PINE PSYCHOANALYTIC CENTER, INC. NEWSLETTER

P.O. Box 920762, Needham, MA 02492 Volume 22, No. 3, Spring 2011

EDITOR'S NOTE:

In stark contrast to the beard-stroking, silent analyst who is passively 'waiting for the transference to develop,' we include in these pages many examples of a kind of activity, vitality, and creativity among analysts that is exciting just to hear about. The new PINE Website will soon go live, by virtue of the hard work and determination of Julia Matthews, Deb Shilkoff, and Sarah Lusk. With this new resource in mind, Deborah Offner was inspired to write a personal essay reflecting on the way the internet is enhancing our lives and affecting our clinical practices. In a separate article, I use this opportunity to explore some of the ethical dimensions raised by the use of digital media in clinical psychoanalysis—ethical issues so new and dynamic that they haven't yet been formally regulated by the ethics boards and risk management groups we rely upon for guidance.

We also include a historical perspective: Elissa Arons and Susan Workum describe a project they have maintained for sixteen years. Working with a group of women judges, Drs. Workum and Arons offer the support and illumination of a psychoanalytic lens on juridical practice. This article is a helpful reminder that attention to psychoanalytic applications beyond clinical practice has been woven into PINE's fabric from its inception.

TABLE OF CONTENTS

Another example of reaching beyond our consulting rooms is captured in our reprint of a brief article from the *Boston Globe* that inspired Michael Good to write a letter challenging J. Allan Hobson's rather myopic perspective on dreams.

Deborah Offner's report of last fall's scientific meeting with Jack and Kerry Novick, along with Sarah Lusk's interview with the Novicks, provides a case study in an analytic approach that is founded on full engagement with the community in which the Novicks serve, reaching beyond their caseload to effect change.

Finally, my report of a recent faculty meeting presentation by Dr. Ray Levy of MGH describes how contemporary psychotherapy research is breathing new life and hope into the practice of psychoanalysis.

Best wishes to all for a refreshing summer.

Clinical Practice in a Digital Age: A Candidate's View

Deborah Offner, Ph.D.

Psychoanalyst's Technology Guide (2011)

Your practice		*Your patients*	
OUT	**IN**	**OUT**	**IN**
Yellow pages	*Web pages*	*E-mail*	*Googlechat & Black Berry Messenger*
Long-distance telephone sessions	*SKYPE*	*Group e-mail*	*Twitter*
Pad & pen	*Keyboard*	*Home page*	*Facebook*
PC	*ipad*	*Meeting @ bars; getting "fixed up" by family members*	*Online dating*
*Voicemail; live answering service **	*E-mail*		
		Video games	*Online gaming*

** Really?!

At PINE's most recent Candidate Meeting, Dr. Sarah Lusk reported that our institute will launch the reconstructed Web site this summer… complete with six minutes of live video and links to Facebook and Twitter. While even the youngest within our psychoanalytic community can recall a time when the World Wide Web was a novel, virtually incomprehensible concept (and "electronic mail" just marginally less so), technological advances are now wholly embedded in our personal and professional lives. While some journalists and social scientists argue that the influx of communication technology into American culture has increased personal isolation, others appreciate the myriad ways that electronic media can expand and enrich our individual relationships and social networks. Regardless of one's philosophical or professional stance, clinical practice demands our recognition of technology's cultural presence—in our professional roles and identities, and in the lives and minds of our patients.

The innumerable ways that electronic media connect people seem far more compelling to me than the ways in which they might compromise communication or exacerbate isolation. There are, of course, instances of overuse or misuse of technology, in both ordinary and psychotherapeutic relationships. Learning how we, and our patients, can maximize the benefits and avoid the pitfalls of technological communication presents a continual challenge.

Consider the obvious tribulations faced by those of us in child and adolescent practice.

I had been seeing an extremely reluctant 11-year-old girl ("Caitlyn") in weekly psychotherapy for six months. Several days before our next scheduled appointment, I received an email message from her father ("Peter"):

> *Hi,*
> *Sorry but Caitlyn can not make it to this weeks plan. She has something right after school.*
>
> *Peter*
> *Sent from my iphone*

Two hours later, I received a follow-up note from Caitlyn's father.

> *Hi . . .*
> *You can ignore the last e-mail.*
>
> *Caitlin sent it!*
> *We will see you Wednesday.*
>
> *Peter*

Or, on a different level, consider the way in which self-disclosure might compromise the privacy of a third party. I wrote a brief autobiographical statement for a psycho-

analytic publication, focusing on my career path and mentioning, in passing, my current family constellation. My psychoanalyst husband was chagrined when one of his patients confronted him with the fact that having Googled me (my full name is on our shared office voicemail message), he discovered this piece, thus learning that we have a young daughter.

My husband felt our daughter was unnecessarily exposed and wished for me to remove this particular essay from the Internet. I was torn—I hadn't written anything I minded any of *my* patients reading; but I had to pause to consider what I might owe my husband/colleague in this situation.

In less controversial moments, those of us who work with children and adolescents are continually exposed to the ways in which technology not only affects or shapes but *is* their lives. At a recent independent school conference, a counselor at a local boarding school quipped that just this year, one of the items on the Independent School Health Association (ISHA) health behaviors survey had become decidedly obsolete.

Her current students were confused when asked, "How much time per day do you spend on the Internet?"

"They are never NOT online," she said. Between computers and smart phones, they are connected 24/7. They simply didn't understand the question."

A student at the high school where I work recently mentioned that he knew his ex-girlfriend had met with me earlier that day. I paused, unsure of the protocol regarding confidentiality in this situation—do I say "I cannot confirm or deny that," go stony-faced, or nod? Before I could decide, he remarked, "She put your meeting in her Facebook calendar." While I had to ask myself, "Did she mean to tell him?" I decided that her public disclosure rendered me less accountable. And frankly, for a moment I felt kind of important.

In everyday life, digital media afford us, and our patients, many new relational opportunities. Consider the case, reported on National Public Radio's Morning Edition last month, of Rachel Salazar and Ruben Salazar ("A Typo Spells Romance for RP Salazars," May 13, 2011). This couple "met" in 2007 when Rachel (originally from the Philippines) was living in Bangkok, Thailand, and Ruben Salazar was in Waco, Texas. Because they happened to share the same last name and first initial, their email addresses were nearly identical. One morning, Ruben checked his email, and he found a note intended for someone else.

> I discovered it said RP Salazar followed by two numbers," he says. "I figured, 'Hey, my email is the same exact thing without the numbers, so they probably sent it to the wrong person.

Ruben, 39, noticed that this other RP Salazar was in Bangkok, so when he forwarded the email, he added his own little message.

> Something to the effect of "Hi, Rachel, it seems as if this message came to me instead of you. I'm in Waco, Texas, U.S.A. Have a great day. p.s. How's the weather there in Bangkok?"

The two gradually began a correspondence. Both felt that they were able to be open with the other, to reveal things about themselves, to this other person halfway around the world. One day Ruben accidentally hovered his mouse over Rachel's email address, and her picture popped up. Viewing the photo, he was taken with her beauty. After several months of email communication, Rachel planned a trip to the U.S. to meet Ruben. By the end of their sixth day together, Ruben proposed. Four years later, the Salazars remain happily married.

Though laptop computers and cell phones have long been viewed as distractions in the classroom, some educators are now incorporating communication media into their teaching using a method called "backchannel." Students post comments about readings, and responses to the instructor's and peers' comments on platforms like Twitter. Programs like Google Moderator allow students to post their individual questions and then vote on which of the group's questions they would like the teacher or professor to answer. At Purdue University in Indiana, which invented its own technology, "Hot Seat," finance professor Sugato Shakravarty notes that before he incorporated the backchannel method, many of his students did not feel comfortable speaking up. Those quiet students now post comments and ask questions that appear on a screen in the front of the classroom.

It's clear to me... that absent this kind of social media interaction, there are things students think about that normally they'd never say (Speaking Up in Class, Silently, Using the Tools of Social Media. *NY Times,* May 13, 2011).

In clinical practice, the potential applications of technology are endless. Patients read us text and email exchanges so we can hear the exact wording of "conversations"

Continued on page 4

they have with significant people in their lives. E-mail also allows us to be in contact with our patients in meaningful, but non-intrusive ways. On a recent week-long vacation, I was able to receive important news from my patients (a long-awaited positive pregnancy test, a first marathon completed, a reunion with a previously estranged family member). A lot can happen in a week, even within a single practice, and it is nice to be kept in the loop without having to be available in "real time."

Of course, one of the most vital benefits of Internet-based communication is the expansion of the consulting room. The advent of SKYPE provides free-of-charge, Internet-based long-distance calling and now includes a video component so patient and therapist can see one another. Perhaps the highest profile example of the interface of SKYPE and psychoanalysis is Elise Snyder's psychoanalytic training program through the China American Psychoanalytic Alliance (CAPA). CAPA, founded in 2006, aims to promote mental health services in China by training Chinese professionals in psychoanalysis and psychodynamic psychotherapy, and by providing them with psychoanalytic treatment. The majority of the supervision and treatment in this program is done with American psychoanalysts via video SKYPE. To learn more about this program visit their Web site: www.capachina.org.

More quietly, many of us maintain relationships and regular appointments with patients who travel for work, or move away and wish to continue therapy or analysis at a distance. I have ridden the technological wave along with a twenty-something patient of mine, with whom I consulted regularly by telephone when she attended college out of town. During this time, we agreed that our telephone sessions were far from second-best.

Not unlike the couch, the telephone provided a stimulus-free space within which my patient could free associate and explore the transference in ways that had been more difficult to do face-to-face. Having been back in town for some time, my patient recently departed for an international study opportunity. We decided to continue working together over SKYPE. Interestingly, just before she left she decided she would prefer not to use SKYPE's video component. The reason? "I think I want to keep it more like when we were talking on the phone."

Last year I received a voicemail message from a father seeking a psychologist for his young daughter. In his message to me, he asked, "Do you have a CV you could send me? I looked on the Web but I could not find it." At that moment I realized that however presumptuous the question, he had a point. Currently, prospective patients do expect that psychoanalysts will have a Web presence, complete with our credentials. You can guess whether I returned the phone call. But you can also know that when I was contacted by a Web designer asking whether I would engage him to design a site for my practice, I readily agreed.

In life, as in practice, there can be drawbacks to the popularity of this new virtual transparency. Everyone and their mother have a Facebook page now—literally. An adult patient of mine whose divorced mother has questionable dating judgment and fluid boundaries was understandably dismayed to see her mother's photos of herself with a new boyfriend (to whom my patient had not yet been introduced)—posted on her mother's Facebook page.

Patients now arrive at our offices knowing far more about us than they ever have before. Just a couple of years ago, a long-time psychotherapy patient Googled me on a whim, then promptly regretted it. It felt like a boundary crossing—to both of us. Today, patients routinely "Google" us when given our name as a referral. And I have received several excellent referrals to my own practice through a colleague whose name these patients found on the Web. (She referred them to me because her own practice was far too busy!) At least based on these cases, it seems that highly educated professionals search for psychotherapists by typing in relevant terms such as "marital counseling" and "Cambridge, MA."

One might argue that technological proficiency continues to be optional for psychoanalysts. And let's face it—we are notoriously late, reluctant, and non-adapters. (My own analyst has no computer in her office, has yet to get a smart phone… and schedules her appointments in a *Week-at-a-Glance*). You don't have to have a Facebook page, a Web site, or a Blog to practice in contemporary culture. But unless you pause to consider how digital media shapes the culture we share with our patients, and perhaps to explore how you might use it… you may miss out.

Ethical Practices in the Communication Age

Sarah Ackerman, Ph.D.

The Internet is changing everything. Who could begin to list or account for the ways in which social, financial, political, corporate, medical, or legal relationships have been altered by email, web access, social networks, and other technologies? Advances happen so rapidly that even as we take stock of our circumstances, they change. Sherry Turkle, one social theorist who has devoted herself to researching the effects of these technological media since the 1970's, expresses shock at the way things have evolved. Even as cultural theorists were gaining a hold on the impact of email, the Internet, and cellular technology, they weren't recognizing the changing relationship that individuals were having with their increasingly smart phones. In her recent book, *Alone Together (2011)*, Turkle recounts that individuals increasingly exhibit symptoms that we might think of as "insecure attachment" to their phones, or the connections they promise. People report that they feel their phones vibrate from across the room; they experience anxiety when out of cell phone range; they sleep with their phone; and they mourn them when they go missing. As analysts, we could play an important role in investigating the complex transitional space that these new media devices are occupying. At the same time, analysts and analytic communities alike need to reckon with our own presence in digital space.

The American Medical Association, the American Psychological Association, the American Psychoanalytic Association, and other organizations concerned with the practice of psychotherapy have been slow to develop ethical guidelines on the clinical use of email, instant messaging, Skype, cell phones, and social networks like Facebook and Twitter. Risk management companies have not yet accumulated the basis of knowledge needed to inform medico-legal standards of practice. Without a foundation of ethical or clinical or risk management standards of practice, clinicians are at some risk.

At PINE, we now have a growing habit of digital communication. Our new website aims to expand our accessibility to a wider public. Website content devoted to visitors beyond our membership is the primary focus, with the intention of using the website to advertise and market our clinical services and our analytic training. Social networking sites have been identified as goals for promoting PINE, and within our membership, communication by email is an increasingly common way of promoting dialogue. With all of this growth in process, it seems wise to take a step back in order to consider issues of ethical practice in electronic communication. How can we safely protect patient confidentiality and privacy in the use of email and social networks? What are helpful and meaningful ways of promoting our profession via the internet, and what should we watch out for in that regard? These are questions about risk management and about public relations, so I took them to two experts. Thomas Gutheil, Professor of Psychiatry and Co-Founder of the Program in Psychiatry and the Law at Beth Israel Deaconess Medical Center, Harvard Medical School, shared his thoughts in response to my questions about clinicians and Internet use, as well as directing me to some important research in these areas. Dr. Gutheil has served as special consultant to the American Bar Association and the Risk Management Foundation of the Harvard Medical Institutions, and is a leading expert on medico-legal issues, malpractice, liability prevention, and risk management. Jake Lynn, Director of Public Affairs for the American Psychoanalytic Association (APsaA), was also receptive to my inquiries. He has worked as a press secretary for government officials, coordinated the Bloomberg Administration's Small Business Services Department, and directed public affairs for the NY Historical Society, and his mission now is to promote APsaA and psychoanalysis in general through conventional and modern technologies. I will now discuss the information I received in response to questions I posed under two major topic areas: email in clinical practice and the wider use of social networking and websites in marketing.

EMAIL IN CLINICAL PRACTICE

What are appropriate guidelines regarding using email as a form of communication to and from patients?

Dr. Gutheil, representing a risk management and forensic perspective, was quite conservative in his recommendations about the use of emails in clinical practice. He shared a forthcoming article by Bhuvaneswar, Gutheil and others (manuscript-in-progress), which explores the delicate issues inherent in the use of email communication with patients. Obvious risks are apparent to anyone who has used email with some regularity—emails are commonly forwarded,

Continued on page 6

deleted, or misdirected accidentally, or otherwise, creating a risk of a loss of confidentiality and a risk of a delay in response. For this reason, the American Medical Informatics Association (Silk and Yager, 2003) recommends obtaining written informed consent with a document that advises the patient of some of these risks of email. With the rising use of smart phones and multiple computers to access email, risks of violation of confidentiality are further increased. Clinicians should use password protection and encryption software on all of their gateways to email to ensure patient confidentiality (Bhuvaneswar, Gutheil, et al., manuscript-in-progress). What is clear is that while patients might think little of the risks with respect to their confidentiality, clinicians are responsible for protecting their patients, and should be as cautious and thoughtful as possible in that regard.

However, Bhuvaneswar, Gutheil, et al. move beyond these broad-scale risks in using email for therapist-client communication in order to analyze the potential meanings, fantasies, and dilemmas wrapped up in the instantaneousness of an email message. On many levels, email communications blur the boundaries within which an analytic treatment takes place, and these authors delineate several of these ways.

Time is altered in the digital world. Email, Bhuvaneswar, Gutheil, et al. (manuscript-in-progress) suggest, subverts the clear boundaries around time that are foundational to our work. Emails document the time of day when an email is sent. Email addresses can reveal personal vs. professional identities, and skilled users can locate the server origin from which an email is sent. Thus, emails can "activate transference," by providing additional information about the clinician outside of the hour. When responding to a patient's call, clinicians are mindful of the time and place in which they speak with a patient outside of the therapy hour. With email, it is easy to overlook comparable concerns—such as how a patient might respond to seeing that an email was sent late at night, or on a holiday—and not to bring this into the dialogue within the hour.

At the same time, there is a tremendous amount of ambiguity in email.

> Despite the vividness and superficial 'clarity' of words visible on a screen… the means by which these ambiguities can be understood, by both patient and therapist, are limited to however that screen can be manipulated—by being turned off, revised, started and put down, then returned to in a completely different frame of mind, deleted, revised, not checked when expected, forwarded to others (which the patient, though not the therapist, reserves the right to do), saved, printed, disseminated or brought, in paper form, to a session far removed from the moment in time in which words were exchanged, where remembering the exact feelings may be difficult (Bhuvaneswar, Gutheil, et al., manuscript-in-progress, p. 7).

Clinical work is founded upon a dialogue between two people in real time. The various potential disjunctions in time within the experience of writing an email and in reading it break up a communication that is both instantaneous and fragmented. The silence of not responding to an email for an interval in time as compared to silence within a clinical hour is radically different.

An additional ambiguity surrounds the place of a communication by email. It is entirely realistic for a patient to picture his analyst in bed with a laptop, receiving or responding to his email. Regardless of reality, such fantasies can imbue an email from an analyst with a sense of seduction that may not get discussed face to face.

The authors caution that therapists should attend to the nature of their own inclinations to email patients, recognizing that this can signal problems in countertransference:

> E-mailing from one's lunch break, car, train, an elevator, the gym, or some other social venue (all made possible with the broad availability of public Internet access terminals as well as handheld devices) is one way of intensely engaging the patient outside the session, in domains where, if therapist and patient accidentally encountered each other, a polite non-verbal acknowledgement (such as a nod, or a small smile) would typically be thought of as sufficient for preserving the alliance while maintaining the frame (Bhuvaneswar, Gutheil, et al, manuscript-in-progress, p. 9).

While analysts might elect to be more forthcoming than to offer a simple nod in crossing paths with a patient outside the office, it does make sense to think of the parameters that drive these decisions, whether in actual encounters with a patient, or in moments of sending off emails. The meaning of these alterations in setting must be understood, or at least explored.

Sherry Turkle (2011) underscores this message for the broader public: the use of smart phones to be in constant contact is actually ex-

acerbating feelings of isolation and dislocation. Turkle reports of interviewing children who long for their parents' undivided attention—a time during which they don't have to compete with the addictiveness that variable interval reinforcement in the form of email, Facebook, or Twitter, provides. In other words, it may not be good for anyone's mental health. For our patients, emails promote a fantasized omnipresence that deemphasizes separateness and boundaries; they encourage an expectation of an instantaneous response; and they invite a blurring of the professional's role. Certainly, it may be important for patients to have the ability to communicate something that may not have found its way into the office, and patients may use email to do this. But as is obvious, these communications need to be brought into the office, to be discussed in person, in real time.

Another consideration in the phenomenology of email communication is the frequent miscommunication that has been noted by email users. Email makes it difficult to communicate the full range of what a clinician means to convey. In the absence of facial cues, tone of voice, awareness of the place or mood or state of the recipient, and the indifference of the machinery of the computer, emails often miss their emotional mark (Bhuvaneswar, Gutheil, et al, manuscript-in-progress). This is a real problem when clinical communication is at stake. It also seems a worthy topic of concern for emails on delicate or emotional topics among PINE's membership.

A final technical concern with respect to email communications with patients is that emails document and record a conversation, and that conversation can be entered as evidence in a claim of malpractice. It is recommended that emails be printed out and included in a patient's permanent medical record (Bhuvaneswar, Gutheil, et al, manuscript-in-progress).

Dr. Gutheil summed up his position on email quite succinctly. He advised that emails "may be used for minor logistic matters, but should NOT be used for substantive content since they are not confidential enough. Patients who want to [communicate by email] anyway should generally be redirected to appointments or letters. In any case, they should be told why not to use emails" (Gutheil, personal communication, 4-25-11). This may be a more conservative stance than many of us deem necessary. It may also be a difficult stance to maintain with younger patients, who are accustomed to peppering direct conversations with follow-ups by phone, email, or text messages. Similarly, when working with children in therapy, parents may find email a convenient way to keep the therapist informed and it may feel difficult to redirect them if the parents are not being seen frequently. However, it seems important to call attention to these risks with respect to confidentiality, prior consent to email communication, and blurring of boundaries.

With thoughts about PINE membership emails, I inquired about the kind of confidentiality one might expect with emails sent to group lists or list-serves. How should or can concerns about forwarding of emails be addressed?

Dr. Gutheil's response was to re-state that "emails are generically NOT confidential; that's the problem." The tendency to forward emails, he stated, is particularly problematic in the context of list-serves. Clinicians are responsible for what they distribute to a list-serve and should not send anything that they do not wish to have disseminated to others (Gutheil, personal communication, 4-25-11). This suggests that we should limit our communication by email to more concrete and less emotional communications, and be thoughtful before we press, "send."

Mrs. Alice Rapkin, PINE's administrator, informs me that some institutes forbid the submission of any clinical material by email, even if it is attached as a locked file and the identity of the patient has been concealed. What recommendations are suggested in this regard? Is there a safe way to send clinical reports via the Internet?

Dr. Gutheil agrees that PINE should make it a matter of policy that no clinical information (control case reports, supervisory commentary, even student evaluations) should be sent by email. As he put it, "Basic rule: anything on the Internet may appear in public in some form" (Gutheil, personal communication, 4-25-11).

Jake Lynn, from APsaA, was essentially in agreement. He described how this concern was foremost among members of a new APsaA list-serve for institute administrators. He reports that most institutes do not accept clinical information that is submitted as a simple email attachment. It is safer to encrypt information with "zip files" or to information via the "Dropbox" software (https://www.dropbox.com).

MARKETING AND OUTREACH ON THE INTERNET

What about recommendations regarding the use of Facebook, Twitter, LinkedIn, and other social networks for marketing, both for individual clinicians and for PINE as an institute?

While there are important risks to consider in the use of social net-

Continued on page 8

works, Jake Lynn couldn't emphasize strongly enough the value of a comprehensive marketing strategy for APsaA, which now rivals the much larger American Psychological Association in its online presence. As Lynn put it:

> If created strategically, and as part of a complete package of marketing 'tools,' social engagement by way of the Internet can lead to more candidates at PINE, more patients for individual practices, and a more favorable view of our profession in general. APsaA embraced the power of social media in 2009 and has regularly added new layers of social media outreach, and the results have borne fruit. Since the organization launched a Facebook page in August, 2009 it now has 700 'followers' across the country, many of them students or prospective candidates who attended an APsaA Meeting based on the news they have received by 'liking' the APsaA Facebook page. In only 18 months since it created a LinkedIn group (open only to APsaA members, Society members or those who belong to the IPA) there are 175 people who share ideas, referrals and opinions on current issues related to psychoanalysis (personal communication, 5-13-11).

However, Zur and others go on to identify risks, challenges, and disincentives to marketing psychotherapy services on social networks, flagging the complex "technical, cultural, professional, clinical, ethical, and legal complexities involved (Barnet [sic], 2010a; Grohol, 2010; Keller, et. al. 2010; Kolmes, 2009; Younggren & Harris, 2010)" (Zur, 2011).

One important area for consideration with respect to social networking sites is what exactly is being marketed. Facebook pages are generally recommended over Facebook profiles. These pages can function like an expanded business card, indicating aspects of the scope and nature of a treatment option, and also representing other aspects of a professional or organization's public life. However, these pages can still communicate a lack of attention to important aspects of the treatment being delivered. One example is my recent experience in receiving a group email to all of the patients of my dentist's practice, inviting us to "friend" our dentist on Facebook. This email seems to have raised more concerns than "friendships," because the dentist subsequently sent out an apologetic clarification about patient confidentiality and the limits of the Facebook profile to be presented.

For analysts, these concerns are even more complex. We need to consider whether having a social network "friendship" with patients constitutes a dual, or multiple, relationship. The information to be disseminated needs careful attention with respect to the risks of self-disclosure on the slippery slope to boundary violations.

Jake Lynn's recommendations for analysts promoting their personal practice is to create a website first, and then follow up with additional connected layers of social media channels, if desired. He feels that Facebook and Twitter can provide more measurable benefits to organizations as a whole (such as PINE), by building a 'fan base' of those interested in the group's activities and news updates.

Violations of patient confidentiality is a topic in and of itself with respect to social networking. Zur (2011) flags the risk of violations of "confidentiality, privacy, and HIPAA compliance" in the possibility for a client to disclose personal information on a therapist's wall. Jake Lynn points out, however, that it is now possible to delete a wall entirely or to limit it to approved individuals (personal communication, 5-13-11).

Some contend that privacy settings often do not deliver the kind of privacy that they promise. Zur (2011) distinguishes between the use of "a 'passive' website, or what is called 'business card' type website, describing [a therapist's] practice and expertise" as contrasted with social networking sites that are "active, interactive forums requir[ing] much more care and attention regarding the confidentiality and privacy of the therapist-client communication." However, Jake Lynn feels that these concerns are overblown. In two years overseeing APsaA's social network, Lynn has not encountered any circumstance in which a patient posted compromising information on an APsaA network.

Dr. Gutheil's recommendation is that because "Facebook and Twitter are sieves that allow lots to flow through and are easily violated in various ways, websites that are professionally designed and professional-looking are the way to go, with scrupulous attention to their content, avoiding promises, guarantees, etc." (Gutheil, personal communication, 4/25/11). Jake Lynn counters that social networks should be a vital part of an individual or group's marketing plan, as they help to drive traffic back to the original website.

It is also important to turn our attention to thoughts about "Googling" and being "Googled." I have read some recommendations that it can be useful to use search engines to find out about a client that has been referred for treatment. As well, it has been noted that patients commonly "Google" us as a way of checking out our reputations,

training, and ethical status. What should we keep in mind in this regard?

According to Gutheil (2010), this is a growing area of risk because of all of the information available online. Patients can access information from websites, blogs, posting venues (Facebook, Twitter), and search engines (Google, Yahoo!, Bing, etc.), plus information sites like Board of Registration pages and professional listing organizations. With Google Maps, patients can potentially access photos of our homes, and with real estate transaction records, they can find out what we paid for them. While we can control some of the posts that come up under our name, many, many sources of information are "involuntary" posts. Further, much of this information is rarely updated or checked for accuracy. Much has yet to be written about the dynamics surrounding this situation (and I suggest that analysts are uniquely suited to this task), but on a practical level, we might wonder what kinds of responses are recommended.

As with the careful considerations about the role of countertransference in driving an impulse to email a patient, inclinations to "Google" our patients seem like clear red flags. Without prior consent, such actions also seem like potential boundary violations, and certainly signals of countertransference concerns. Dr. Gutheil recommends that such a step only be taken when a clinician feels compelled to do a criminal background check (personal communication, 5-9-11).

In response to patients' acknowledgements of "Googling" their therapist, while the meaning of such behavior must be explored, that exploration can only occur within a setting of established limits. Therapists are responsible for finding ways to engage a patient when they feel that a line has been crossed. They also have a right to terminate a treatment in which they feel that their boundaries have been irreparably violated.

In closing, the growing range, availability, and accessibility of digital means of communication are clearly complicating the analytic field. Yet as Jake Lynn put it, "Clearly, society will never return to the days of the typewriter, the handwritten letter, or relying solely on U.S. mail to communicate." It is important for analysts at PINE to be proactive in establishing proper limits and standards about the use of digital technologies for communication, and as a group, we should consider creating an institutional framework on these matters as well. These are matters of preserving the highest ethical standards of respect for patient privacy, confidentiality, and welfare. They are also matters of promoting a practice that has been marginalized in many circles where it deserves to have a voice. Questions about how to "market" psychoanalysis, and whether to value the generation of "hits" to a website over the appropriate communication of meaningful content on a website beg for further exploration, thought, and conversation. Our unique psychoanalytic perspective on issues surrounding these topics could be instrumental in pushing for a deeper understanding and appreciation of the nuances of the use of digital technologies in the communication age.

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The Creation of a Peer Group for Judges

Elissa Arons, M.D. and Susan Workum, M.D.

When the Psychoanalytic Institute of New England (PINE) created the Psychoanalytic Foundation of New England in 1995, one of its major goals was to promulgate the institute's knowledge in the community. As analysts, we had limited practical experience in how to accomplish this.

Fortunately, the Foundation's community board members (from a range of non-analytic backgrounds) were full of ideas. One of our board members, a district court judge in Massachusetts, knew how difficult and isolated a judge's life is. She felt that a discussion group could help judges cope better. "I began by identifying judges who work in 'people' courts (district, juvenile, probate and family courts). A judge working in these is likely to have direct contact with people—litigants, victims, families—as many as 50-80 cases come before her every day." She explained to the potential participants that it would not be a support group in the sense of a therapy session, but rather, an opportunity to explore professional issues of mutual concern, having to do with understanding human behavior, and to confront openly the difficult nature of their work, to draw support form one another. She found that women judges were more interested in participating than the men she approached. Two analysts volunteered for this project, Elissa Arons and Susan Workum.

A core group of six judges and the analysts began meeting monthly at that time. The format was an informal potluck dinner in the home of one of the analysts. From the beginning there has been an outpouring of feelings and experiences about difficult cases, painful situations, power or lack thereof, isolation, helplessness, fear, and anger. The content of the conversations has included complex cases, ethical dilemmas, the politics of maneuvering in an "'old boys' network," delicate (and not so delicate) administrative responsibilities, and competition with peers (mostly male) for senior positions.

The scope of what judges face daily is daunting. "Judges are closely and publicly scrutinized," wrote one juvenile court judge. "In our position we observe or experience racism, sexism, and ageism. We also confront our society's most difficult social problems: violence, substance abuse, and child abuse and neglect…I confront overwhelming and difficult cases involving children and families."

The group's composition of women created an immediate intimacy, once the judges understood that our "agenda" was merely to lend our psychoanalytic understanding to whatever issues they brought up. They had never known a confidential peer supervision group, which is essentially what we were creating.

> I have found the cooperative nature of this venture, the sharing of experiences, conversation, gratifying," wrote a district court judge. "My colleagues on the bench outside the group naturally share 'war stories' as do most professionals, as we did when we first started meeting. Gradually though, Elissa and Susan have helped us shape these experiences so that they take on new meaning.

Another juvenile court judge reported,

> The group provides me with the support and encouragement I need to keep up the good fight. The experiences of the more seasoned judges, coupled with the insight provided by our psychoanalysts, provides a new perspective. I am becom-

ing more objective, while my sensitivity and intuitiveness are increasing…I am a judge who is becoming less judgmental!

A third juvenile judge wrote, "The group right now is made up of all women. I find this refreshing after dealing all day with a court system [that is] predominantly male. The weaving of professional and personal stories in a beautiful setting over a delicious meal is restorative."

At first the group served as an arena for feelings, but then we began to look at the concepts of transference and countertransference, and how these forces affect all of us. As one of the juvenile judges wrote, "It is only in the past few months that we have had... material to read, which I have found to be of great help… Reading about countertransference has provided instant recognition of what may be happening to me in the courtroom, and just knowing about it has helped me take a step back from the emotional tension that frequently marks a courtroom proceeding."

A district court judge wrote,

There is a concept we have characterized as 'instant transference.' We have only begun to explore the ways in which we, as powerful figures working in our courtrooms, inspire or evoke responses in those individuals who come before us, and whose lives are altered by our decisions…Those of us who have received threats of harm, or complaints of judicial misconduct, have experienced the sense that the perceptions of those who appear before us are not always based upon the reality of what transpires in the courtroom. We have also begun to discuss the concept of countertransference, and the ways in which we react to those who appear before us. Is it not important to understand those reactions and perhaps put them aside, in the interest of improving the administration of justice?

Another district court judge commented,

It is my hope that we as judges may be able to develop techniques to share with our peers about lessening the stressors of our work and become better judges in the process. Perhaps the real benefit of our group will be in this area—to develop the means to confidentially yet candidly explore the intricacies of our work and the ways in which we can improve our responses to the tremendously complex problems of human life we are called upon to resolve.

The group has continued to meet, although less frequently in recent years. The project has been a gratifying process for the two analysts. This is an extraordinarily dedicated and intelligent group of judges, who serve in the front line of a community increasingly denuded of service resources. They must make dozens of critical decisions daily, in short time, with partial information and full public accountability. As they have absorbed a more analytic stance in listening to issues, they have developed a rich range of insightful and supportive responses to one another, which we can also hear filtering into their work from the bench.

Dream doctor
April 3, 2011

Lisa Birk

The Harvard psychiatrist J. Allan Hobson was a myth-buster from an early age. At age 4, he personally determined that Santa couldn't fit down his neighbor's chimney; at 8, he dispelled the local superstition that headless snakes don't die until sundown by marching into the woods, finding some snakes, and chopping off their heads.

He built his professional reputation on busting another myth, a big one: Sigmund Freud's theory of dreams. This was the influential idea that dreams are coded messages from our deeper unconscious selves. Aiming squarely at Freud, Hobson and a succession of collaborators documented people's sleep cycles, monitored their brain waves, and tracked chemical changes in the brain. In a series of books driven by five decades of research, Hobson argued that what's really happening when we dream is that our forebrains — the center of thinking and memory — are offline, while our visual, auditory, and emotional centers are not only online, but lit up. Bizarre and powerful dreams aren't caused by repressed desire, he argued, but by biology. Dreams may be fun to think about, but they're really just a side effect of sleep.

Continued on page 12

Now Hobson, an emeritus professor who lives in Sicily, has written a memoir that moves toward a new theory of dreams. Our dreams do have meaning, he now suggests: It's just not the meaning Freud had in mind. "Dream Life: An Experimental Memoir" begins — perhaps strangely, for such a committed rationalist — with an imagined scene, the story of his own conception. It tracks his fetal and infant brain development, and then recounts highlights from his work, his family, even his affairs. He uses this data, personal and scientific, to support his new theory, the "protoconscious," activated when we dream. This dreaming self isn't just responding to life (as Freudians would have it), but rehearsing for life. And dreams' emotional content can be a window into our own makeup. On average, 30 percent of our dreams are anxious. To Hobson this isn't a problem to be fixed, but information: Perhaps we're biologically programmed to be anxious one-third of the time. As for what we're anxious about — well, that's personal.

This transcript was edited from interviews conducted by phone and via e-mail.

IDEAS: What did Freud get wrong about dreams?

HOBSON: [Sleep researcher] Bob Stickgold says that Freud got it about 100 percent wrong and 50 percent right. What he was right about is that dreaming is important. And that it was very scientifically informative.

IDEAS: In the '50s when you studied psychiatry at Harvard, Freudianism still reigned?

HOBSON: You know what they were teaching us was wrong. People don't get schizophrenia because their mothers are sending them double messages. That's silly. They don't get schizophrenia because they have the Oedipus-complex — if they have the Oedipus complex. This is what we were taught!

IDEAS: You built your reputation on studying the mechanics of dreaming, the neurophysiology. Around 2000 something changed, and you began to look at the actual content of dreams.

HOBSON: I had NIMH [National Institute of Mental Health] support for 35 years. They always said, "Study the brainstem, but don't study the dreams." OK? So I had become a secret dream scientist. And I couldn't tell anybody about it. Then I got a phone call from the MacArthur Foundation. "Don't call us, we'll call you. You're a genius. We'll give you a lot of money. We want you to study dreams!"

IDEAS: Your new theory — you call it "protoconsciousness" — posits that dream content is a rehearsal for life, not simply a reaction to life. Is there a practical application?

HOBSON: The practical application is that a lot of the things that you assume are learned are probably innate. This takes us all the way back to Immanuel Kant, who said that ideas were innate. He argued with people like John Locke [who said] that everything was tabula rasa. That people were born a blank slate. This kind of argument has been going on for 200 or 300 years. Now we see in dreaming a strong indication that Kant is probably right. That's why the thing is so important.... Because if you assume that everything is learned, then you're going to make all sorts of mistakes. You're going to assume you can teach anybody anything. And it's clear that you can't.

IDEAS: You've written that dream content is random —

HOBSON: I never said that. I said there is a random aspect to content generation.

IDEAS: So in conscious life, can dreaming be helpful?

HOBSON: What I expect to learn a lot from is dreaming, not the dream.... The more common dreams are anxious dreams. What does that mean? It means anxiety is more important to survive. Elation is something you do at a party. You do to attract other people. But you better be sure you're going to get through the jungle before you have the party. You've got to survive in order to be happy. What dreams are telling us, I think, is that this is the nature of the beast. It's not that anxiety is symptomatic. It is that anxiety is.

IDEAS: Your book is not a typical memoir. Is there a value to challenging the status quo?

HOBSON: I'm skeptical about any absolute set of rules, scientific rules, moral rules, behavioral rules. I'm very skeptical that one size fits all. That's one reason why I don't feel bad about taking on Sigmund Freud. I think Sigmund Freud has become politically correct. Psychoanalysis has become the bible, and I think that's crazy.

IDEAS: Even now?

HOBSON: Frankly, I'm just as concerned about the current craze with biology, because I think the drug companies are calling all the shots. I think psychiatry has gone from the frying pan into the fire. And what I want to do is I want to pull it out of there. But good luck!

IDEAS: According to "Dream Life," you spent 10 years reading all of Proust twice! Ten pages a day.

HOBSON: I simply admire his persistent and revealing self-analysis and his description of mental life in and at the edges of sleep. His self-observation is much more careful than that of Freud. I have the same goal in my new book: to tell a compelling story openly and honestly. That includes my own sleep, my own dreams, and my own brain troubles. I think we can all contribute to a more naturalistic portrait of ourselves.

IDEAS: Do you have a favorite dream?

HOBSON: I had one in which I'm running across the Swiss Alps. I'm virtually weightless. I'm almost flying. There's water under my feet and yet I don't get wet. I feel great. I see all the mountains. I see all the water. I see the rocks under my feet. It's psychedelic.

Lisa Birk is project manager at Improbable Research Inc. She may be reached at cellardr@aol.com.

Re-Interpretation of Dreams
Rapping a bit too hard at the window into self

April 10, 2011

In her interview with J. Allan Hobson ("Dream doctor," Ideas, April 3) regarding his attempts to challenge Sigmund Freud on the nature of dream life, Lisa Birk correctly states that "dreams' emotional content can be a window into our own makeup." That observation is not new, and it was brilliantly demonstrated by Freud in 1899 in his classic opus, "The Interpretation of Dreams."

Dreams can provide individuals with a window into how their minds work. A person once related a dream to me about being in a room with jalousie blinds on all the windows. In recounting the dream, he was startled to realize that he himself had jealous feelings and had been blind to them. It was a pivotal experience brought to awareness by recounting a dream.

Hobson does us a favor in reminding us of basic truths about how dream life can be put to use. But why is he also so busy trying to "chop off the head of the snake" by undercutting Freud? Let dreamers decide what individual dreams signify to them.

Dr. Michael I. Good
Chestnut Hill

The writer is an associate clinical professor of psychiatry at Harvard Medical School and is affiliated with the PINE Psychoanalytic Center.

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THE POWER OF PERVERSION
OPEN SCIENTIFIC MEETING ON NOVEMBER 13, 2011

Presenters: Jack Novick, Ph.D. and Kelly Kerry Novick
Moderator: Ava Bry Penman
Reporter: Deborah Offner, Ph.D.

On November 13, 2010, Jack and Kerry Kelly Novick presented their theoretical and clinical paper, "The Power of Perversion," at a Scientific Meeting co-sponsored by BPSI and PINE. In her introduction, Ava Penman, the conference moderator, noted that she, Jack, and Kerry Novick trained together in child psychoanalysis at Anna Freud's Hampstead clinic in London. On a more contemporary note, Ms. Penman informed the child practitioners (and parents) in the audience that Kerry Novick, who practices in Michigan, blogs about parenting issues every Saturday morning on annarbor.com.

Jack and Kerry Novick, who have together studied sadomasochistic functioning at all ages for many years, presented their model

Continued on page 14

of development, psychopathology, and psychoanalytic practice with both child and adult patients with "perverse" psychic organization.

The Novicks started with vignettes of two adult psychoanalytic cases. Both were highly successful professionals, presenting with significant troubles in their personal lives. Ms. G. suffered from depression and had had several previous psychotherapies that ended badly; Mr. M. had experienced marital and anger management problems. Both patients exemplified the challenge of patients whose personalities function with a perverse organization. Each of these patients' behavior was characterized by repetitions that deviated from the path of progressive development. The Novicks noted that patients like Ms. G. And Mr. M. live out an unchanging cycle, rarely improving or constantly sliding back into old patterns. Their treatments typically end prematurely or unsatisfactorily.

These patients illustrate the Novicks' definition of perversion as a deviation from the path of progressive development, in which unchanging, sadomasochistic personality structures and relationships cycle continually with no change or forward movement. This closed-system stasis, the total lack of change and growth, epitomizes perversion.

The Novicks went on to describe how their way of thinking about development had evolved beyond the traditional, linear model typically used by analysts of all schools. Most psychoanalysts use what the Novicks term a "single-track model." Moving beyond this "single track" model, the Novicks postulated a "dual-track" model (following Freud's lead in his dual track model of development) in which there are two systems of self-regulation and conflict resolution.

In the dual-track model, one system, the open system, is attuned to reality and characterized by joy, competence and creativity. The other, the closed system, avoids reality and is characterized by power dynamics, omnipotence and stasis. In closed system functioning, relationships have a perverse, sadomasochistic pattern. The primary defenses in this system are omnipotent beliefs; externalization, denial, and avoidance—all of which represent attempts at self-protection. In the closed system, the person's aim is to control the other, rather than to change the self. Pain is central to the closed system as a means for attachment, defense, and gratification. Attachments result from forcing other people to comply with one's wishes rather than working to develop a relationship. The Novicks emphasized that their open and closed systems are not diagnostic categories; nor are they meant to distinguish between individuals. Rather, these constructs describe potential choices of adaptation within each individual or any challenging point in development.

Here the Novicks broke to entertain questions and comments from the audience.

Question: In the case of Ms. G., the woman with the failed therapies, did she blame the therapist or herself? How did she describe her failed treatments?

KN: She said she'd gained a great deal but that both therapies had ended badly... This model helps us understand patients who are "widening scope," more disturbed than the narrowly defined "analyzable" patient. Our model comes out of frustration with existing models that don't work. We came up with a different idea. The "single track" (regression and fixation) model won't work for our patients or their families.

Question: How does reality-testing factor in? [Are you distinguishing between primary and secondary process thinking?]

JN: No, there is primary process and secondary process in both the open and the closed systems. The importance of primary process thinking in the open system is illustrated by play. In an open system, you can play, fantasize, pretend—but you recognize that it's not realistic [as opposed to in closed system, where reality testing is compromised].

Question: Is there a correspondence between closed system and Kleinian theory?

JN & KN: Yes, but not the Kleinian view of development. Ours is epigenetic, a constant interaction between constitutional and experiential, with plasticity and change throughout life.…

The Novicks then moved to their joint presentation of the case of Peter, an 8-year-old boy. Peter's parents brought Peter because he had become aggressive toward his mother. In sessions Peter was angry and destructive. He overturned furniture, ripped papers, knocked holes in the wall. He repeatedly told his analyst to "shut up" and attacked him verbally. Using projection and externalization as his primary defenses, Peter ridiculed his therapist, calling him nerdy and stupid; describing him as poor, hungry, and alone, without family or connections. Peter would eat snacks in front of his therapist, taunting him with how good the food was and how he had no intention of sharing it. It appeared that Peter's own feelings of deprivation generated his intense need to deprive the other. Peter would also call his mother on her cell phone from the therapist's office, demanding to be rescued from the filthy,

disgusting analyst. Peter feared germs and dirt in the analyst's office, insisting on washing his hands thoroughly in the bathroom after every session.

Peter's developmental history revealed the origins of his sadomasochistic way of relating to his therapist. Shortly after Peter was born, his mother, for medical reasons, withdrew from the family into work outside the home. When Peter was one, a full-time au pair joined the family. When Peter was three, some sexualized behavior raised his parents' concern; and when they inquired, they learned from him that his au pair had been sexually abusing him. The au pair had apparently threatened Peter that if he told anyone about the sexual acts, he would never see his parents again. In fact, the parents dismissed the au pair at this time. Hence, Peter began the phallic phase—a time when mastering the distinction between assertion and aggression is a central task—by essentially making his au pair of two years disappear (because of his revelation). As Peter moved into the Oedipal phase, his confusion of assertion and aggression became sexualized, taking on a masochistic character; and his Latency phase was marked by intense competitive strivings to control others. Peter vacillated between wild, bullying behavior, on the one hand and extreme inhibition, victimization, and panic on the other.

The Novicks argued that Peter's mother had effectively abandoned him in infancy. She turned away from Peter. Peter then tried to maintain his connection to his mother through his intense feelings of pain, rage, and deprivation.

The Novicks explained that this was the first strand in the development of a sadomasochistic, omnipotent, closed-system way of relating. In closed system functioning like Peter's, the child attempts to keep the other person under control as a defense against pain and helplessness. Subsequently, not only the sexual abuse itself, but the outcome of his revealing it, reinforced Peter's magical belief in his omnipotence—he made his au pair disappear. The Novicks described the analyst's characteristic countertransference response to Peter's externalizing transference: feeling helpless and unable to think. They went on to explicate the techniques Dr. S. used to help Peter.

The Novicks described techniques for engaging with Peter's sadomasochistic, closed-system functioning in order to introduce the possibility of more adaptive, open-system functioning for this child. The analyst established a therapeutic alliance with Peter by empathizing with how powerless Peter felt and respecting Peter's attempts to feel strong by acting wild and trying to control other people. He emphasized Peter's very real strengths and capacities, thus supporting more mature and healthier ego functioning where it already existed. Using a platform of open-system realistic competence, it gradually became possible to interpret Peter's continuing pressure to feel good through closed-system sadistic destruction and belief in his own omnipotence. Then they could delineate the conflict between Peter's closed-system functioning, characterized by aggression and destructiveness and his open-system functioning, characterized by worldly knowledge and athletic ability. Finally, Peter was introduced to the Novicks' concept of "emotional muscle." Derived from the early analytic notion of ego strength and linked to current interest in resilience and protective factors, "emotional muscle" derives from courageous engagement with reality, even painful reality such as Peter's sexual abuse.

The Novicks explained to the audience that Peter's emotional muscles were weak from his overuse of closed-system omnipotent defenses. The analyst's stated goal of helping Peter develop stronger emotional muscles provided a metaphoric therapeutic goal that he and Peter could pursue together. The analyst first allowed Peter to externalize onto him the abandoned, helpless child Peter had been; the work could then proceed to reconstruction of Peter's early history, based on the session material and Peter's transference. In concurrent parent sessions, Peter's analyst offered similar understanding, education, and support to Peter's parents. As the treatment progressed, Peter was able to talk about his terrifying childhood experiences, and to tolerate and in fact appreciate his parents' and analyst's limit-setting, which ultimately helped him feel safe. Ultimately, Peter was able to integrate the previously fragmented parts of his personality and his parents were able to integrate their family history into their understanding of and relationship with their son.

The Novicks began the next Q & A section by posing their own question.

JN & KN: [What was the role of] limit setting with Peter by the therapist and parents?

JN & KN: To help Peter develop internal controls. [Limit setting] provides a backstop for the child's impulses. You need to establish safety rules in the therapist's office. One of the most important tasks in parent work is to help parents set limits.

Axel Hoffer: (References the Novicks talking about how children try to feel powerful/omnipotent instead of helpless)...

Continued on page 16

which can lead to unhealthy development. Why do you put "perversion" in the title of this talk? Are you talking about sadomasochism as a perversion? Are you including fetishes or other kinds of perversions [in your theory]? And is there a link between your question and sexuality?

JN: Perversion was originally a religious term that described deviating from the right path. We view the path of development as progressive: you either continue to develop and grow through your last day… Anything that deviates from that represents a perversion [in that] it prevents growth and change (i.e. progressive development). A solution that depends on pain leads to rage, attack, excited triumph, guilt, and the further feeling of victimization. In the case of Peter, when Peter and his family could engage together and talk about how bad the sexual abuse experience was for him, then he could progress.

Monty Stambler: Your techniques remind me of Fritz Redl's "new tool salesmanship [an anti-bullying intervention]:" introducing new methods of coping. Sounds like a milieu therapy of a delinquent. Do we get to analyzing the closed system part?

KN: Most analysts do open system interventions—but analysts do it without actually talking about it because there is no theoretical model that includes it. We are expanding our technical repertoire. People don't feel sure that these techniques are analytic. This is simultaneous work—material must be addressed in a two-fold way, and the way to work most effectively with closed-system issues is on the platform of open-system development, functioning and recognition. Our model encompasses what we all actually do. The reality of what we do is represented in the theoretical model because we know this is effective. Also, in the definition of "What is analysis?" there has been a gradually more and more restrictive definition of acceptable technique. These methods from the two-system model add to our clinical repertoire...

Michael Dvorkin: I am impressed by the fullness of the technical interventions with Peter... how active the therapist was and the extent to which he used a bigger tool kit. I think psychoanalysis needs to broaden the way we think about therapeutic action.

JN: We are trying to restore psychoanalysis as a multimodal technique, not defined solely by interpretation of dreams, or interpretation of transference, or interpretation of enactments. We have a broad range. Narrow technical theory applies only to a very narrow group of patients, maybe just psychoanalytic candidates?

The Novicks moved to their second case, "Nick," a 19-year-old presenting with suicidal thoughts, as well as inhibitions in academics and work, and limited, constricted interpersonal relationships. Again, Nick's early history, as gleaned from parent interviews, informed the analyst's understanding of this patient's current defensive functioning. Nick's mother had become clinically depressed when Nick was a toddler; subsequently, during Nick's middle childhood, she was hospitalized and heavily medicated for continued depression. During both periods, Nick's parents blamed him for his mother's condition, indicating that she was overwhelmed by having to care for him. Nick's father, a successfully functioning professional, was so intensely competitive that he could not take pleasure in Nick's substantial intellectual gifts. Finally, Nick's older brother resented him and treated him with hostility. The parents did not or could not protect Nick; thus he also felt responsible for his brother's aggression toward him.

Nick used defensive omnipotence and externalization to cope with the traumatic experience of loss, rejection, and helplessness within his family. In a six-year psychoanalytic treatment, Nick's analyst recognized and acknowledged that Nick had developed these closed-system adaptations out of necessity, having no viable alternatives at the time. He empathized and engaged with Nick's pain and rage. He also sought to identify and elucidate Nick's areas of open-system functioning. Working within an established therapeutic alliance with mutually constructed treatment goals, Nick became aware of ways to maintain safety and connection without clinging to omnipotent beliefs. He was able to acknowledge and verbalize his rage at women, identifying its roots in his feelings of disappointment in and rejection by his mother.

Nick was able to develop and confront his own conflict between his defensive, self-protective closed-system functioning and the riskier but more adaptive and satisfying open-system functioning that he came to discover through the transference relationship. The analyst helped Nick, an athletic, young man, conceive of his ego-strengthening work as building "emotional muscle" that would help him better regulate his feelings. Nick told his analyst that his emotional muscle would allow him to know his feelings, but would not destroy the analyst nor cause the analyst to attack him.

The Novicks concluded that the omnipotent, sadomasochistic solution is a perverse defense that

people will do anything to protect, including self-injury or suicide. Treatment does not eradicate but rather must respect closed-system solutions, while offering the patient opportunities to recognize and try out open-system solutions. Only when the patient finds that more adaptive, fulfilling solutions are available will he set aside his sado-masochistic defensive system.

The Novicks again opened the floor to audience questions.

Neal Kass: How do you think about love in a clinical situation? Using love as an indicator of where I am with a patient—when I am in a loving place with someone I can work with them in their closed system versus when their closed system is at odds with me and I'm not able to experience love?

JN: Freud said that the cure is through love. I think that love that is built on respect, admiration of real qualities in the person—love can be curative, but love within a closed system is enthrallment and [therefore] not constructive. We wrote a paper "Love in the therapeutic alliance," about the destructiveness of the patient wanting to be omnipotent, to make the therapist do whatever [she or he] want[s] him to do.

Postdoctoral Fellow, Cambridge Hospital: Can you say something about the patient's "high" in reverting to the closed system experience?

JN: The tie is to pain, to a mother who induces pain. The child gets "addicted" to pain in the mother-child relationship. A quote from one of my patients is, "Love walks with pain." She says that she feels she is with me when she is in pain. I note that this is [like] being with her mother. The patient being in control of pain—that is the appeal.

Audience member: The closed system seems like a one-person system: lonely, but predictable and in control. The open system includes another person, and therefore is not predictable, because you have to wait for the response of the other person.

Audience member: How have you been influenced by systems theory?

JN: Not explicitly so, though family therapy has been in the background. When we work with parents, we do think about the "system."

KN: A way of experiencing people and working with them. As we were taught about it, it meant that we should be able to take any phenomenon and look at it from multiple points of view. Psychoanalysis is the only way of looking at human behavior in a multi-dimensional way.

Given the range of innovative and clinically useful ideas, and the evocative case material that the Novicks provided, it seemed that many of us in the audience regretted that we had only a single afternoon to learn about the theoretically innovative and practically useful ways the Novicks have developed for working effectively with extremely challenging child and adult patients. For those of us who would like to incorporate the Novicks' theory and technique into our practices, I can recommend their 2010 book, *Emotional Muscle: Strong Parents; Strong Children,* along with their earlier publications. And for those of us searching for tips about parenting, stay tuned into Kerry Novick's weekly blog, "everydayparenting," Saturday mornings on annarbor.com and at buildemotionalmuscle.com.

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Interview with Kerry and Jack Novick
Sunday, November 14, 2010

Sarah L. Lusk, Ph.D.

One of the questions I think a lot of people have had is how you write together. Who writes the music and who writes the lyrics? How that process goes for you. It was seamless yesterday.

KN: Well, that's pretty much how it is. We have been writing together since 1968. So it's been going on a long time. We really do write together. I'm usually the one who's at the computer. But we really do construct sentences together. Sometimes one of us will draft a section we've already discussed and then the other one will look at it and then we'll edit it together. So, in practical terms, it's varied, but it is very much doing it together.

JN: It's hard to think of how we do it together, 'cause we just do it together.

KN: There isn't a specific methodology. We talk a lot before we write. And then there comes some point when we start writing down ideas on bits of paper. And then there are several different yellow pads sitting on the table. Then there's usually a moment when I say, "No, I have to create a document and we're going to start writing it now." Then we usually print it out a couple of times and go over it and change it. Occasionally, radically; reorganizing, rearranging.

JN: This one we were writing up to the last moment.

KN: Yes, we were on the bus coming up from New York on Friday morning. And we were doing the rewriting.

JN: Mostly because it was too long.

KN: Mostly for time. Too long; too dense. It was hard to find what we didn't want to include. But, it was also fun.

JN: It was fun cutting out.

KN: Do we say this here, so we don't have to say this over here? Do we need to repeat this? So it's not that different from writing on one's own. It's just that we do it together.

Two minds are better than one!

KN/JN: Yes, we find that. It's fun!

JN: Even if we write a paper on our own. I wrote that paper, "Sex, Drugs and Rock and Roll." I'll write it, and then I'll say, "Kerry, you gotta read this paper." And then we work on it together, and it becomes our paper.

KN: A lot of stuff may have started off as one of us, but turns into both of us. Some of the papers that became chapters in *Fearful Symmetry* were like that. Because some of those were written by one or the other of us and then reworked into being by both of us. So our major ideas really have come out of work together. We started off with slightly different intellectual styles in that I usually wrote by building up all the details, all the bits and pieces, and coming to a conclusion at the end of a paper. And Jack usually wrote by stating a hypothesis or a thesis and then supporting it. So that was an interesting process when we started writing together; that we were really coming at it from different ends. But over the years there's more and more overlap. We've learned from each other so now I don't think our approach is that different.

JN: What was really hard, for this paper, we had just been pushing to finish our *Emotional Muscle book*. And that was an extraordinary exercise for us in that we were really trying to write in a way that could be clear to intelligent mothers, teachers, parents, grandparents. Not only to not use jargon, but not get too abstract for things one just takes for granted. And that was really a tough exercise.

KN: That was a great demanding exercise, and fun, because it was really, "Does this make sense?"

JN: Yeah, "Does this make sense?" And after having done that then we went back to writing this paper and it was like "I don't like writing this way." Or it's too abstract … it was hard.

KN: Yeah! And it has made us think, the experience of doing the psychoanalytic preschool, which we started in 1994, so it's a long time now, and 25 years before that of doing preschools consultations with parents and teachers, really, really pushed us to tell it like it is. And to use language that people can understand because a parent or teacher will just dismiss you if you are abstruse in some way, or say something arcane about the unconscious without framing it and putting it in context. So we've been trained by the people we've worked with to say it clearly, and

if we can't say it clearly, to suspect our own theory. So that's been a growing issue and a growing skill. But writing the *Emotional Muscle* book crystallized it for us; that "Oh yeah," when you put it down on paper. It has to be as straightforward as when you are talking to a group of teachers. Then I think we could say it has spoiled us for scientific writing or we could say thank goodness, maybe we can have a small influence on how people write psychoanalytic papers. Because a lot of stuff is pretty turgid and pretty obscure, and I'm not sure that means it is so wonderful.

JN: We had our daughter help us with *Emotional Muscle*. And she says you have to remember that parents of young children have no time to read.

KN: And they're exhausted.

JN: They're exhausted. At the most they'll pick up the book and read one paragraph.

KN: Or they'll dip in; look in the index for "Tantrums" because that's what they're struggling with, or they'll read the chapter about the age of their kid. And so that was helpful advice. We did some beta testing with the book with parents from the school and people we knew and our daughter who has two little kids. And we got a very favorable response. Also from some of the teachers at a couple of schools who don't have little kids, were saying, "This was so helpful with my teenager; this will make me a better parent."

I wondered if you had ever considered doing Podcasts. Thinking of parents not having time to read.

KN: People have suggested that. We think we will get into that. This book will spur us to do that. I also write a weekly on-line parenting column, for annarbor.com, as well as our blog at buildemotionalmuscle.com/blog. (http://www.annarbor.com/entertainment/parenting/everyday-parenting-questions-for-kerry/)

It's wonderful! ...I noticed in your blog that you used no jargon at all. So, that was really lovely. How often do you do it?

KN: Once a week. It's quite a discipline to try to write something substantive; usually I try to keep it to 600 words; which is really short. If it's 600 words, it's more likely to be put into the weekly print version of Ann Arbor.com, so I try. And of course the comments are fascinating because people do write back. There is such an unexpected range of things. Sometimes they're really sensitive and thoughtful, sometimes they're off the wall, and sometimes they didn't get it. And that's a useful corrective 'cause then I think, did they not get because I wasn't clear or because they didn't want to get it? I can't always tell. It's interesting.

A lot of ideas come from those comments, I'm sure.

JN: Yeah!

KN: Um, hm. Yeah. And cross-fertilization with the work with schools, which brings us into contact with the issues that families face.

I'm curious to learn more about how you met. You were both at Hampstead, and Ava (Penman) was there.

KN: Yes.

KN: Jack was the year ahead of me, and Ava was a year behind me. So we were all there at the same time.

JN: We had this unusual experience. I had four or five people in my first year, but by the second year four of them were gone, for various reasons. So I was alone in my year and the same happened in Kerry's year.

KN: Yeah, there were three in my year and two dropped out before Christmas. So in my first year and his second year we were alone in our class, so they put us together.

JN: They put us together as a class, and in fact they put us together with the year ahead, Anne Hurry's class.

KN: So we were thrown together that way. And then you (JN) asked me to work on a project with you on the "Projection and Externalization" paper. So we started writing in 1967; in 1967, we first wrote the paper. And in 1968, we started working on the "Beating Fantasies" research project. So the rest is history. We got married the year…

JN: 1970…

KN: … I graduated from Hampstead. And then we were established in London. You were finishing the adult training at the British.

JN: I finished my child training in 1969 and was asked to be on the Faculty at Hampstead. I had started my adult training at the British in 1968 and finished in 1973. I then joined the Faculty of the British Psycho-analytic.

KN: And then we had two children. We were established in London, and then he got a job offer in Michigan.

Continued on page 20

I wondered how you had gotten to Michigan.

JN: Michigan was a psychoanalytic center at that time. And we had a number of friends, like the Shericks—Ivan Sherick—and Fred Busch. And Ivan came and said, "There's a vacancy in the Psychiatry department as Chief Psychologist." And I said, "Naw"… Then we thought about it, and there was that feeling of, "Mother will take care of us."

KN: Go to the University, the institution.

JN: We'll have a pension, insurance, and sick pay.

KN: We had two little kids at that point, and I wasn't working. So we were solely dependent on a private practice income. And it felt…

JN: … precarious.

KN: ... uncertain.

JN: It was the idea the institution will take care of us, so we did that. We had never been to the Midwest.

KN: It was a big adventure. Looking back, I think, wow, we were brave! Out into the unknown. And it turned out to be a great place to live. We love Ann Arbor. It was wonderful to raise children there. We had our third child there. We stayed at the University—I stayed three years and you stayed four years, because universities do have a down side. And also then the biological revolution happened and swept the department clean within a year. So we left. And then there we were back in private practice! (*everyone laughing*) But it was fine. We were teaching at the Michigan Psychoanalytic Institute, and soon afterwards the Michigan Psychoanalytic Counsel was formed. There are two groups in Michigan, two training places, and we are on the faculty of both. So that was nice.

JN: And I'm still at the university in what is called a "dry appointment," I don't get paid. I supervise some of the residents, occasionally and I teach seminars ... The analysts are very active at the department of psychiatry. They do all the clinical supervision for nothing; which is ridiculous…

No money, but hopefully some…

KN: Well, the analysts live in hope that somehow they're going to get back into departments of psychiatry. I think it is maybe a fifty year project, if at all. I go back and forth on whether I think it is a worthwhile use of time. I am much more interested in, and much more hopeful about the impact of analysts in other community endeavors like schools, the veteran's programs. Stuff like that seems to me to actually accomplish more, and make psychoanalysis accessible to the community in a way that this huge recruitment effort for training… I think everybody is in all these psychiatry departments trying to recruit candidates, and that seems to me just a different kind of self-perpetuation, rather than saying, "These are robust, powerful, useful ideas. Let's go out and show the world how useful they are. And then the rest will take care of itself." It's just a different approach.

JN: We've been able, through the school—which is not a therapeutic school, so it's a normal population, or so-called normal population–we've been able to fill all our child candidates with analytic cases, just from the school.

KN: With patients. With the kids from the school or siblings of the kids from the school, or parents of kids from the school. Because once people in the school discover that, they say stuff like "Oh, you're a psychoanalyst? But you're so practical!"

JN: "And you make sense!"

KN: And the ideas make sense to them; it completely demystifies the whole thing. And you have a relationship already, because of already being in the school, and in the context of that relationship, you can make a successful referral, which ordinarily is very difficult. So most of our child candidates are filled up with patients. And we provide patients to a lot of adult candidates, too. It's been very fruitful. Now the Michigan Psychoanalytic has opened a therapeutic preschool in the Detroit suburbs just last year that all of us child people have been instrumental in getting off the ground. It's nice, 'cause we have the regular preschool in Ann Arbor and the therapeutic school in the Detroit suburbs, which makes for venues for our child candidates to work and learn to work with families, which we think is integral to doing good work with children and adolescents. So the school thing has been pretty amazing. It has led to the National Alliance for Psychoanalytic Schools, which is another fun thing.

I so hear Hampstead in everything you are saying: that idea of having the school be part of the community and having the community be part of the school.

JN: Absolutely!

KN: Well, that's the tradition we've written about, about altruistic analysis which is something,

I think, all Anna Freud's students got from Anna Freud, who got it from the early psychoanalytic movement, which was very socially conscious and very invested in making psychoanalysis and psychoanalytic ideas available to everybody and not have it be a coterie thing. I think it just comes automatically to all the child analysts.

JN: So that has been exciting. We have to watch that the school doesn't so take over our thinking and our work, that we kind of lose the fact that we are analysts, we're not teachers.

KN: And we're adult analysts.

JN: We are adult analysts. So, mainly our work has been focusing on the application of child psychoanalytic ideas to adult work, and that's been a bit... There's a struggle. There's a real resistance to that. Well, the idea that "Well, that's child play therapy…" or something. But, you know, if you take it from a child perspective then you really begin to expand your adult work. That's been a big thrust of our work from the very beginning.

KN: Um, hm.

I *know I'm going to get myself in trouble, but my experience is that child analysts make the best adult analysts.*

JN: I think so. I would agree.

KN: We completely think so!

JN: We completely think so! And Anna Freud's idea of the ideal institute is one in which you would be trained and have a clinical experience with the whole range, the whole life cycle.

Of starting with children first, though, too, as well.

KN: We think children first makes sense. The idea of the complete analyst to us is to treat people of all ages and candidates at Michigan who are in our combined program—we have something at Michigan called, "First case, best case." It doesn't matter what you get first, you start doing analysis. And then, on the child side, we really think that immersion is the best way to learn, so we help people get cases as quickly as possible. On the adult side they have a more measured, sort of rationed approach to it. Often people end up with more child cases, but the application of child work to adult, as Jack was saying, is sometimes an uphill battle. I don't think we can imagine doing adult work without a developmental perspective, without a sense of ongoing parent/child issues. If I have an adult in analysis and I am not hearing about their parenting, then I know there is something going on. But often, I think adult-only analysts haven't been trained to listen for that stuff. And there are not enough supervisors on the adult side who are also child analysts, which I think has an impact on an institute as a whole.

JN: And the whole thing about reconstruction or the interpretations one makes, the difference between interpretation based totally on theory—if you are a Kleinian, or a Lacanian, or this, you'll make this or that kind of interpretation—is contrasted with someone who is steeped in developmental experience. You don't really go according to a theory. You say to the patient, "When we talked yesterday...," and use a developmental image as an example. You really have in mind the child of two, the child at three, a child at four. And I will say, "you remind me of…" I won't say, "This happened to you. But it does remind me of the kind of behavior of…" I sometimes use examples from the school in interpretations. I'll talk about the school and I'll say, "It reminds me of the three year olds at school." It's interesting to see them coming from the adult training and the current emphasis on the….

KN: The here and now relationship.

JN: Not so much... I mean the different theories; they don't integrate. They start talking about projective identification. To really say, explain to me what do you mean? What do you mean by that? If I can't understand, maybe something's wrong with the concept.

The idea of what that looks like with a person, a patient.

KN: Yes, how can you actually use it in a session? It's one thing to say, "Oh, this was projective identification." Well, so what? How are you going to feed back to the patient what you're understanding and experiencing together? And that is the only utility of a concept. So this idea of developmental images, which comes out of intimate knowledge because of being child analysts and working with families, of what is going on internally at any given moment in development. Then one gets a developmental image in the middle of a session with a grownup, because things are configuring in a certain way. And that is what one can feed back in a vivid way whereas, "you put your feeling into me," doesn't do it, and the patient thinks you're nuts!

JN: And it is abusive.

KN: It imposes what you are feeling, where you are coming from rather than, "I'm sharing

Continued on page 22

with you that what we are talking about makes me think of." Then it's just offered, it's not imposed.

JN: And it comes so easy, not pulling, "I read this by somebody." It just comes easily when you have that experience. I am thinking about a case where the way this guy was relating to me was on and off and on and off. And I said, "One day you're here, and one day you're not here. What happened to you? Why do you function this way?" He was in his late 30's, just getting married. He said to his mother, "What is this on and off, being here and not being here?" Because he was told he had had an ideal childhood, and that he was so much fun, and everybody loved him. Turns out, his mother was having an affair starting when he was two years old. She would go away every weekend. Mother would be away and then come back. Father would stay with the kids while mother went off to be with the boyfriend. So she was gone every weekend. From that I could then begin to picture what her state must have been like, and what kind of mother she must have been. I sensed that she must have really loved him, but she was also preoccupied with what was going on. It was a really big thing that was going on between husband and wife. But that flowed so easily and I could say, "We could imagine your mom, she loves you, but she was totally preoccupied." And he said, "She would be on the phone for hours and hours talking to a friend. So she was there, not there, there, not there." It doesn't need any big theoretical leap into whatever—mirror neurons or mentalization. We know this is how people relate. And you can immediately say it in such a way that he could take it, and listen to it, and hear it; understand why he was so anxious, why he felt the bottom was always going to drop out. I really love supervising because it makes me realize how much I take for granted. It's a very good corrective.

KN: Yeah, how do I put this together? I have learned so much from supervising. Just like working in the schools forces one to articulate things in a clear, commonsensical fashion, supervising forces one to think through the ideas and teach somebody how to think in the session; putting together what they've read, what they've heard from the patient, what they've learned from their own work. And that development of the integrative capacity so that it becomes automatic and preconscious for the supervisee is really fun and exciting as a process. It teaches me then to unpack, to say, "Well, how do I do that? What ideas do I draw on? When I hear x and y in the material the supervisee brings, where am I coming from? Why am I hearing this and that?" So unpacking that together with the supervisee is really fun. I love supervision. It's a very generative activity, somehow.

Your practices sound like they have quite a nice array of children, adults, supervisees, writing, and consultations.

KN: I tend to not have a whole lot of kids in my practice at the moment, partly because I usually try to refer them to a child candidate because I want them to have their cases, learn about it and graduate and join the faculty. (*everyone laughs*) But it is a nice mix to have the whole age span. It is really nice to be a child, adolescent, and adult analyst, because there is also all kinds of cross-fertilization from the adult patients to the child patients. Because that direction has also been important, and that isn't talked about a whole lot, how being an adult analyst informs one's child work. I remember there was a symposium about the mutual influences at Michigan about 25 years ago and the child analysts said one of the contributions adult analysis made was the idea of understanding what matters later. And that if you only think from a child perspective, it seems like everything is significant, whereas if you are an adult analyst you get a sense of what kinds of things actually do have an impact, what lasts. That was a very helpful idea that I continue to use. I also think about how being an adult analyst gives one a different perspective on the predicament of parents, and how the child may not be occupying as much space in the parent's mind as the parent does in the child's mind. This was a finding of a simultaneous analysis project at Hampstead years and years ago where they had children in analysis and their parents in analysis, and a third analyst looked at the reports from the two analyses and did a bit of a comparative study. They found that the space occupied by the child in the parent's mental landscape was often very small. It was not reciprocal, which was pretty astonishing to a lot of people.

JN: I think another interesting thing for us was when, somewhere in the late 80's, we became more and more interested in thinking about parent work, and began to write about it, explore it, and to incorporate it more explicitly into our actual work. Now we are expanding it explicitly into our work with adolescents, including late adolescents. That, of course, meets with a lot of questions, anxieties, and assumptions. That's been exciting, really revealing of whole dimensions which we tend to lose if we keep out the parents.

KN: The dynamic interplay be-

tween what is going on in a kid and what is going on in the parent. You get that perspective if you have them all there.

JN: And how you can hit road blocks with an adolescent, for example. It's just not moving, and you are working with the parents and then begin to work on something totally separate from whatever was going on with the kid, but as the parents can engage with it, I wouldn't say resolve it, they engage with it…

KN: And you make some dynamic breakthrough, some insight...

JN: Some insight and the kid moves ahead like that.

KN: And the kid's treatment is unblocked, even when you didn't beforehand see the connection. What goes on in families is a dynamic interaction. I find the parent work affects my adult work too, because that heightened sensitivity to family dynamics that comes from the experience of working with the parents of child and adolescent patients then becomes part of reconstruction with adult patients, a sense of how they are relating to the internal parents in their heads, etcetera, etcetera. So again, I think for us the scientific work and the clinical work inform each other so much. There is so much back and forth along the age span; it all gets put together.

What is your understanding of what the resistance is to parent work, because resistance is not just with adolescents?

JN: No, it's with child work too!

KN: It's hard! It's really hard work. And it's messy, and irritating, and takes extra time you probably aren't paid for. It's one thing to set up regular sessions that are paid for, but if you work with children and adolescents you've got the parents calling you up, you've got emails, you've got reports from teachers: there's all kinds of stuff. We all have transferences to parents. So we are ambivalent to start with, and then most people who work with children are kind of automatically consciously and unconsciously identified with the child. We've got our own rescue fantasies to contend with. So there is a tremendous piece of internal work for the analyst to do to remain, as Anna Freud put it, equidistant from the child and the parents. And there's a pull. It also happens that there can be a pull to identify with the parent if the child is being really ratty. And then you feel guilty… It's hard! We wrote this book, and we're like the gurus of parent work, and I know that I procrastinate if I have to call a parent. I know that an extra day or two may go by before I get around to that phone call. It's just jolly hard. So, I think that is a huge source of the resistance. And then there are incompletely understood analytic principles about privacy and confidentiality, and I think when they are taken literally and applied in a concrete fashion, and a one size fits all fashion, then people start making rules about what you can and cannot do. And that doesn't serve anyone well, except that it makes it easier for the analyst. If you never see parents of adolescents, then you just don't have to think about what the gains and losses would be. Rules make it easier.

More convenient, not necessarily easier.

KN: Yeah!

JN: More convenient; that's a good, good distinction. Because actually, when you engage in parent work, the work gets easier.

KN: The treatment takes off!

JN: But not convenient! And I think there is that extraordinary resistance to work with parents. Many reasons. I think mainly they are unconscious; our own conflicts with parental figures. We want them to like us.

KN: And Poppy Furman talked about the general difficulty in psychoanalysis in dealing with child stuff, and I think it affects parent work, the primal fear of the Ur-Mother.

JN: We talk about that in our book. It is sort of speculative, but it must be there. It is there. There is this powerful pre-gendered mother who can do everything.

Kerry, what did you call it?

KN: The Ur-Mother. It's the term Erna Furman used in her discussion of the resistances to child analysis.

JN: There are so many other things, too. Mothers are very tuned into reality, unlike an adult patient. An adult patient will come and they are in such need, they'll say, "I'm glad I finally found this great analyst who is going to save me." Whereas parents come, and they are really looking out for their child. They're saying, "Are you going to abuse my child? Are you going to be good to my child?" They are reality-oriented in that moment as part of the protective mechanism, so they are checking you out.

KN: Parents look at who the analyst really is. They don't come in with an automatic positive transference the way an adult patient comes in. So child analysts have to really be people that a regular per-

Continued on page 22

son could trust. 'Cause they are going to entrust their child to you.

JN: We find sometimes the person with his adult training can get adult cases but he can't get child cases; he keeps losing cases with child work. He gets the referrals, he works with them a little bit and the parents don't want to continue with him.

KN: I've found that adult patients have a broader spectrum of tolerance for individual differences among analysts. And parents don't. And in a way it's a sign of health in a parent that they are being appropriately protective of their child if they are a bit suspicious at the beginning. And that too makes for a counter-reactive reluctance on the part of child analysts to work with parents because we feel judged, not just as a therapist, analyst, but as a person.

JN: And it's hard to reach a point of respect for a parent, especially when they are coming in and doing…

KN: Not such great things with their kids…

That's so terribly difficult!

JN: It's those kinds of conflicts that we have. I think also there is this… we all must have the same idea that kids have that there is a zero sum game, that if I love you then I can't love anyone else. All the love goes in one place, there is nothing left. So if I love the child patient, then I can't love the adult parent. And if I do find myself respecting her, admiring her, feeling for her, then I am betraying the child.

A loyalty…

JN: Betrayal as a therapist if you are working with both.

KN: Like an over-identification with a child's view of relationships.

JN: A limited amount of love. We have to go!

Yes we do!

REPORT ON "INTEGRATING PSYCHOANALYTIC RESEARCH LITERATURE INTO THE PINE CURRICULUM AND EXPLORING ITS RELEVANCE TO CLINICAL ANALYSIS," A PRESENTATION BY RAY LEVY AND IRA LABLE

Date: April 28, 2011
Reporter: Sarah Ackerman, Ph.D.

On Thursday, April 28th, the PINE Curriculum/Faculty committee meeting was held at the home of Jim Barron, Chair of the Curriculum Committee. This meeting, co-sponsored by Stephen Kerzner, Chair of the Faculty, centered on a stimulating presentation by Ray Levy, a psychodynamic clinician who is the Clinical Director of the Psychotherapy Research Program at the Center for Psychodynamic Therapy and Research at Massachusetts General Hospital. A paper that Dr. Levy co-wrote with Ira Lable, who is also involved in this research, was highlighted within the presentation. This meeting provided a clear and comprehensive summary of the state of the art of psychodynamic psychotherapy process and outcome research and an overview of the conclusions that have been well supported by the literature in this area to date. It also clearly generated both feelings and questions that attendees at the meeting were eager to have more time to discuss.

Dr. Levy began by posing four essential questions that outcome research is oriented toward.

- What treatment works?
- What treatment works for whom?
- How and why does it work?
- What is the cost-effectiveness of psychodynamic treatment as compared to no treatment (for a diagnosis such as borderline personality disorder)?

Dr. Levy described the protocols and measures commonly used in the research in this area. CBT treatments typically employ randomized, double-blind protocols, which are the model used in drug research and much of medical research. These protocols randomly assign patients to a form of treatment, and ensure that neither patients nor outcome raters know which form of treatment a patient is receiving. Clearly, this protocol doesn't work or make sense within the theoretical structure of a psychodynamic model that is so focused on individualistic responses to the patient's presentation, so a naturalistic protocol is often used. In this protocol, the therapist makes the interventions that are clinically driven by the patient whom she is treating, and process measures (series of measures) are used with both

patient and therapist to determine with which orientation the treatment is most closely correlated. The treatment orientation and individual process variables can then be correlated with outcome, arriving at the active ingredients of a treatment. One interesting aspect of the process measures used is that they assess many different specific interventions, and therefore can capture the regular "interdisciplinarity" of a treatment, wherein a dynamic clinician may pepper her treatment hours with cognitive-behavioral or interpersonal psychotherapy interventions. The frequency of these three kinds of interventions can then be measured in relation to the patient's outcome.

Dr. Levy went on to describe how virtually every researcher in the field of psychodynamic outcome research has developed her or his own treatment manual with which to direct dynamic interventions. He listed 24 such manuals, including a mentalization manual (Fonagy), a manual focused on defenses (Perry), a manual centered on core-conflictual relationships (Luborsky), and an object relations focused manual (Kernberg). When these manuals are employed, treatments are time-limited and the study design conforms to the gold standard of research protocols, the randomized controlled study, with a comparable number of sessions to the CBT models. It is interesting to know that while CBT treatment research consistently documents the efficacy of their time-limited treatments, it has been found that CBT treaters in the general population see their patients for much longer courses of treatment, raising questions about what other interventions they find necessary.

With respect to the first two questions, does psychodynamic treatment work and if so, for whom, Dr. Levy asserted that there is now clear and comprehensive evidence of the effectiveness of psychodynamic treatment due to meta-analyses by Leichsenring and more recently, Jonathan Shedler. However, he also noted that standards in the psychotherapy research world demand that any study be replicated by a second psychotherapy research lab for the treatment to be considered a fully accepted evidence-based treatment. In studies focused on particular diagnoses, including mood disorder, anxiety disorders, PTSD, eating disorders, substance abuse disorders, Cluster B of the personality disorders (including borderline personality), and Cluster C of the personality disorders (Avoidant personality and Obsessive-Compulsive personality disorder), the evidence in favor of the particular utility of psychodynamic treatment is well supported. The above-mentioned meta-analyses also find larger effect sizes for dynamic treatments three years after termination, indicating that psychodynamic treatments promote ongoing growth and change after termination. Further, psychodynamic methods have been associated with successful outcome for clinicians who practice a range of treatment modalities, including CBT. Several meta-analyses, which looked at the effect size across 60 or more published studies, have also confirmed these individual findings, showing that dynamic treatments are more effective than placebo therapy, supportive therapy, or treatment as usual; and dynamic treatments are often shown to be equally effective as CBT.

This good news also raises questions. If dynamic treatments are clearly supported by evidence, why are they not included as one of the evidence-based treatments, or covered as such by many insurance companies? One answer to this question is that cognitive-behavioral research has had a longer history of research, and has found a way to perform what is largely considered to be the "state-of-the-art" research methodology, the use of randomized double-blind studies. Another answer is that analytic audiences do little to engage with or promote this research. In fact, some analysts have attacked the notion that psychodynamic treatment effects could be measurable. Among the audience at this meeting, many seemed surprised to hear how strongly and consistently these treatment effects have been documented. Just the day before, I had been telling a supervisee, in response to a question about CBT, that if a patient has a specific complaint around panic or anxiety, CBT probably is the treatment of choice. I did not know that short-term dynamic interventions with patients with anxiety disorders have actually proven to be as effective as CBT.

At this point, Stephen Kerzner described the elation that he felt in reading an article that conveyed these outcome findings, a pleasure in the idea that our utility as clinicians *is* measurable and clear (Cortina, 2010). Dr. Levy's response to this was quite interesting, in that he said that comparisons of different treatments are like horse racing, in the sense that results vary by study and are easily argued and refuted. The meaningful direction in which research needs to proceed is to illustrate how a treatment is effective, what is happening within a treatment, what works, and for whom.

This moved the discussion into a question about this research goal, the questions around how and why and when dynamic treatment works. Axel Hoffer asked a characteristically straightforward but complex question: If psychoanalysis is, as he feels, an art, then can it be

measured or compared? He wondered if we can ask if Renaissance art is better than contemporary art, but also claimed that he does feel that the art of psychoanalysis has improved over the years. We didn't have time to pursue the ideas that follow from this question, but it served to remind us that there is something ineffable, immeasurable, or perhaps unquantifiable, inherent in the nature of our work. Many of the studies of psychodynamic research involve therapists adapting to a manual for treatment and agreeing with the patient to a short-term treatment. This is a far cry from the art of psychoanalysis, which is so tailored to a contract between two individuals centered on the needs of the patient. But even acknowledging that, there is clearly a value in relation to the medical world and the insurance industry, in researching the form and structure of our art. This could have occupied us for the evening, along with many questions that emerged about how measures are designed, what they actually measure, what might confound these measures, and a broader interest in what these clinical treatments under study are like. (What would it be like to agree to videotape every analytic hour with a patient, and ask both the patient and yourself to complete comprehensive outcome measures every 24 sessions? Would agreeing to that change the way you work or what the patient experiences? Would it measure what really happens in analysis? Anyone interested in participating in such research should contact Dr. Levy, who has completed such a study.)

Dr. Levy pushed on to describe the more focused research questions about how and why and when dynamic treatments work. This research is, again, surprisingly confirming of our theoretical assumptions. There is compelling evidence of the value of the therapeutic alliance. The therapist's skillfulness and responsiveness are more strongly associated with outcome than the therapist's adherence to a particular technique. Both interpretation and transference interpretation show a more delicate relationship to outcome, with some indication that a treatment alliance and relatively low frequency of interpretation in general are correlated with successful outcomes. The specific factors that have been found to predict a positive outcome in a study of short-term psychotherapy for Panic Disorder include: the patient's contribution to the therapeutic alliance; exploration and focus on negative or unacceptable affect; and a discussion of termination in the context of exploring the patient's worries about separation and dependency.

In closing, Dr. Levy suggested that this work is still in the beginning stages. One challenge for dynamic researchers is to document the specific value of dynamic techniques and show that these effects are more important than common factors. Future research, he suggested, will complexify the models of research, looking at intervening variables that moderate effects (for example, effect of deepening of feelings, in the company of a strong therapeutic alliance). For those who, like many of us in the audience, left this evening with a wish to know more about this evolving research. Dr. Levy did pass around a book that he and Stuart Ablon edited that is a collection of process and outcome research in psychodynamic psychotherapy. A new book is due out this fall. (References are listed below.)

Cortina, J. (2010). The Future of Psychodynamic Psychotherapy. *Psychiatry,* 73(1): 43-56.

Levy, R.A. & Ablon, J.S., Editors. (2009). *Handbook of Evidence-Based Psychodynamic: Psychotherapy: Bridging the Gap Between Science and Practice*. Springer Press: Totowa, New Jersey.

Levy, R.A., Ablon, J.S., & Kaechele, H. Editors. (2011). *Psychodynamic Psychotherapy: Evidence-Based Practice and Practice-Based Evidence.* Springer Press: New York,NY.

NEWS AND NOTES

Rodrigo Barahona, Psya.D. had a radio interview on WUNR-AM 1600 on April 28, 2011 on the topic "Psychoanalysis and Addiction." This program was hosted by the National Alliance on Mental Illness (NAMI-Latino).

Fred Busch, Ph.D. presented "Do Words Matter?" at a Panel of the American Psychoanalytic Association entitled "Do the Words of the Analyst Still Matter" (Chair, J. Lichtenberg) in New York in January, 2011. He presented "Thinking about Process" at the Invited Panel at the Division of Psychoanalysis of the American Psychological Association, "Honoring Martin Bergmann" in New York in April, 2011. Dr. Busch presented "Creating a Psychoanalytic Mind" at Clinical Workshops for Candidates and Faculty and as well presented a paper at the Seattle Psychoanalytic Institute in Seattle in May, 2011. In Ottawa, Canada, in June, 2011 "Hmm, That's Funny" was presented at the Canadian Psychoanalytic Society Annual Meeting at an invited clinical workshop where he was also a discussant. Dr. Busch has been elected to the College of the Board of the *International Journal of Psychoanalysis*.

Howard B. Levine, M.D. presented "Countertransference: From Anxiety to Method" at the April 2011 meetings of the European Psychoanalytic Federation (EPF), Copenhagen, Denmark.

Sarah L. Lusk, Ph.D. was appointed as a Candidate representative to the APsaA Committee for New Training Facilities (NTF).

Jacqueline Olds, M.D. presented at Grand Rounds in Psychiatry at UMass. Medical Center (Worcester) and gave a couple of speeches on The Lonely American at St. Catherine's College in Kentucky.

AUTHORS

Ackerman, S. (2011). Panel Report: "Is Infant Research Useful in Clinical Work with Adults?" *JAPA,* 58(6):1201-1211.

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Drago, M.C. (2011). Sadness and Separation: Necessary Companions, *Colonial Times Magazine*, March / April.

Lable, I., Kelley, J.M., Ackerman, J., Levy, R., Waldron, S., and Ablon, J.S. (2010). The Role of the Couch in Psychoanalysis: Proposed Research Designs and Some Preliminary Data, *JAPA*, 58(5):861-887.

BOOK REVIEW

Levine, H.B. (2010). Baranger, M. and Baranger, W. (2009). *The Work of Confluence: Listening and Interpreting in the Psychoanalytic Field*. *JAPA* 58: 1231-1237.

ANNOUNCEMENTS

We are pleased to announce that the Cambridge Health Alliance Department of Psychiatry as a whole was recently awarded the Harvard Medical School Harold Amos Faculty Diversity Award. **Jay Burke** and **Maggie Alegria** received special mention for their support of cross-cultural work, but for the very first time, the award itself was conferred on an entire department. The following PINE Psychoanalytic Center members are affiliated with Cambridge Health Alliance: **Ayelet Barkai, M.D.**, **Neal S. Kass, M.D.**, **Kimberlyn Leary, Ph.D.**, **Alfred Margulies, M.D.**, **Ava Bry Penman**, **Bliss Rand, M.D.**, **Laurie Raymond, M.D.**, and **Stephanie Dee Smith, LICSW**.

PINE PSYCHOANALYTIC CENTER, INC.

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NEWSLETTER

PINE Newsletter
Published by the
PINE Psychoanalytic Center, Inc.

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