of anonymity, writing, "[the analyst should] preserve anonymity and not contaminate the transference by reality factors which restrict the role of fantasy." It was argued that face-to-face psychotherapy would inevitably provide too much reality information concerning the analyst, and would therefore prevent full development of the transference neurosis. This thinking began to shift in response to an increasing focus on the therapeutic interaction. An uncontaminated transference was neither possible nor even desirable, and the transference was inextricably wedded to reality aspects of the analyst (Gill, 1984). Neutrality was increasingly distinguished from abstinence, with some arguing that it was the maintenance of techni-

cal neutrality that was important for allowing a psychotherapy to be converted to an analysis (Oremland & Fisher, 1987). It is important to note that this opinion is not universally shared, as in the argument from a self-psychological perspective that true neutrality is impossible, and the analysts appropriate stance is best described as sustained empathic immersion (Stolorow, 1990). It is unclear how psychotherapy and psychoanalysis are to be distinguished from this viewpoint.

While conversion is an increasingly acceptable practice, there is surprisingly little written on how it is to be accomplished. Rothstein, who has written most extensively on how to engage reluctant patients in analysis, argues that overly restrictive conceptions of analyzability prevent many patients from receiving appropriate analytic treatment. Like Freud, he argues that the only reliable way to determine analyzability is through a trial of analysis. He holds the controversial opinion that "a trial of analysis is the optimal treatment for most people who seek analysts' help regardless of the presenting manifestations of their difficulties." He emphasizes the personal nature of the evaluation and the importance of the patient-therapist match in the determining analyzability. He does not truly offer any absolute contraindications for analytic treatment, stating that this is solely a matter of individual clinician's preference. By definition his perspective clearly results in the greatest possible number of patients being found appropriate for a trial of analysis; however, in dismissing exclusion criteria, the approach minimizes the potential harm a trial of analysis may do to an inappropriate patient.

Rothstein argues that reluctant patients need to be engaged on their own terms. He writes of alterations in the frame including frequency of sessions, use of the couch, and setting of the fee. To effectively address specific resistances, Rothstein argues it may be necessary to allow patients the experience of gratification of their desire for alterations in the frame. At the same time, he suggests framing the request as a self-defeating masochistic enactment. He states, " I inform the patient that I am willing to begin his analysis with him sitting up, and at the frequency he suggests, with the understanding that we will attempt to understand why he is unable to accept the recommended frequency." It seems unlikely that refusal of an initial recommendation for analysis is always best viewed as a masochistic enactment. One could envision patients for whom an initial, rapid agreement to an intense, lengthy treatment might represent a masochistic enactment.

Further, a patient may refuse out of the desire to protect himself from the unknown. Unconscious fears of analysis as a facilitator of a regressive loss of control and as a re-activator of feared desires may be more prominent motivators in an initial refusal than masochism (Bernstein, 2000). A prolonged initial phase may be necessary to address these resistances, and to avoid a self-defeating enactment by proceeding with treatment in a considered manner.

There are many practical problems that candidates face when seeking to convert patients to analysis. External factors may play an inhibiting role. Often working with smaller practices, and frequently with sicker patients, candidates' practices may serve less well as sources for converted cases. While Rothstein's methods may be helpful in working with appropriate reluctant patients within candidates' practices, given current progression criteria, these patients are not considered to be analytic patients until they agree to full treatment, which may further complicate the candidate's maintenance of neutrality on the issue. This often raises the potentially thorny issue of being able to offer analysis to a patient at a significantly reduced rate while being unable to do so for less frequent sessions. This can make it difficult to engage patients on their own terms, and may often be experienced as coercive.

Having no experience in providing the treatment, it can be difficult for candidates to fully understand the nature of the differences between psychotherapy and psychoanalysis and the reasons for choosing one over the other. The candidate has to make the recommendation based on a faith that usually derives from his own treatment experiences and their identification with their analyst, supervisors, and instructors. As these identifications are never without conflict, addressing a reluctant patient's resistances to analysis presents a difficult challenge for the candidate for whom similar anxieties, uncertainties, and resistances are likely operative.

Understanding and overcoming these resistances is a vital part of allowing oneself to have the experience of analyzing and become an analyst. However, I believe there are several changes that would be very helpful in easing this process. Rather than being seen as a prelude to training, conversion needs to be at the center of analytic education given that converting cases is a necessary skill in order to have an analytic practice. To that end, psychotherapy training should be emphasized, with specific attention to the different indications, techniques, and goals of supportive, expressive, and classical psychoanalytic treat-

ments. The differences in technique between an analytically oriented treatment with a patient inappropriate for analysis and an appropriate, but reluctant patient must be a central focus. Therefore, analytic treatments focused on treating specific diagnostic groups should also be included in the curriculum. The upcoming elective on Transference Focused Psychotherapy is a welcome addition in this regard. Further, process groups focusing specifically on the conversion process would be helpful as candidates could see how analysts address resistances to analysis while maintaining neutrality and how the patient's stance toward analysis evolved over time. In order to encourage the development of skills in the conversion of cases I would consider limited credit being given for those involved in less frequent treatment with reluctant patients. In order to promote the exploration of resistances to analysis within a neutral framework, credit should not only apply to those cases that ultimately convert to analysis. These changes would acknowledge that skill in expressive therapies and in the conversion of cases to psychoanalysis is vital to the modern psychoanalyst and to the future of psychoanalysis as a whole.

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HERE'S LOOKING AT YOU
FRANCIS BACON

on the metro the man across
the aisle began all his sen
tences with *I prophesy . . . . .*

the Missouri Fox Trotter is a three gaited horse horse Mars was 36.5 million miles from earth on September 21, 1988 inside the house is a man inside the man is a brain inside the brain a box in side the box a woman inside the woman a brain inside the brain a house inside the house a man inside the man a brain inside the brain a bet on a Missouri Fox Trotter named Mars Prophesy . . . . . .

there are many jokes about Descartes in side the box inside the brain inside th e house let's re-examine a stereotype: w hat is it that we think of the man who starts e very sentence with *I prophesy*? are w e sad because the phrase detached itsel f and floated away? no no need to say some thing about the sky. . . . . .

some of it comes back those moments clear and distinct a dis course on method in the touch-me-not assassin beetle woods ca rapace skewered prey recumbent vine snake woods ant lion aphi ds milked wood aphid herding ants red winged black bird on ed ge of wood marsh woods snorting groundhog the woman the man t he box the death of D's daughter his treatise on rainbows ins ide the box the doubt inside the sorrow the retreat into Lati n inside *lumen naturalis* present and manifest inside the atte ntive mind attend to the inside manifest and present. . . . . .

inside the box Missouri Fox Trot
past Descartes to Ovid so one or
two women can turn into trees

now we think
each movement
of the body i
s part of a s
entence put t
he *I* in the
sentence in t
he box. . . . . .

. . . . . fox trotting across the page into the experiment in the woods the house the woman the man the box the brain the joke with *therefore I am . . .*

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INTERVIEW

Christine Anzieu-Premmereur

Introduction

Henry Schwartz

While reading Elizabeth Roudinesco's biography of Lacan last summer I was pleasantly surprised to find that a friend of mine was not only quoted, but there was included a discussion of her family history which had intersected with a chapter in the life of this father of French psychoanalysis. The story concerns the case of Aimée, a hospitalized, psychotic woman on whom Lacan based his doctoral thesis. It is a renowned case history in France for being the inaugurating work in Lacan's oeuvre, as well as his only extended clinical example.

The story itself is not exactly a pleasant one, but coming upon things like this has a way to wake one up to dimensions of a historical record which would otherwise remain an impersonal and distant account. It carried additional interest because it involved Didier Anzieu, a central figure in the development and elaboration of post-Lacanian psychoanalysis in France, who happened to be my friend's father.

I asked Christine Anzieu-Premmereur if she would be willing to let me interview her about this story for an issue of the Bulletin. I like this story because it operates on so many different levels at once, reaching from the most personal relationships to the most public. Among these is a touching and sad story about Christine's family, and Christine's relationship with her grandmother. At the same time it is a story about Jacques Lacan, the eccentric genius, despised too much by some, loved too much by others, but without question the man who single-handedly made psychoanalysis a part of the everyday intellectual life in France, unmatched anywhere else since Freud. It is also a story about the repetition of trauma for Didier Anzieu, first within his family, and then again in his analysis with Lacan.

It is easy to judge Lacan harshly from this story, and no doubt it will fuel the distain many already possess toward him. Bemoaning this fact to a colleague recently he reminded me that the early history of psychoanalysis was filled with stories like this one, where ethical

principles were ignored, boundaries were crossed, and analysands were harmed. From that perspective we can see that this is also a story about psychoanalytic ambition. This is a story where psychoanalytic history comes together with the lives of particular individuals in a way we can now have a more personal relationship with—thanks to Christine's openness and generosity.

HS: *We're going to talk about your family; about what happened between Lacan, your grandmother, and its impact on your father's development: The story of Aimée.*

CAP: Let's start with my grandmother. My grandmother got married and had a child who died at the time of its birth—a girl. She then had what we believe was a psychotic break, but remained psychotic. Then she gave birth to my father in1923.

She had always been a special kind of person. All the women in that family had something special about them. They were poor peasants from Auvergne, in the center of France. They had a certain vulnerability and creativity. But she was the one who had a psychotic breakdown. It wasn't a post-partum depression. She behaved in a way my family could not handle. When my father was a baby she had already been hospitalized once for six months. And when he was two she left and went to Paris where she got involved with the surrealist movement. She was a writer, and had a life there.

I think she did it because she knew her child would be at risk with her. She always spoke of her love and passion for her son, and yet at the same time she was a dangerous mother. She didn't feed him, she didn't care for him, and my father told me that he would sometimes have the sense, not that she wanted to kill him, but that she had tried to push him down the stairs.

In my grandmother's family there were three sisters. My grandmother was the youngest, born in 1892. Three brothers were born after her. My grandmother, Marguerite (Lacan had changed her name in his report), was named after the eldest sister who had died at age five. The middle sister, Eugenie, married a man who left to fight in WWI shortly after the wedding. He had asked my grandmother and grandfather, who had just married, to take care of her while he was away. He was killed in the war, and so she stayed with them. Eugenie was a hypochondriac, but less crazy than my grandmother.

HS: *Was she involved with your grandfather?*

CAP: No, not at that point. They were always very clear about that. That changed when they were old. Of course, this is the first question everybody asks. You can imagine how it was in their own minds. Eugenie was authoritarian, and I think my grandmother felt powerless in her own home. So my grandmother left, and she left the baby to her sister, the woman who was already the caregiver.

HS: *Was it planned, or done impulsively?*

CAP: I think it was impulsive. You know the kind of distress psychotic people can feel. But she also knew she was destructive toward the baby. I think she did it for the baby and for herself. She always had some paranoid delusion or other toward women, and it made her behave in crazy ways. She also wanted to travel and become a writer.

For the family, that was the end of her. There was no sign of her for a while. At a certain point she began making occasional visits because of a delusion that someone was out to kill her son. And then, suddenly, she was on the front page of the newspapers. She had tried to kill an actress. The family felt they had fallen into shame. Everyone knew Marguerite had done something awful. And she was put in the Hôpital Sainte-Anne, on the ward for psychotics.

HS: *Do you know more about the murder attempt? Who was the actress? Why did she want to kill her?*

CAP: At some point she decided this actress, Huguette Duflos, who was well-known at the time, was interfering with her life and preventing her own success. She could not get a book she had written published, and she thought this woman was behind it. I don't know more. I don't know why she chose this woman. One April 18, 1931, when this actress was entering the theater, she waited for her in the street with a special knife she had bought with the wish to kill her rival. But nothing happened. Duflos was able to take the knife from her. The police came, she went to jail, they could see she was psychotic, and in June she was transferred to the psychiatric hospital. The actress eventually decided to not pursue any proceedings against her because of her condition.

Lacan was the psychiatrist in charge of this ward, and so he was in charge of her. Occasionally her husband, my grandfather, would come to Paris to sign for her to be kept in the hospital after she was no longer considered to be dangerous. He continued to sign for years, not wanting her to be released. So, while there, she met with Lacan and he interviewed her.

She was finally released during the war. During WWII there was no food in Paris. They decided to open the psychiatric hospitals. People were dying from hunger. That was the way she finally left the psychiatric ward. Somehow she took care of herself—quite well.

HS: *Was he her therapist when she was hospitalized?*

CAP: She refused. She did not want him to be her therapist. Lacan wasn't an analyst yet—he was a psychiatrist. He was 30 years old,

and entered his training analysis with Lowenstein the following year. He got this great case, because she really was paranoid—he wasn't wrong about that. She was megalomaniacal with persecutory delusions. But she was also a wonderful, incredible person, very cultured, and she was capable, later on, of having a great relationship with her grandchildren. She was crazy, but powerful—someone very important in my life.

So, she told her story to Lacan. They had consultations on a regular basis. She got better. She was well adjusted to the hospital. She was in charge of the library and other things as well. At a certain point Lacan offered her psychotherapy, and she said no. I don't know how many times they ended up meeting—she said only twice, but we felt it was probably more—and eventually he wrote his thesis on her. This publication was an important event, because it was the first time a psychoanalytic theory was applied to a psychotic disease that no one understood at that time. He had asked her to lend him her writings, and pictures of her family. She did, but Lacan never returned them.

At the time the thesis was published my father was a patient on Lacan's couch. My father had no idea his mother had been Lacan's patient. During the war my father was at the Ecole Normale Supérieure [France's most prestigious university], getting a degree in philosophy. He became a philosopher, married my mother, who he had met when he was 16, and I was born in 1950. I have one brother who was born in 1953. Eugenie and my grandfather were the ones who had raised him, but he always knew Eugenie was not his mother.

HS: *Did he know where his mother was?*

CAP: He knew at some point, but I don't know how much he knew, or when. It was a subject no one spoke about. Not anywhere. When I was a child I knew there was a big secret in the family. And one day I remember—perhaps I was five—I can remember the scene precisely. I remember which garden I was in. I hated Eugenie, and I said to her, "I know you're not my grandmother! I know the secret!"

HS: *So you tricked her into telling you?*

CAP: Yes, because nobody would talk about it. And nobody knew where she was. It turned out that she was living in a suburb of Paris, Boulogne, working as a cook for a wealthy family. And she was involved with the church there, taking care of the prostitutes, apparently doing a great job. When the Lacanians later interviewed them they were told, "Ah! Marguerite! She wasn't crazy, she was incredible, she was our friend." She gave all her money to the church.

When I was an infant my parents were living in the 5th arrondissement, in a very small one-bedroom apartment. The building had a central courtyard. And at a certain point my mother would find, day after day, the same woman standing in the courtyard when she came home. She didn't recognize her. But she had the fantasy that it was my grandmother. She knew the family history, and that her husband's mother was probably somewhere in Paris. And this woman looked related. She was right. That was my grandmother. Eventually they spoke, and my grandmother came in with her. My mother introduced his mother to my father.

His mother had kept track of him over all the years. She was very proud of him for having gone to Normale Supérieure. And he was in the first department of psychology in France, the department that Lagache had opened. And that started their relationship.

I always knew her. She'd come to our home on a regular basis. Sunday lunch with my grandmother was like a Cassavettes movie.

HS: *That's scary.*

CAP: She was crazy, but full of love, and very smart, always reading great books, asking questions about what was new in medicine and science. At the age of 70 she was learning how to swim, learning how to drive, learning regional dialects in France, and she always had a lot of energy. She was also a great cook, and well known for it. I became the beneficiary of it. Earlier she had worked as a cook for bourgeois families. In fact, one was Lacan's father. As well as for some well known musicians and wealthy people.

HS: *What did she have to say about Lacan?*

CAP: She hated him. She said he was a fake psychoanalyst, totally narcissistic, talking only about himself. She said he was a liar, and a thief. He took what she had been writing at the time she was hospitalized, and he never gave it back to her or my father. The problem for my grandmother was that Lacan became famous, and then was occasionally on TV. It was enough for her to feel the persecution from him. So she hated him.

HS: *Had he really been so bad to her?*

CAP: Not so bad. But he took her writings, and wrote a thesis about her without asking her. In the thesis he changed her first name to Aimée [tr. "Beloved"], using a name she had chosen for a character in one of her novels.

HS: *She knew about the case history?*
CAP: Yes.

HS: *Did she feel it was accurate?*
CAP: She wouldn't talk about that. She told me not to discuss it with her. It wasn't difficult to reassure her about that. With me, she was full of love. Because of this I have always felt comfortable with psychotic people. I knew how to deal with her craziness. But it was much more difficult when my father was there. With my father she was a paradoxical mother all the time. She would say to him, "it's not good, it's for you" (she motions by forcing a plate of food at me). And when she does it 50 times in 30 minutes it's hard to remain quiet. She was in love with him at the same time that she was mean and hostile—without being aware that she was. She attacked him constantly, and it was awful for my father. He would drive her home to Boulogne with me, and the return trips would be a kind of debriefing session. He needed that.

HS: *What about your father's relationship with Lacan? And how did Lacan's relationship with his mother affect their relationship?*
CAP: Lacan was a training analyst at the Société Psychoanalytique de Paris and my father was in training there. He was sent to Lacan for his personal analysis. I have written a paper on this based on my father's diary from that period, which he had given to me. So they started the analysis, and the schedule was very regular and with 50 minute sessions. It was very helpful for my father. At a certain point in the early '50s Lacan changed his technique. The schedule became unpredictable, and he would interrupt sessions so they were very short. He would have many people waiting for him in his waiting room at the same time, and then choose people to come in out of order. During sessions he would pace, have tea, look at his mail, take phone calls, or even walk out of the room saying to continue the session in his absence. My father reacted to that. It was very uncomfortable for him.

At a certain point a colleague asked my father if he had seen the publication of Lacan's thesis. It was then, when he read the thesis and recognized the story, that he realized Lacan had been his mother's psychiatrist. And it was clear that when Lacan took him on he knew he was her son. It was a huge shock for my father, but Lacan wouldn't talk about it. Each time he tried to address it with him he wouldn't answer. It was the beginning of the end of my father's analysis with Jacques Lacan.

HS: *Wasn't your father a Lacanian early on?*

CAP: No, early on nobody was supposed to be a Lacanian. He was one of those in the Paris Society who was in conflict with the group who were trying to maintain control of the training. In '53 Lacan and Lagache decided to create a new society, la Société Français de Psychoanalyse. They asked the IPA to accredit the training program, but in '64 when Lacan refused to agree to the IPA requirements for the conduct of his clinical work he was expelled. My father, along with Lagache, Laplanche, Pontalis, Widlocher and others founded the Association Psychoanalytique de France, with IPA approval. Lacan went off and opened l'Ecole Freudienne de Paris.

My father had been, like many others at the time, involved with Lacan, but then became one of those who fought against him—in a very harsh way; arguing against him in his papers very aggressively. He never wanted to be called a Lacanian. Their differences had to do with theory, technique, the role of the ego, and of the body. He was attacked then, and he still is, by the Lacanians.

In fact, each time I am around analysts in Paris and I say my name I have someone screaming at me. I can't go to a party with analysts without it. The rage that's still there! But it's really an old story now.

As far as Lacan's relationship with my grandmother is concerned, I have nothing more to say. Lacan did his job as a psychiatrist, but she was never in treatment with him.

HS: *Did she recognize herself in the case history he wrote about her? Did she feel he had understood her?*

CAP: She felt used; that he had used her life to make himself well known. For her, he had stolen her story. She said she was smarter than him: "I knew what he was looking for, sometimes what he said was accurate, but I knew he was just interested in himself, not me."

In the '70s I was a psychology student, before I went to medical school. And I attended Lacan's seminar. Lacan would interview a patient from the hospital where I was looking for patients for another doctor's interviews. So I saw Lacan all the time. I knew he was the "enemy," but I also knew he was this important person. I went to his seminar, I didn't understand a lot, I was part of the scene, and my parents had no problem with it. The problem was between the analytic societies, and it was huge.

That was when there was a real war going on between the two IPA societies and the Lacanians. I went to a preparation course for

"l'internat," the exam to become a resident. When the instructor saw my name he threw me out in the first class.

At that time I was in analysis. My parents said you can speak with your analyst about your grandmother, but not in public. While she was alive, no one else knew my grandmother had been Lacan's case Aimée. She died two months after Lacan, in '81. My father had been right to keep it secret. As soon as it was made public the Lacanians descended on him, me, my mother, everyone in the family. They went to Auvergne to interview anyone who could have known my grandmother, going crazy, because it was Lacan's only case. Many books came out, and it troubled my father a great deal. My father finally decided to give the publishing rights to Elizabeth Rudinesco who was writing about Lacan.

HS: *Did you see any of Lacan's clinical interviews? I've heard he could be very insensitive toward these patients.*

CAP: Yes, it's true. The interview was not for the patient, it was to make a point. But they were all doing it this way. All the instructors were the same. Lacan was no different from the rest. But what he wrote about psychosis was different, and really important: His writing about understanding the psychic function. But he had no special rapport with these patients. He came to the interviews with something in mind that he wanted to demonstrate. It was a good show. But it was not useful for understanding a clinical interview.

I went to the seminar both at Normale Supérieure, as well as after he was kicked out of there and continued at the Law School. Seeing the others who attended was part of the show. There were all sorts of people: Psychoanalysts with their grown daughters on their laps—there was an incestuous quality. And Lacan had an ability to manipulate others. I was impressed by the show, by his ability to abruptly surprise and amaze the audience—to force them to think.

Lacan could work well with psychotic patients, and borderline patients. No better than a lot of others, but still, he was good with them. Some patients have described how attentive and effective he was for them, others described him as provocative and ridiculous. But the way he worked with a lot of patients was really shameful. My grandmother said he was an imposter! And, you know, he cheated all the time with the rules. And there were all these people he had hurt who ended up in sadomasochistic relationships with him.

He gave French psychoanalysis its strong intellectual quality. Psychoanalysis is totally merged with intellectual life in France.

MONTHLY MEETINGS

Alex Lerman, section editor

Editor's Note—Call for Commentary

The APM presentations over the past five months reflect the diversity of interest and talent in our Society. It's our hope that this diversity will continue to widen, through increased participation and discussion in the *Bulletin*, in print and soon online. MEMBER COMMENTS ARE WELCOME, AND WILL BE CONSIDERED FOR PUBLICATION ALONGSIDE THE MEETING NOTES, as space and related editorial concerns afford. Send your commentary, e-mail preferred, to al75@columbia.edu with the program you are referring to and the word "Commentary" in the subject line.

An Empirical Foray Into the Macroprocesses of Psychoanalytic Treatment: Evidence for Differential Modes of Therapeutic Action

Presenter: Eric Fertuck
Discussants: Sidney Blatt, Wilma Bucci
Presented December 4, 2005

Tokens of the commitment on the part of the "Columbia Center for Psychoanalytic Training and Research" to the two terminal words in its title were on display 12/4/05 at a panel discussion built around the doctoral dissertation of candidate Eric Fertuck. The other panel members were Sidney Blatt and Wilma Bucci, scholars and investigators of considerable repute.

In the interest of clarity, panelists will be discussed in the reverse order of the presentation.

SIDNEY BLATT reviewed his concept of *Introjective* ("preoccupied primarily with establishing and maintaining a sense of self-definition as separate and autonomous while defensively avoiding issues of interpersonal relatedness") vs. *Anaclitic* ("preoccupied primarily with interpersonal relationship while avoiding issues of self") personality structure. On Axis II, anaclitic disorders include most of the borderline /histrionic/dependent populations; and introjective disorders include narcissistic/antisocial/paranoid/obsessive-compulsive populations. Blatt illustrated a developmental model in which each of Erik Erikson's stages of personality development were re-framed as part of a dialectic of anaclitic vs. introjective growth, which Blatt claims underlies all human development and psychopathology. All Axis I and II DSM disorders can be coherently classified and etiologically codified using this nosology, Blatt maintained.

WILMA BUCCI reviewed her "Multiple Code Theory," a language-based model of a mind divided into "symbolic" (including but not limited to verbal symbols) and "non-symbolic" domains. Attainment of the therapeutic goal of integrating these disparate psychic elements, Bucci said, can be measured by charting what she termed "Referential Activity" (RA) (language rich in direct sensory elements), as well as "Affect," "Reflection," and "Disfluency." Bucci illustrated how transcribed therapy and analytic sessions can be subjected to computerized analysis, and each of these parameters charted on a minute-to-minute basis over the course of a session. The impact or failure of

the analyst's interventions to alter the nature of the patient's material can in the same manner be scrutinized.

ERIC FERTUCK described research in which he applied Bucci's linguistic assessment tools to gauge the impact of therapeutic interventions on patients retrospectively classified using Blatt's nosology, with the goal of assessing whether varied therapeutic techniques enjoyed different levels of success in the two populations of patients.

Using clinical records and projective testing data from a long-running study of severely ill inpatients at the Austin Riggs center, Fertuck used projective testing and clinical data to classify subjects according to Blatt's introjective/anaclitic nosology. Fertuck analyzed the session transcripts as samples of "microprocess" at the initiation of treatment and at 16 months into treatment.

Fertuck found that a trend to lower Referential Activity in anaclitic (borderline/hysteroidal) subjects correlated with clinical improvement in that population; while the reverse was true with introjective subjects. Anaclitic subjects whose language became more affectively subdued, in other words, tended to be those who showed the most improvement in their diagnostic class; schizoidal/paranoid subjects who became more affectively intense on the same scale were likewise favored.

Fertuck's findings suggested that schizoidal subjects benefited more from psychoanalytic treatment methods; while anaclitic subjects benefited more from less frequent and more-structured treatment interventions.

THE ROBERT S. LIEBERT MEMORIAL LECTURE

Mood Disorders and Artistic Creativity

Kay Jamison
Presented January 3, 2006

Long regarded as among the leading scholars of bipolar disorder, Kay Jamison set a unique benchmark in candor and courage with her memoir *An Unquiet Mind*. In it, she chronicled her own history of relapsing psychotic illness, hospitalization, and recovery through combined psychopharmacology and psychotherapy. Her emphasis on the value of psychotherapy was perhaps the most unexpected feature of the book. As we all know, the revolutionary impact of psychopharmacology on the treatment of mental illness of this kind has led to tendency among general psychiatrists to regard bipolar disorder as a neuropsychiatric disorder in pure form, affording little indication for the "talking cure."

Jamison's appearance at the Association for Psychoanalytic Medicine to give a presentation on "exuberance," a term she applies to the "unique affective correlate of creativity," might thus stir anticipation of a powerful synthesis of neuropsychiatry, psychology, and even Jamison's own personal experience, as they apply to bipolar disorder.

Jamison's thesis, however, was less elaborate: she demonstrated a relationship of manic and hypomanic symptomatology to creative activity in artists, particularly poets. Amid a flurry of charts and portraits she correlated artistic productivity with periods of mood elevation, and showed perhaps a dozen genograms to illustrate the tragic vulnerability among artists and their extended families to mental illness and suicide.

At times Jamison appeared to overstate her case. For example, she cited Ernest Hemingway's suicide as evidence of his affective illness without noting his terminal state of alcohol addiction at the time of his death, nor his lifelong narcissistic symptomatology which may have been of significance to his late-life depression; likewise, Jamison made note the suicides of Anne Sexton and her sister to emphasize the importance of genetic factors in suicide, without noting Sexton's history of dissociative symptoms and other indicators more consistent with Axis II symptomatology, along with biographical features which raise questions about highly aberrant factors behind the veneer of her (and presumably her sister's) superficially "normal" childhood.

Consideration of the epidemic nature of neuro-syphilis and tuberculosis have been included in the differential diagnosis of mood disorders among Europeans of a previous centuries. The study given to both manic-depressive illness and creativity by Freud, Klein, Fromm-Reichman, and generations of clinician-scholars since, may be a worthy topic for a gathering of psychoanalysts on another day.

Jamison's goal appeared to be reduction of the poet to the level of the neuron and gene. Consistent with her thesis, she recited no poetry as she did so.

If a scholar of Jamison's stature credits that the relevance of poetry to our field is limited to genetically-induced metabolic aberrations of neurons in the superchiasmatic nucleus or elsewhere then perhaps it is left to the humble analyst to consider the form, the content, and even the meaning, of a poem.

Mapping Racism

Presenter: Don Moss
Discussant: Dionne Powell
Presented February 7, 2006

Joking that his style was "inverted" Don Moss delivered a provocative paper that it seemed might be more accurately described as both sweeping in scale, and metapsychologically dense. His thesis: psychic reality is comprised of object "maps" in which sexuality is only one of many attributes which determine the hierarchical and self/other status of object representations in the conscious and unconscious mind. The discipline-wide neglect of racism in the psychoanalytic literature represents a failure of the same magnitude as Freud's blunders regarding feminine psychology and the equation of homosexuality with psychopathology.

This error has in Moss's view doomed psychoanalysis to a "hunkered down" and "parochial" status as a kind of "insider's club" in which white analysts and patients collude to deny historical and racial facts, presumably even though their influence on object "maps" exert a paramount influence on the fabric of psychic reality. Only through confronting and renouncing unexamined prejudice, he maintained, can psychoanalysis as a whole move from a "parochial" to a "cosmopolitan" understanding of motivation.

Moss furnished two clinical examples in which an Asian and a Caucasian analysand reported fantasies of racially-tinged acts of violence in a setting of deepening analytic intimacy, which Moss understood as a response to anxiety about the threat to the pre-existing object "map" posed by the analysis.

Moss's brief discussion of these vignettes did not include consideration of the homosexual anxiety that many analysts (Moss doubtless among them) would consider in attempting to understand this kind of clinical material. Homophobia and misogyny were frequently cited in Moss's critique of psychoanalytic theory, however. Moss appeared to regard homosexuality, gender, and race solely as co-equal, and perhaps even interchangeable, "signifiers" in his object-relations model. But not all is symbol: psychoanalysts, he said, must take note of "real" and "historical factors" in their work; or risk error, or even irrelevance.

Dionne Powell's discussion included numerous vignettes of positive and negative transferences crystallized around her African-American racial identity—including many positive transferences in which she

was viewed as an "other" whom her patients experienced as inherently attuned to feelings of abandonment and alienation.

Race serves as "a scaffolding for Pandora's box of fantasies and projections . . . and serves as a cover for group-speak," Powell said. "What should be explored is taken as understood" between treater-patient dyads of the same race.

Powell expressed support of Moss's thesis, yet the terms of her discussion—including references to familiar concepts of paranoia, displacement and projection—appeared to indicate that she did not share Moss's sweeping metapsychological revisionism; nor did she seem to go as far as Moss in condemning modern psychoanalytic practice as inherently "parochial."

Focusing on the predominantly Caucasian makeup of psychoanalysts and their patients, neither speaker appeared to take notice of the climate of lethal anti-Semitism in which the "Jewish science" arose —a phenomenon that doubtless led to a powerful body of "group-speak" and shared assumptions among Freud, his followers, and their patients, of precisely the nature that Powell described. (It also claimed the lives of all but one of Freud's siblings.) On the other hand, it is none other than Freud, of course, who described the power of what he termed the "narcissism of minor differences."

Freud's warning—as in the past week cities erupted in violence sparked by a handful of editorial concerns—seems as timely as ever.

A Matter of Time: Actual Time and the Production of the Past

Presenter: Dominique Scarfone
Discussant: Richard Zimmer
Presented March 7, 2005

Dominique Scarfone addressed the phenomenon of time in unconscious mental life that appeared to represent a modification of the metapsychology of Jaques Lacan. As Lacan developed a topographic view of language as the determinant of consciousness and thus ego structure; Scarfone focused on the quality of time.

While Lacan views unconscious mental life as asymbolic and chaotic; Scarfone emphasized the timeless aspect of the unconscious. Perception of the passage of time in the psychic sense is not a mere consequence of time passing as a physicist might quantify it. Memory is an active creative process, and the sequential experience of time itself occurs only in the present as a product of ego function.

The act of repression, Scarfone said, renders psychic material "timeless," devoid of past, present or future. Dreams and parapraxes represent episodes of "unpast" in which repressed material becomes part of the present moment. This quality, in Scarfone's view, represents the metapsychological origin of the repetition compulsion.

In instances of psychosis, aberrant perception of time renders ego boundaries permeable, and refutation of delusion impossible. To illustrate this point, Scarfone presented a vignette of a woman suffering from delusional fears of poverty continually re-checking her bank balance.

The experience of object loss developmentally predates the capacity to recognize "having" the object, resulting in an experience of loss having *already occurred* when it occurs in later life. A child's destructive impulses are repressed and re-experienced in the present in what Scarfone considers deferred action (the phenomenon by which Freud claimed that the Wolf-Man's primal scene exposure did not exert neurotogenic influence until the consciousness of his patient was sufficiently developed). A child's struggle to comprehend loss is undertaken in the domain of developing language: here Scarfone cites the 'fort/da' sequence from *Beyond the Pleasure Principle*.

For this member of the audience, Scarfone's presentation was dense and at times difficult to follow. The experience of listening to it, however, imparted a sense of vitality, such as occurs when one unexpectedly hears a phrase of music or poetry that inspired passion in

one's youth: for a moment one is young again. Scarfone wields Freudian concepts with an immediacy and lack of qualification one rarely encounters in the halls of American psychoanalysis—deferred action, repetition compulsion, the topographic model, as well as an unapologetic examination of metapsychology itself—stripped of the disappointments and qualifications of subsequent maturity.

In Scarfone's world, it would seem, it's always 1919.

Introduction to the November Meeting

The November scientific meeting of the APM consisted of a presentation by Stephen Sonnenberg and a discussion by Arnold Cooper. We have included an abridged version of Dr. Sonnenberg's paper, and the response by Dr. Cooper in its entirety. We do this to highlight the educational issues being addressed in these two pieces and to promote additional dialogue, which we believe would be valuable, among our readers.

H.S.

The Educational Boundary

Presenter: Stephen Sonnenberg
Discussant: Arnold Cooper
Presented: Nov.1, 2005

Definition and Introduction

The educational boundary refers to the zone of privacy that is supposed to surround the activities engaged in by faculty and students during analytic training. In other fields it is assumed that what takes place between and among teachers and students is appropriate material for open scrutiny by colleagues. But because of the very private nature of the psychoanalytic experience, in which deeply personal discussion of very private information should take place between teachers and students to facilitate good learning experiences, respect for the privacy of what transpires takes on a unique position as a tenet of the educational process. In this essay I bring this issue into focus, and add this new term to our nomenclature, because I believe this will help us in our roles as analytic educators, when we must focus our attention on two major problems within our institutes: (1) We have so far failed to carefully delineate the ethical boundaries and standards, and rules regarding privacy that should guide the education of candidates; and (2) We have so far failed to acknowledge and master the difficulties we have because of the intense feelings that are generated in both students and teachers about each other.

The examples used in this paper are all very elaborately disguised.

BACKGROUND

The literature on psychoanalytic ethics and boundary violations, which describes those who commit gross violations, as well as analysts who commit what are sometimes referred to as non-sexual boundary violations, has been a source of attention and concern in recent years (Gabbard, 1999; Gabbard & Lester, 1995a, 1995b; Gabbard et al., 2001). At one extreme of the spectrum of violators are truly psychopathic analysts who will stop at nothing to achieve selfish goals. These analysts are frequently noted by their colleagues to be pathologically narcissistic, envious, vindictive, arrogant, competitive, and mean spirited, and will consciously employ intimidation and manipulation to gain personal advantage. At the other end of this continuum are analysts who may violate sexual boundaries or function poorly as regards their ethical behavior for complex reasons, without conscious destruc-

tive intent. The relatively well functioning analyst will recognize that she or he shares a place on a broadened continuum, knowing that at times, before careful self-reflection and planning, she or he has, at least briefly, engaged in the attenuated seduction of a patient in the midst of a transference-countertransference engagement. The problems of working analytically with patients who are at the same time analytic students, and the challenges of defining and maintaining appropriate boundaries within analytic institutes, have been emphasized recently by Kernberg (1998a, 1998b, 1998c), and Eisold (1994).

The analytic educational boundary is unique in the world of education. That is so because the psychoanalytic teacher relates to the student in an especially intimate way: She or he discusses extremely sensitive privileged information possessed by the student, and there may be a mutual sharing of very personal experiences and ways of thinking about one's self and others. A supervisor and a supervisee have a boundaried relationship, as does a training (educating) analyst and a student analysand, and sometimes an advisor or classroom teacher and a student. Thus, by the boundaried relationship I am not simply referring to the confidentiality surrounding the training analysis dyad, which is the usual focus when analysts consider this concept.

The analytic educator within such a boundaried relationship, as well as those outside it, often do not think carefully about what is appropriate behavior between the educator within and the educator on the outside. Analysts regularly, rather than rarely, lose focus on what is appropriate behavior of an outsider who acts or does not act on the boundaried relationship. For example, in well documented cases of analysts impaired by developing dementia, colleagues who are teachers of students in analysis with the impaired analyst far too frequently look away rather then ask the student analysand if they have become aware of the cognitive problems of their analyst.

I believe, then, that many of the behaviors by teachers which harm students occur because analytic educators are not used to thinking carefully in terms of the boundaries that circumscribe and define the relationships students share with those who educate them. Action to cross the boundary or inaction to not cross it can be educationally damaging. I also believe that while we are increasing the regularity with which we discuss case material regarding difficult boundary issues, our ability to discuss these same issues as part of our training efforts is lagging behind.

AN ATTACK AGAINST THE TRAINING ANALYST

A candidate nearing the end of her training sat for an oral examination. On the examining committee was a young analyst who had long ago been in an unsuccessful treatment with the candidate's training analyst. He was quite angry with this senior member of the faculty, harboring a grudge, and believing that the analyst was not capable of performing a truly successful analysis. What he was not aware of consciously at the time of the oral examination was that he believed that this analyst was so incompetent that he could not work well enough to successfully analyze any candidate, equipping that potential analyst to function effectively. Unconsciously trying to prove this point, in the course of the oral examination he relentlessly attacked the candidate. The candidate fortunately was thoughtful, highly competent, and quite confident, and passed the examination. But rather than it being a positive experience, which in the candidate's mind was associated with pride in her professional and personal growth, it was remembered as an unacceptable attack. It caused the student to slow down her institute progress, and for several months became the focus of her analysis.

AN EFFORT TO SUPPORT THE TRAINING ANALYST

A training analyst was involved in an effort to reform an aspect of admission policy at his institute, and had encountered resistance on the part of the old guard. A candidate analysand of that analyst was not particularly gifted at using the verbal and pictorial imagery of his analysands as he worked, and was in supervision with one of the old guard analysts, who was interested in the clinical use of dreams. In fact, that analyst worked in a very traditional way, was not particularly interested in more contemporary aspects of two person technique, and often advised colleagues to view much of what was said in analytic hours as though the analysand were producing dream material. In that institute each candidate had an advisor, and this candidate's advisor was a close friend of his analyst. When candidate and advisor met every few months, the advisor learned that the candidate was finding the work with the old guard supervisor quite difficult, but rewarding. Eventually, the advisor began to question the candidate's choice of that supervisor, suggesting that rather than experience frustration, he should capitalize on his strengths as an analyst, which were in the area of interpersonal management of conflict, and change to a supervisor who was more interested in that focus of clinical work. After hearing

this for a year the candidate left the old guard supervisor. Clearly, the reason for this had nothing manifestly to do with the political struggles within the institute, and could be understood as good educational advice by the advisor.

AN EFFORT TO SUPPORT THE ADMINISTRATION OF THE INSTITUTE

A candidate with a Ph.D. in Business Administration, with enough course work in psychology to entitle her to membership in the American Psychological Association, had worked for a number of years in a university setting. She had written a book on the problems encountered in the administration of organizations. Shortly after her admission she won her institute's annual candidate prize, for a paper on problems in administration. She presented this paper to her new colleagues at the analytic society, to much acclaim, and she was asked to consult by the administration of the institute, as they were working to revise the bylaws governing the organization, and devoted many hours to the project. She began to fall behind in her reading for classes, and delayed taking a first analytic case because of the time she was devoting to helping the institute administration. When her advisor, a junior faculty member, suggested to the president of the institute that the lack of a first case was having a negative effect on the candidate's educational experience the president accused the junior faculty member of envy of the candidate for her prized position. It was not until well into her second year at the institute that the candidate recognized that she was not gaining the insight into individual psychology which had led her into training in the first place.

AN ATTACK AGAINST A SUPERVISOR

A candidate was in supervision with an individual who was a leader in his institute. The supervisor was an older man, with a national reputation and a charismatic personality. He was also old fashioned, somewhat authoritarian, popular with candidates, and an object of envy and competition among his colleagues.

It happened that the candidate's analyst did not like the supervisor, because of a bitter rivalry with him. While he had been restrained when the candidate chose the supervisor, he had taken a different approach whenever the candidate associated to him or the case under his supervision. Then, the analyst was harshly critical of his colleague. Eventually, in response to this, the candidate asked the education

committee for a change in supervisor, though previously he had been quite satisfied by his learning experience.

The education committee became involved. A member of that committee spoke with the candidate, and then the supervisor, who sat on the education committee, spoke about his experience with the candidate. He talked about how well he had thought the supervision had been going. Curiously, the candidate reported that his analyst had encouraged him to switch supervisors, and the entire education committee was aware of the bitter rivalry which existed between the training analyst and the supervisor. In the end, the education committee was critical of the supervisor, suggesting he had been authoritarian and insensitive to the candidate, and had missed the boat about how the candidate had felt overly controlled by him in the conduct of the case. The supervisor concluded in his own mind that envious colleagues were using this situation to attack him. There was never any discussion among the relevant faculty members of the many interpersonal issues which "might" have been involved.

From the perspective of the candidate's education there was a significant loss. The candidate had been misused by his analyst in a personal struggle, and as time passed he came to know it. He then began to hold back in using his analysis to discuss countertransference issues experienced with his control cases, for fear of how his analyst might misuse such associations in ways which reflected his personal feelings about other supervisor colleagues. When, at the time of his graduation, he looked back on his analytic education he was regretful at this loss of the opportunity to have an analytic experience in which he could learn more about his countertransference tendencies and responses.

This example is particularly interesting because many years later both the former training analyst and the former student analysand came to a meeting of the minds about what had transpired. In frank discussion the former analysand characterized the former analyst as behaving vindictively and mean spiritedly, and with the advantage of time and hindsight the former training analyst agreed that had been the case. In what we believe is a rare example of reconciliation, the former members of this analytic dyad agreed that the analyst had been out of line. This had a healing effect on the former analysand, who for many years had felt not only cheated but ignored by those in whom he had placed his trust.

A COMPLEX EXAMPLE

Bob was a candidate in analysis with a person who had come highly recommended by a respected teacher. After about a year the analyst became harshly critical of Bob, often raising his voice as he sarcastically told him that he wasn't "analyzing correctly." Bob, filled with idealizations about analysis and the person to whom he had been referred came to believe he was at fault. He did not question the technique of the analyst, or wonder about the possibility that the analyst was impaired.

After two years of verbal assault by the analyst Bob had become very anxious, irritable with his wife, children, and friends, and at times suffered from serious insomnia. When he brought up the possibility of a consultation the analyst said that such a move would destroy the analysis. When Bob asked why there was no reply.

Eventually, Bob left the analysis, in part because of his painful, increasing anxiety. After leaving the first analyst, Bob began with another analyst, and after about one year of careful reflection recognized that the first analyst had been emotionally disturbed. He called the chair of the education committee to speak about this situation, asking for a meeting. He was told they could talk on the phone, that a meeting wasn't necessary. Bob then explained his concerns about the first analyst, and was told by the education committee chair that "I always thought he was seriously disturbed. Thank you for coming forward. Something will be done."

By the time Bob graduated from his institute, he had become aware of many other candidates who had similar experiences with the first analyst, and had switched analysts after suffering, in some cases, severe personal damage. In some cases the ripple effect included the suffering of spouses and children. All had experienced very substantial interferences in their analytic educations.

Bob was aware that nothing was ever done to attenuate the damage caused by his first training analyst, who continued to practice with that status. The damage to the institute was great as well. Because this was a relatively small institute, the impaired training analyst had affected a large percentage of candidates. For the most part these individuals did not remain affiliated with the institute. The effect of this was that these individuals did not encourage potential applicants to apply for analytic training, and the institute experienced a significant decline in the size of its student body.

A few years after his graduation Bob had his first opportunity to discuss what had happened with several colleagues who had been

teachers during his candidacy. Each reported that most on the faculty had not known what to do as they witnessed candidate after candidate drop out of analysis with the training analyst. Bob also learned that the chair of the education committee had been a close friend of the training analyst and had done nothing after their phone discussion. Those on the faculty who were not friends of the training analyst had felt unable to suggest his loss of training analyst status for fear of being seen as his enemies or as adversaries of the head of the education committee.

DISCUSSION AND REMEDIAL SUGGESTIONS

In my examples I have tried to illustrate a few of the ways the education of candidates is compromised when the concept of the educational boundary in psychoanalytic training is misunderstood or not recognized at all. These examples also attempt to focus on the role of personal relationships between and among members of the institute faculty, and the ways these relationships affect the education of candidates. Finally, I have noted the ways personal qualities such as pathological narcissism, vindictiveness, arrogance, and mean spiritedness among faculty members come into play.

In trying to understand the seemingly ubiquitous nature of institute abuses, I offer an explanation. I am aware that in analytic communities many of us experience regression much of the time. Since Freud's first efforts at describing analytic technique, we have moved from the notion of the "objective" surgical practitioner to the empathic observer, and more recently to the very involved participant observer. This leaves us both more empathically involved and more psychologically vulnerable than in earlier periods in the history of psychoanalysis. These vulnerable conditions and their acceptance in us, while potentially valuable when we are self-analyzing analysts effectively engaged in the therapeutic mission of analyzing and supervising, can represent a difficulty when we perform administrative and educational functions, because there we are not accustomed to working with our own intense emotions. Indeed, our tolerance as analysts and analytic educators for more prolonged regression makes clarity of thought much harder when we function naively in the non-therapeutic educational realm, where we must be aware of our own difficulties with the regulation of narcissistic vulnerability, personal disappointment, envy or jealousy, intensely competitive feelings, and tendencies toward arrogance, vindictiveness, the desire for revenge, and mean spiritedness.

In fact, we analysts defend against recognizing such intrapsychic states. Our resistances then makes us even less able to perceive what is going on in our interactions with colleagues, in settings which require judgments about our own personal shortcomings, and the ways we function in groups. Then, we simply don't pay attention to how poorly we function when engaged in educational activities.

I believe that in the majority of instances it is not the psychopathic analyst, but the naively self-confident and unknowingly arrogant analyst, who is most likely to misbehave and violate the ethical standards and boundaries of analytic education, without awareness of the level of his or her envy, narcissistic discomfort, out of control aggressiveness and competitiveness, and even rage and hatred. I also believe that such behavior is often encouraged by group pressures. It is extraordinarily difficult for us to understand ourselves in the regressive web of the group experience of institute life.

CONCLUSION

In my examples, the consequences of the action and inaction of faculties were neither examined systematically nor remedied institutionally at the time the problems occurred, and personal, educational, and administrative challenges were not seen for what they were. Even though the situations as I write of them are dramatically clear, and on some level in each instance at least some faculty members knew that their institutes were suffering from the misbehavior or acting out of even troubled analysts, nothing was done at the time to address what was wrong.

I want to underscore my view that most faculty analysts who act in the ways I have described do so without full awareness of the consequences of their personal shortcomings or interpersonal motivations and behavior. This is so because we are members of a profession where regression and keeping secrets are what we are accustomed to living with, which renders our complex task of self-reflection and interpersonal cooperation even more difficult. But I also want to emphasize that our profession's failure to carefully delineate the ethical principles and standards that should govern the education of candidates, and study the use and misuse of educational boundaries during that educational process, must be remedied. Most analysts who have failed in the ways I have described have done so because they are unaware of the psychodynamics motivating their and their colleagues' thoughts and actions, the group process pressures influencing them, and the concept of the educational boundary.

Discussion of "The Educational Boundary"

Arnold M. Cooper

Psychoanalytic education is a hot topic these days and Dr Sonnenberg is making a significant contribution to the discussion by focusing on a group of problems that he labels educational boundary violations. He gives us the opportunity to know exactly what he is talking about by providing some rather appalling case examples and we are very grateful for that. But calling these behaviors educational boundary violations may blur several important distinctions between the way we view sexual boundary violations and educational boundary violations. Boundaries imply rules. The boundaries for sexual transgression are simple and clear. Thou shalt not. The boundaries of educational transgressions are not always crisp and cannot be written into a simple set of rules. Sexual boundary violations generally involve unethical behavior on the part of a single individual, but educational boundary violations involve unethical behavior on the part of a group. Perhaps it is closer to gang rape.

I will begin by briefly reviewing the individual cases.

Case 1—The attack on a candidate by an examiner who didn't like the training analyst and so attacked his patient. There is nothing especially psychoanalytic about this instance. It could happen in any educational institution where a student is defending a Ph.D. thesis and a committee member has a grudge against the student's advisor. This is obviously unacceptable behavior by an educator and his institution. We expect that any reasonably well-run educational organization would see to it that such an individual recused himself from the examination.

Case 2—The analyst attacks the candidate's supervisor. Dr. Sonnenberg describes this as "unconsciously, it was the wish of the advisor to embarrass the supervisor... what seemed like a constructive educational intervention by an advisor, etc." I find it hard to believe that this was unconscious. This degree of malice is quite up front, and it could have seemed "constructive" only to someone totally naive about the institute's politics. This has little to do with educational boundaries since by implication there would have been no problem if the advisor had given good advice. This is an example of cronyism between an analyst and an advisor with the student being sacrificed for the sake of their personal tie.

Case 3—An effort to support the administration. The institution and its inept leader sacrifice a candidate's development to gratify petty immediate needs of their own, an example of administrative incompetence and personal selfishness. Apparently no one in the institute raised questions and there were no institutional mechanisms for exploring the situation. We are told that "Some observers within the institute believed that the president was pathologically narcissistic, arrogant, and competitive, but the president's refusal to look inward and share his conclusions with colleagues meant that some of these beliefs could never be more than questions." Why not? An institution is responsible for its teachers and cannot excuse damaging behaviors by calling upon the unconscious. Self-analysis is an unlikely cure for malignant narcissism. Why was it up to the president alone? It sounds like George W. Bush is running an analytic institute.

Case 4—The attack against a supervisor. Dr. Sonnenberg comments, "it happened that the candidate's analyst did not like the supervisor, because of a bitter rivalry with him." As in the first case, these things don't just happen. In these examples a false notion of analytic secrecy and confidentiality is misused to allow educational malfeasance and gratify personal wishes. An entire Education Committee, aware of the rivalry between analyst and supervisor, remains silent. Why? The Education Committee failed to carry out its duty.

Case 5—Although labeled a complex example, I find this example quite straightforward. We are all familiar with institutions where whistle-blowers are punished and the perpetrator of the crime goes free. I think that in NY it would be criminal behavior on the part of the institution not to take action when malpractice by an impaired physician has been reported. Someone should have taken responsibility for reporting the case to the Ethics Committee of the American. There is no privilege involved here. Furthermore, the patient had no sense that he had any recourse and could discuss his training analysis with some responsible authority. The confidentiality of the training analysis is the obligation of the analyst, not the candidate. Candidates should be informed that they can go to someone else and get advice if they think their analysts are behaving badly. This in fact is spelled out very clearly in the Columbia guide to candidates.

I want to emphasize again the vast difference between our institutional response to sexual boundary violations and the response to these varieties of educational malfeasance. I am concerned that we may hamper our effort to reform our educational practices by con-

sidering these as boundary violations rather than institutional failures. Sexual boundary violations are individual, non-institutional, and there is no ambiguity or ambivalence about one's attitude towards a response to sexual boundary violations. Reporting and investigation have been rigorous and sanctions or re-education have been prompt and appropriate. Dr. Sonnenberg is calling our attention to the fact that the educational problems reported here are in every way different. Reporting, remedial measures, sanctions and even the conviction that something unacceptable has occurred are all missing in the cases described tonight. Dr. Sonnenberg and I are in general agreement that these are institute abuses, but he is more focused on the individual pathology of the involved educators, while I am emphasizing the organizational issues.

Under the best of circumstances, an analysand has trouble coping with an impaired analyst or just an analyst who is a bad fit—a very important issue, as Judy Kantrowitz has informed us. But in the so-called training analysis situation, the failure of fit or competence becomes a responsibility of the institute as well as of the analyst. There is a growing movement around the analytic world to abolish the title of "Training Analyst" with its political baggage and oxymoronic connotations, and to separate the analytic function from any educational or institutional aims. But this can only be an ideal, unachievable in practice, and the oversight of the institute cannot be eliminated.

If we are not to identify these as boundary violations, what should we call them? I couldn't come up with a good label, other than to refer to them as institutional malfeasance. In the examples we have been given, one or more faculty members—impaired, rivalrous, pathologically narcissistic or submissive, grandiosely ambitious, etc.—sacrifice an analytic candidate to further their own career interests, and the responsible educational organization takes no action even after the information is available. How would we respond to a school that took no action against a teacher who was abusing a child? I am sure that we would immediately want to know who was responsible for permitting such an abuse, we would bring it to the attention of all concerned parties and demand action on the part of the school administration to assure that it would not recur. That is what we should be doing in analytic schools. I would prefer that the term "educational boundary violation" be reserved for something like an analyst or supervisor insisting on the correctness of a single point of view concerning analytic theory and technique, thus handicapping the candidate's optimal intellectual and affective development. That might be a pedagogic issue.

There is an extensive literature on what Lewin and Ross in 1960 called the syncretic dilemma. They described that the affective aims of treatment and the pedagogic aims of supervision are often in conflict and must be sharply separated; a boundary that is desirable, but that cannot be fully realized in practice. Harold Searles in 1955 had already brought parallel processing to our attention—describing the ways in which the relationship of the candidate and his patient is duplicated in the relationship of the candidate and his supervisor, and is in fact an important source of information about the analysis. Today, aware of the intersubjective viewpoint that dominates much of our analytic philosophy, we may wish to rethink the concept of the syncretic dilemma. There are at least five interrelated participants in analytic education: the candidate, the analyst, the supervisor, the classroom teachers, and the institute and its representatives. These are all interacting parties that require constant monitoring by each other. There can be no clear-cut boundaries. As with countertransference and role responsiveness, no analyst can avoid leaking information to his candidate concerning his feelings about the supervisors and the institute. No supervisor can totally hide his feelings about the candidate's analyst and his colleagues, and every candidate knows something about his analyst's standing within the institute. Furthermore, enactment is today seen as an unavoidable aspect of every analytic relationship, and I would suggest that it enters every supervisory relationship. We can assume that everyone involved will know more than they have been officially told. This added complexity of intersubjectivism puts a different light on the notion of boundaries, and makes syncretism an integral part of analytic education, something to be considered at all times, rather than regarded as an undesirable artifact.

I would like to touch on a few specific questions raised by Dr. Sonnenberg's presentation:

Secrecy and privacy: Dr. Sonnenberg refers to "the zone of privacy that is supposed to surround the activities engaged in by faculty and students during analytic training." I think this overstates the case. Supervision is entirely an educational enterprise, in which the analyst-patient relationship, with its mandatory confidentiality, does not apply. The supervisor is a teacher, and like all good teachers, he is privy to lots of private information in his role as friend and helper. However, as part of an educational enterprise, it is his duty to report malfeasance when it occurs, and it is the duty of the institution to act on such information. The analyst is committed to privacy, but to give privacy pri-

ority over the need to protect a vulnerable patient is malpractice. We should take care that notions of analytic privacy and secrecy are not misused as a shield against the openness that is required to avoid institutional corruption. Privacy should not prevent us from informing the patient that his analyst is demented. There is nothing sacred about psychoanalysis and when we undertake the care or the education of another person, we have agreed to sacrifice a portion of our own privacy, since we must submit to scrutiny concerning our competence as healer or educator. Where privacy concerns are exaggerated, we get the paranoid institutions that we have heard about tonight.

Questions of responsibility: An educational institution should be designed to assure the highest level of faculty competence, to reveal the failures and successes of educational goals, to make decisions concerning the progression towards competence, and to evaluate the teachers and the students. The training analyst system is under attack today because election to the position occurs through procedures that are unacceptable to a large segment of the profession. Furthermore, training analysts are not periodically re-examined vis-à-vis competence, we are not required to demonstrate our continuing analytic education, we do not have to meet scholarly standards, nor are we graded in any way. The psychoanalytic institutes described by Dr. Sonnenerg have not accepted the responsibility for protecting and shepherding the students under their care, using privacy as an alibi. Such a system invites corruption and reform of the existing procedures is part of the intense debate going on now in the American concerning the role of the Board on Professional Standards.

Questions of the etiology of our educational difficulties: Dr. Sonnenberg offers several explanations for the extraordinary educational malfeasance that he has described. He refers to the "naively self-confident and unknowingly arrogant analyst...without awareness of the level of his or her envy, narcissistic discomfort, out of control aggressiveness and competitiveness, and even rage and hatred....who is most likely to violate ethical standards.." We all know some arrogant, self-confident, aggressive analysts, but the idea that these people are totally naïve and unknowing boggles the mind. Something doesn't ring right about the idea of analysts retaining that level of naiveté in the thick of an analytic community. How did they get to be and how do they remain analytic educators? Analysis is supposed to cure or at least ameliorate narcissistic naïveté.

Dr. Sonnenberg also suggests that, "It is extraordinarily difficult

for us to understand ourselves in the regressive web of the group experience of institute life." While it is true that group life has its regressive aspects, we may expect that a group of analytic educators would do a little better than ordinary crowds and masses. It is almost half a century since Bion wrote *Experiences in Groups,* and we analysts are supposed to know something about ourselves and our group behavior. Dr Sonnenberg may be right that analysts are unusually naïve and regressed, but that only restates the problem—it is not an explanation of how an analytic institute can behave like the Bush Administration.

As another possible explanation, Dr. Sonnenberg attributes the prevalence of educational violations to the change from a one-person to a two-person psychology, with its increasing intersubjectivity and immersion of the analyst in the patient's subjective state. I don't see it that way. I know of no evidence that educational malfeasance is more frequent today than in the past. In the more authoritarian psychoanalytic past, transgressions were less likely to be aired, but they were there. Further, I fail to see how empathic immersion makes us more susceptible to corruption, malpractice, envy, etc. Empathic immersion doesn't excuse bad behavior; it allows us to understand it. Our understanding of the inner motivations of the criminal and being able to feel some of the same urges within ourselves in no way diminishes our capacity for judgment. (Kohut, the father of the current empathic movement, was explicit in distinguishing empathy from its consequences. He once described that the Germans preparing to bomb Rotterdam equipped their Stuka dive bombers with sirens, understanding that the additional noise of the sirens would further terrify and disorganize the populace, making them easier targets for the German forces. Kohut described this as an empathic maneuver on the part of the Germans. They understood the inner feelings of their victims.) If anything, the current two-person psychology, enhancing our knowledge of the experience of the other, should help us to clarify our ethical judgments rather than mute them in favor of some notion of "anything goes because I can understand it."

Finally, Dr. Sonnenberg tells us that "we are members of a profession where regression and keeping secrets are what we are accustomed to living with, which renders our complex task of self-reflection and interpersonal cooperation even more difficult." I would have drawn the opposite conclusion from that description. We should be experts at self-reflection and awareness of the needs of the other, and at least pretty good at controlled regression in the service of the ego, to use an old phrase.

If I try to discern a source for our educational carelessness and hubris, I would attribute it to the remnants of the movement phase of psychoanalysis; our isolation from neighboring disciplines, our self-inflating notions that our knowledge is arcane and incommunicable, our pride in being members of an impossible profession doing superhuman work, and our claim that we are therefore exempt from the ordinary rules and restrictions of organizational life. Too often, we retain the practices of a cult rather than a profession.

Is there a remedy for institutional malfeasance? I know that it is a bit of pie in the sky, but I think that repair of the institutional problems that Dr. Sonnenberg has so vividly presented requires a vast reorganization of our education enterprise. For all its faults, the university has been the most reliable and productive container of our educational ideals in the Western world, and as Anna Freud and her father said a long time ago, the university model should be the educational ideal towards which we strive. We flatter ourselves that we are part of an impossible profession. In fact, a great deal is known about how to teach, educate, train and administer, but we often fail to apply this knowledge to our own educational institutions. Otto Kernberg, in his important paper, A Concerned Critique of Psychoanalytic Education (IJP 2000, *81*, 97–120), listed 15 questions that are vital in assessing the health of an educational institution. I will repeat a few of them that are relevant to the problems that Dr. Sonnenberg describes.

1. Is research methodology and concern built into the program?
2. Are multiple psychoanalytic theories and clinical approaches respectfully taught?
3. Is there a functional candidates' organization in place?
4. Are scientific developments at the boundary of psychoanalysis taught?
5. Is there a functional, non-political method for appointing training analysts or for assigning the authority to analyze candidates?
6. Is there a functionally changing curriculum in place?
7. Do supervisors communicate with each other and with seminar leaders?
8. Is the personal analysis of the candidate totally separated from the rest of the educational experience?
9. Is there a functioning mechanism in place that helps to deal with candidate or faculty breakdown or incompetence in a humane yet responsible way?

I will add my own item 10. Is there a transparent system for faculty advancement?

I think an institute that can answer yes to these questions will not suffer the ills that Dr. Sonnenberg has so vividly described for us, or at least will suffer fewer of them.

I want to thank Dr. Sonnenberg for giving me the chance to think and talk about these issues, and I apologize for committing the discussant's sin—perhaps talking more about what is on my mind than on his.

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