NEWSLETTER

NEW YORK STATE SOCIETY OF CLINICAL SOCIAL WORK PSYCHOTHERAPISTS, INC. SPRING 1991 • VOL. XXII, NO.1

KEYNOTE PANEL

Continuing Evolution of Psychoanalytic Thought: Infancy to Adulthood

Third National Clinical Conference Features Hampstead Series

Report by
Alice Medine King, CSW

A major feature of the National Clinical Conference, Committee on Psychoanalysis (November 1-4, 1990, New York City), was a series of workshops on the theory and technique of the Hampstead Child-Therapy Course and Clinic (The Anna Freud Centre), London, England. The closing keynote panel of four discussed "Comparative Theoretical and Treatment Advances in Child and Adult Analysis: A Hampstead Perspective."

Moderated by conference co-chair Rosemarie Gaeta, panel members offered working theories and case material reflecting their training at Hampstead.

Katherine Rees, MSW, PhD, BCD

Cognitive Dimensions in Technique

Rees advanced her central theme of the importance of increased inquiry and knowledge of the development of normal cognitive capacities and processes, a common ground for child and adult analysts. While adult analysts often feel the need to modify technique to treat the narcissistic and borderline state, she noted that child analysts have the advantage to observe and study the cognitive processes *in statu nascendi* and how they interface with other aspects of intrapsychic development — the shaping of fantasy, anxiety, defense and the capacity for self observation. Substantiating how this increased understanding could lead to more precise and helpful interventions, to a fine tuning of clinical work, Rees stressed the importance of working with children in the "here and now" to help them develop new cognitive structures, since their conceptual ability or sense of self may not be developed.

Through the concepts of sense of time and death, Rees demonstrated that more exact knowledge of the child's cognitive capabilities would influence the therapeutic process by both patient and therapist. Similarly, more precise knowledge of how childhood memory is organized and reorganized at different developmental stages would allow an accurate assessment of the child's ability to make connections and the effective use of genetic interpretations and reconstructions.

Rees offered a detailed clinical example of a 6-year-old boy. She had the unusual opportunity to see the child again as an adolescent and to compare the two levels of cognitive development. The case material presented when he was 6 reflected a boy whose behavior mirrored his inner

continued on page 3

Managed Care and Mental Health: Can We Have Both?

By John Chiaramonte, CSW, BCD
Chair, Vendorship Committee

The idea of managed health care seems contagious among insurance carriers as they seek a solution to health costs that have overburdened many corporations. Employers across the nation are dropping 50 to 90% of their health plan options, and mental health and substance abuse benefits are particularly vulnerable. Costs for these areas of health care are rising faster than others; they are judged to be less critical than medical/surgical benefits; they affect fewer employees; and employers at the top level still feel uncomfortable dealing with the subject (Boland P, *Making Managed Health Care Work;* 1990).

Managed Care vs. Optimum Treatment

The choice of a Health Management Organization (HMO) that can provide employee benefits without total sacrifice of various options is financially appealing to an employer. However, has the effort to reduce costs via an HMO reduced [mental health] care as well? The HMOs would like us to think not and have spent huge sums of advertising money to convince us. Yet, are the 20 reimbursable sessions per year (typical of an HMO) enough when treating the borderline patient, or when a

HMOs must respond to both clinician and patient.

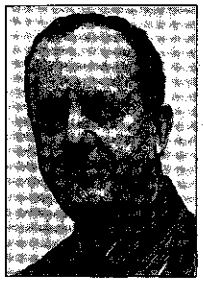
woman's anxiety in dealing with her boss retraumatizes a history of childhood sexual abuse, or when a seemingly reactive depression is really an exacerbation of a chronic depressive condition? Most often they are not.

Managed health care, to be a model for efficiency (and not a synonym for less cost,

continued on page 4

EXECUTIVE REPORT

A Well-Defined Focus for CSWs Fosters Success



Over 20 years ago a hardy group of clinical social workers decided that they wished to improve the status of clinical social work and that of the clinical social worker. Toward that end they banded together to form a beginning, dynamic nucleus of determination. The seeds sown by our founders have been responsible for the sundry courses of action, over the last two decades, that has propelled our State Society forward.

We are using essentially the same game plan today that we did some 20 years ago. Despite our relatively small numbers, we have been inordinately successful. What's our secret? The answer is our focus. We have campaigned within well-defined boundaries and have extended our field of focus only when such expansion was in the best interest of the clinical social worker. We have not tried to compete with NASW, a much larger organization than the Federation. Indeed, on the state and local levels there is usually a spirit of cooperation between the two organizations. However, because of NASW's broad-based interests, they have not maintained a concentrated focus on the clinical aspect. It is in this area that our State Society and the other member state societies of the National Federation excel.

Through trial and error, our political focus is regularly resharpened, and our gains publicized (through the persistent efforts of our lobbyist and the legislative, vendorship, membership and PR committees). Program-wise, our education committee, with substantial input from chapters, has developed and implemented solid, pertinent educational offerings. Cases in point: the collaborative effort between the State education committee and the Met chapter education committee in the planning of the timely program for the May 1991 Annual Membership Meeting and the workshops now being offered in Core Diagnosis, Private Practice and Family Practice. Our chapters also plan and conduct educational programs that tap and utilize the expertise of their members. The result is an expansion of our scope of knowledge plus increased membership as word spreads about our concern for the clinical social worker.

Through trial and error, our political focus is regularly resharpened.

Structurally, our organization is unencumbered by the top-heaviness seen elsewhere. Built-in safeguards are provided by our chapter system that, together with our by-laws, place all the chapter presidents on the executive board with voting power dependent on each chapter's membership. Committees (state and chapter) focus on issues pertinent to the social work clinician and work collaboratively toward common goals. The needs of clinical social workers — direct practitioners and administrators, those in agencies, schools, clinics, hospitals and private practice — are explored and addressed. An atmosphere of friendliness pervades and there is flexibility in getting things done. Much of the time our efforts are even fun! When the focus is reasonable and well-defined and when the goals are clear, the interested and concerned will follow those pathways that promise even higher levels of professionalism.

Philip Banner, CSW, BCD
President

An Open Letter...

This is an open letter of thanks to the amost 40% of the members of the Society who responded to my questionnaire on working psychodynamically with the older patient.

The study was an attempt to understand what the effects of knowledge about aging and attitudes toward the elderly might have on the therapist's decision-making process regarding the treatment of the older patient.

The rationale for the study came out of the historical and current problem of underservice to the elderly by the mental health profession. Possible reasons for the under-use of services by the elderly have been hypothesized as follows:

1. The medical profession does not make referrals for therapy to the older patient.

2. The elderly are not familiar with the nature of psychotherapy and what value it may have for them.

3. Agencies do not outreach to the older population in the community they serve.

4. There is a resistance based on the client's transference and the countertransference of the mental health professional in all disciplines, i.e., social work, psychiatry and psychology regarding working with this population.

Studies indicate that exposure to and training in working with the older patient can make a difference in currently held negative attitudes or expectations by therapists. Once a therapist actually works with the older patient, less stereotypical and more positive expectations of treatment occur.

My study is currently in the process of being analyzed. When this is complete, I will share the results with the Society and with those individual members who have requested the information. It appears that

continued on page 3

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Issued three times in 1991

Advertising Rates/Sizes

Size on Page	Measurements	Cost
½ page (hor.)	7⅜" x 4⅞"	$250
½ page (vert.)	3⅝" x 10"	$250
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½ column (vert.)	2⅜" x 4⅞"	$85
½ column (hor.)	4⅞" x 2⅜"	$85

Classified: $1 per word, minimum $30, prepaid.

Advertising for Summer 1991 issue due May 15.

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OPEN LETTER *(continued)*

in our community there is a true interest in understanding and working with the older patient, as well as a need for clinical social workers' involvement in research.

Your responses to the study have been gratifying and exciting, as were your notes of good wishes and encouragement; they are truly appreciated and wonderful to receive.

Once again, please accept my thanks for your time and effort in responding to the questionnaire.

Sincerely,
Ellen Gussaroff, CSW, BCD

CONFERENCE *(continued)*

chaos and whose play revealed his helplessness and feeling of worthlessness. Over time a play animal emerged who felt completely 'stuck,' but gradually began to interact with other farm animals, reflecting his feeling safer and his movement in the therapeutic relationship as well as replicating themes of his own family interaction.

Through symbolic play the child was able to share his affective experiences and begin to see links between his inner feelings and fantasies. His play revealed a lessening of guilt (his older sister had died when he was one year old) as he began to feel better about himself while organizing his sense of self. "He had been able to engage in analytic work on conflicts, fantasies and defenses, as long as one met him at his own level," i.e., in keeping with his cognitive capacities.

When Rees saw the boy as an adolescent, he demonstrated an "incredible" advance in his conceptual abilities and was able to work at a new level of understanding. Now aware of his age appropriate anxieties which were stirring up old feelings, he was able to verbalize his anxieties.

Rees reiterated that increased knowledge of conceptual and cognitive transformations offered child and adult analysts the opportunity to deal with a greater range of pathology.

Dale R. Meers, DSW, BCD

Ego Psychological Distinctions Between Maturational, Pathological and Culture Deviance

Dale R. Meers paid tribute to Anna Freud, to her "quiet, classical, revolutionary application of theory to practice". He

continued on page 6

Confidentiality and the Victim of Sexual Abuse

What is the Therapist's Obligation?

By Hillel Bodek, MSW, CSW, BCD

We have received a number of inquiries recently from CSWs who are concerned that records of their treatment of sexual assault victims are being subpoenaed, usually by prosecutors.

It should be noted that **a subpoena is only a command to produce** a given record or for a person to appear at a given time and place. **A subpoena does not order the disclosure of the material produced, nor does it compel the subpoenaed person to give testimony.** *People ex. rel. Hickox v. Hickox,* 64 AD2d 412 (First Department, 1978.)

Absent certain special circumstances (e.g., child abuse), communication between certified social workers and their patients are privileged. *(Civil Practice Laws and Rules* section 4508.) Therefore, generally without the **informed** consent of the patient, neither the records of the patient's treatment nor information concerning his/her treatment should be disclosed.

In cases of sexual assault, prosecutors sometimes wish to review the records of the victim's therapy to help determine whether an assault actually took place or to help prove that the victim manifests psychosocial sequelae of having been sexually assaulted. Similarly, defense lawyers also seek the records of alleged victims' treatment.

Limits of Privilege

A recent decision by the Appellate Division – First Department of the New York State Supreme Court clarifies the limits of the social worker/patient privilege in this situation. In *People v. Berkley,* 157 AD2d 463 (First Department, 1990) the court upheld the conviction of a rapist who alleged that he was denied a fair trial because the trial court refused to compel the social worker at the Victim Services Agency to provide his lawyer with the record of the victim's treatment.

The Appellate Division held that although under the so-called *Rosario* rule a defendant generally has an absolute right to review prior statements made by prosecution witnesses, the courts have recognized a limitation on this disclosure rule with regard to materials for which a privilege is asserted and for materials that are not in the actual possession of the prosecutor.

It was undisputed that the records of the Victim Services Agency were not in the possession of the prosecutor and that the prosecutor had no way of obtaining them other than compelling their disclosure by judicial order, which the trial court refused to issue. However, the defendant asserted that the victim in this case had waived the social worker/patient privilege by testifying at the trial.

Generally, when a person places his/her mental state at issue, such as by suing someone for infliction of emotional distress, this plaintiff is deemed to have waived any privilege that exists between herself/himself and the health care professional with regard to such emotional problems.

The Appellate Division held that the social worker/patient privilege was not waived by the victim when she testified at the criminal trial. "[w]e cannot agree that such a privilege, if it existed, was waived by the complainant's testimony. The complainant is not a party to a criminal prosecution and, in this instance, she did not place her mental state at issue."

CSWs should not turn over materials regarding their patients who are crime victims.

CSWs should not turn over materials regarding their patients who are crime victims nor discuss their treatment of patients with a prosecutor or defense lawyer in a criminal case absent the explicit, written, informed consent of the patient. If a prosecutor requests the victim's treatment record, the CSW should point out to the prosecutor that, under the *Rosario* rule, once records are turned over to the prosecutor, such records will be in the prosecutor's possession and

continued on page 4

MANAGED CARE *(continued)*

less care) must "reprioritize" around mental health issues. Its challenge is how to deliver the most cost-effective (not the cheapest) care: combining the right mix of clinician and service to produce the best outcome in the shortest (but not necessarily short) time or with the least amount of resources. For this to occur, HMOs must respond to the outcry of both clinician and patient, and review guidelines for mental health benefits.

Necessary vs. Unnecessary

Currently HMOs see their goal as eliminating "unnecessarily" lengthy psychotherapy treatment and providing the most cost-effective care for "necessary" mental health services. Necessary services are defined as those services required to restore function to a dysfunctional individual. Ongoing dysfunction (and therefore the need for extended services) is defined in terms of risk for hospitalization or danger to oneself. While mental health providers agree with managed care professionals that restored function is a prime concern and focus of mental health services, they are quick to add that just as important is the ability to maintain one's functioning and avoid future dysfunction. The latter treatment goals may require more extended treatment and concomitant extension of mental health benefits by the HMO.

Necessary services are defined as those . . . required to restore function to a dysfunctional individual.

Indemnity Plans vs. Managed Care

Can a compromise between the financial constraints of the employer and the mental health needs of employees be reached in this climate? The solution may not be too far from today's indemnity plan insurance and the HMO. The differences between an indemnity insurance plan (e.g., Blue Cross, Met Life, etc.) and an HMO plan are the limitations placed on services approved and the amount of provider reimbursement allowed. That is, instead of having a mental health benefit dollar ceiling as most indemnity plans have, the HMOs impose a ceiling on allowed services. This translates into major savings for the HMOs. Whereas new major medical contracts written in 1991 will have a $1500 minimum outpatient reimbursement for mental health benefits in New York State, HMOs typically are liable for one-fourth that amount. For example, US Healthcare will pay $370 for 20 outpatient sessions per year: $40 for the first two sessions, $30 for the next eight sessions ($10 co-pay), and $5 for the next ten sessions ($25 co-pay). Any further outpatient treatment (other than to avoid hospitalization or in life-threatening cases) will be totally at the patient's expense (an HMO therapist must agree to accept a maximum fee of $50 for sessions after the 20 sessions allotted).

What happens if treatment must continue past the 20 sessions? In such a case, the HMO plan would still only reimburse $370, the patient would be liable for $1830, (assuming 30 additional sessions) and the therapist would receive $2200 (total) for the 50-session treatment. On first consideration one might say that this is beneficial for the patient who would have to pay more under an indemnity plan. For example, at $80 per session for a 50-session treatment, the plan would reimburse $1500, and the patient would pay $2500 plus deductible. However, in reality neither patients nor EAP personnel are finding this to be so. Many patients find the jump from paying $25 a session to $50 a session to be prohibitive to their continuing in treatment, and they opt for short-term treatment where a longer treatment would be advisable. This burdens the EAP counselor who too often must provide additional service because of the limitations of the employee's insurance plan. Patients often find that with an indemnity plan they are able to negotiate a fee which affords them the choice of longer term treatment.

Can an HMO tailor individualized treatment plans?

The solution to the dilemma of meeting both patient needs and employer financial constraints would appear to lie in the HMO's ability to tailor individualized treatment plans, to clarify both long- and short-term goals, and to provide a reasonable portion of the resources necessary to meet these goals. Perhaps programs such as the new Blue Cross/Blue Shield "Blue Choice: Point of Service Indemnity Program" currently being reviewed by the NYS Department of Insurance is a move in that direction. Once this new program is clarified, the vendorship committee will report. □

Vendorship Update

Clinical social workers treating **Medicare** patients must accept Medicare assignment. CSWs must accept the determination by the Medicare carrier of the "allowable charges" for covered services as their fee for those services. Clinical social workers may only bill Medicare patients the difference between what Medicare allows and the amount Medicare pays. There are severe penalties for not following this law. (See Hillel Bodek's "Medicare Guidelines for Clinical Social Workers" in the December 1990 National Federation newsletter.)

People in the News...

"Can This Marriage Be Saved?" This long-running monthly feature in *Ladies' Home Journal* was based on **Arden Greenspan-Goldberg's** contribution in the December 1990 issue.

Arden (Rockland) is also negotiating a book contract on eating disorders of the female athlete.

Mary Anne Cohen (Brooklyn) is the producer of a weekly radio show on eating disorders: "French Toast for Breakfast: Declaring Peace with Emotional Eating." Tune in — Wednesdays, 8:15 a.m., WNWK, 105.9 FM. Mary Anne is director of The New York Center for Eating Disorders.

Congratulations to **Roslyn Gold** (Queens) for receiving her doctorate. Roslyn Gold, DSW, is a clinician in private practice. Her doctoral dissertation discussed aspects of suicide; her research concerns death, dying and bereavement. Dr. Gold is a board member of Queens Mental Health Society, a member of the American Association of Suicidology and the Hemlock Society.

CONFIDENTIALITY *(continued)*

must be turned over to the attorney for the alleged rapist/sexual abuser.

A far better way of helping the prosecutor to be assured that there is no clinical evidence that the alleged sexual abuse did not take place would be to speak with the prosecutor after obtaining the patient's explicit, written informed consent, for the limited purpose of indicating that fact.

Note: Emphasis added throughout. □

"Continuing Evolution" Attracts International Participation

By Mark Sehl, CSW, BCD

Social work psychoanalysts in 1990! Some 500 streamed into the Vista International Hotel in New York City from 28 states, Canada, Germany and Austria. This third national conference of the Committee on Psychoanalysis — the largest to date — was probably the first time so many clinical social workers came together as psychotherapists and psychoanalysts, reinforcing their heritage as social workers.

The theme of the 4-day event, "The Continuing Evolution of Psychoanalytic Thought: Infancy to Adulthood," contained a sub-theme involving the relationship between analyst and patient and the attunement of analyst to patient. One was struck for instance by the eloquence of Jean Sanville and her comments on the process of analysis. Her keynote address, "Interpreting Reparative Intents," spoke of patient and analyst interpreting each other in that often "silent dialogue" out of which the patient "as agent" evolves and a new beginning emerges. Dr. Sanville reopened thoughts I have had about what happens in the interplay of transference and countertransference that leads to repair.

Crayton Rowe's paper in part focused on the beginning interviews with a particular patient. The introspection into initial reactions to a first encounter with his patient led to his sensitive understanding of this patient's despair about never being understood. This laid the path for further transmuting internalizations. Over a period of 4 to 5 years, a once rigid, hard-to-reach patient developed the capacity to find joy in life. Mr. Rowe's clinical presentation was preceded in this workshop by a paper delivered by Dr. David MacIsaac, who sensitively delineated the theory of self psychology as it related to the archaic selfobject transferences.

Sylvia Teitelbaum's workshop on countertransference proved to be another example of sensitivity to a patient's horrifying experience with another therapist who told this patient she was boring. Mrs. Teitelbaum understood that her patient's withdrawal into a "shell" was, although not very exciting, a safe place where she could feel protected.

This understanding and respect for a patient's resistance could also be seen in Dr. Steven Marans' ability to take his cue from his latency age patient when certain comments and interpretations were not an effective means of reaching this child.

In his keynote address Dr. Rudolf Ekstein spoke of transference neurosis and countertransference as never ending. He traced his evolution and transformations of identity as he spoke of old transitional objects, then moved to new ones that in turn provided bridges to the future. He traced the flow of his life as he moved from one generation to another, speaking of relationships with his students, his children and his grandchildren.

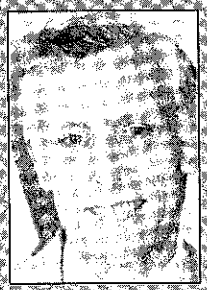
Ending too soon, this conference can be thought of as a new beginning for clinical social workers. It will change, occur in another city, with a different theme. But the spirit will remain; a spirit of hard work and sacrifice for a profession that has fought hard to be recognized.

Stephan Becker, Dr. Soc. Paed. Founder and President, Association of Psychoanalytic Social Work, Federal Republic of Germany.

Ernst Federn, MSW, Vienna, Austria. Keynote speaker: From Psychoanalysis to Clinical Social Work: An Evolutionary Process.

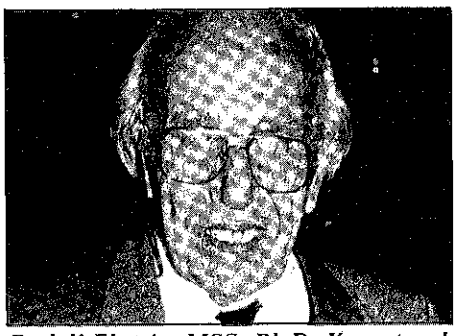
Jean B. Sanville, MSS, Ph.D., BCD, editor, Clinical Social Work Journal. Keynote address: Interpreting Reparative Intents.

Tribute to Crayton E. Rowe Jr., MSW, BCD



On behalf of the National Committee and the National Federation, Rosemarie Gaeta, co-director of the Conference, presented a plaque to Crayton E. Rowe Jr.

The National Committee on Psychoanalysis presents this award to Crayton E. Rowe Jr., MSW, founder of the National Committee on Psychoanalysis, whose vision, leadership and dedication have for the past decade inspired the birth of this organization committed to the advancement of the Clinical Social Work Psychoanalyst. November 3, 1990.



Rudolf Ekstein, MSS, Ph.D. Keynote address: The Life Cycle of Relationships: Parent and Child, Man and Wife, Teacher and Student.

noted that, although they have been honored in name, significant contributions still have not been well understood or utilized.

Meers highlighted the history of ego psychology with particular focus on Anna Freud's contribution to theory construction. He noted that prior to her publication of *The Ego and the Mechanisms of Defense* during the 1940s, there was little recognition of her work. Meanwhile Hartmann had gained ascendancy as the major ego psychologist with his concepts of the formation and functioning of the ego and, together with Lowenstein, of the refinement of the dual instinct theory. Meers suggested that consistent with Hartmann's reliance on energic and genetic principles, he followed Freud's metaphor of a hapless ego riding perilously on an instinctual id.

Anna Freud's formulations advanced Freud's work for use with a wider range of pathology.

Tellingly Anna Freud rediscovered another metaphor of Freud: of an infinitely, deviously defensive ego that disclaims responsibility for the id. Drawing on her clinical work and research with children, she refocused analytic perspectives from the primacy of the oedipal complex to the relevance of mothering and preoedipal developmental conflicts. Anna Freud's elucidation of ego defenses and regressive impairment carried unorthodox and far-reaching theoretical implications and clinical applications. Her formulations advanced Freud's work for use with a wide range of pathology.

Freud, partly in response to the dissidents of his libido theory and primacy of the Oedipal, introduced the structural theory, reformulating the concept of anxiety as a signal and introducing the death instinct. Meers described the resulting increased understanding of ego functions, adaptive and defensive aspects, and their importance in treatment. He also noted the ensuing challenge and conflict within the psychoanalytic community surrounding the understanding and treatment of borderline and narcissistic disorders. He asserted that Anna Freud's conception of ego development could provide the bridge to research the gaps and help resolve the ongoing controversy.

Lastly, Meers discussed the relevance of defense analysis in clinical practice, noting that the technical restraint needed has not been understood or practiced enough. Not to do so, he asserted, could lead to therapeutic zeal and use of premature, incomplete or inaccurate developmental interpretations, thereby reinforcing or supporting the patient's resistance to insight. Clinical material illustrated the value of Anna Freud's required "use of meticulous observation and parsimonious intrusiveness in eliciting a patient's self understanding". The integration of Anna Freud's teaching is reflected in Meers' statement that psychotherapy means "our gentle perseverance in educating our patients that their cure depends upon our capacity and theirs to look at what they say to us, how they say it, when they forget, distort, displace or otherwise defend themselves from understanding here and now...."

Steven Marans, MSW

Play and Talk

Steven Marans addressed the similar goals of child and adult psychotherapy: understanding the inner workings of the mind and their influence on daily life; making what is unconscious conscious in an attempt to widen the range of personal adaptations.

He considered the differences between work with adults and with children in terms of developmental status, motivation for treatment and ways in which material is articulated. The level of comfort in working with adults may be greater, Marans suggested, because their modes of communicating are more immediately familiar (or predictable) to the therapist than those employed by the child. Continuing the contrast, he noted that the adult patient comes to treatment in pain, recognizes discomfort and strives for normalcy. The child usually comes into treatment because parents bring him with an identified problem. The adult, resistances notwithstanding, is agreeing to work with the therapist and to reveal him or herself in order to make changes. The child plays, not necessarily to reveal himself or herself to the therapist, but because this is his/her developmentally determined way of achieving pleasure, working over inner and external experience and mastering anxiety.

The child therapist cannot be bound by modes employed by the adult psychotherapist.

In play the suspension of reality allows for fantasy to be accompanied by action; in play there can be no consequences in reality. Within this framework of imaginative play activities the child can enact what otherwise might be repudiated by either internal or external prohibitions and constraints.

The child therapist cannot be bound by modes employed by the adult psychotherapist, Marans noted, and related a story about Anna Freud's vain first attempts at child analysis through use of the couch and free association. Marans shared his own experience as he attempted to link his 8-year-old patient's emotions during play to his real life and how such comments would abruptly bring to a close an episode of elaborate play. After several months the patient himself changd Marans' approach when, in exasperation at the therapist's interpretation, the patient stated that "it's not real anyway". Not until 10 months into the analysis did Marans venture more interpretive comments, made in relation to the ambivalence toward the boy's biological mother (he was in foster care). This marked a beginning change in the boy's play and response to the therapist.

In summary, the means of achieving the similar goals in child and adult therapy are essentially different. Work with adults is based on their wish for change, while child analysts must deal with the suspension of reality without a wish for change. The adult must give up reality while fending off regressive fantasies — the child must relinquish the realm of magic to adapt to reality.

Carla J. Elliott-Neely, MSW, PhD

The Process of "Working Through" in Child Analysis

In his concept of "working through," Freud observed that adult patients required time to assimilate the insight gained from the interpreted resistances. Elliott-Neely noted Freud's linking "working through" to the repetition compulsion and the emphasis he placed on the concept as a means of conflict resolution and psychic change. Although Freud's work focused on interpretation and resolution of neurotic conflict in adulthood, "working through" took on additional meaning as the scope of psychoanalysis widened. Elliott-Neely underscored the amplifica-

continued on page 8

BOOKS

Four Therapeutic Approaches to the Borderline Patient

Andrew Druck, PhD
Aronson Press, New York,
1989, 400 pages

Reviewed by
Thrae Harris, CSW

Dr. Druck's book goes far beyond discussion of four approaches to the treatment of the borderline patient: it is an invaluable summary and comparison of the last 40 years' most important analytic thinking on this subject. The work is organized into four models: Kernberg's, the representational self-deficit, ego deficit, and classical. Druck examines Kernberg in detail as well as classical analysts who stretch technique. From this framework he looks at issues such as confrontation or support of defenses, interpretation within a supportive context, gratification and abstinence, the use of transitional objects, the therapeutic alliance and what is mutative.

A Patient "Seeks the Truth"

Dr. Druck begins by detailing the treatment of a young man who came into therapy because he was lonely and could not establish a steady relationship with a woman; he had had four brief therapy experiences and two psychiatric hospitalizations. Looking at the material from different perspectives, Druck demonstrates that one does not necessarily have to adhere to one point of view, although eclecticism may confuse the treatment and the patient. This patient sought out only idealized men and women, e.g., ministers from campus religious organizations, and asked them question after question in order to learn the "truth". He felt at times

Druck demonstrates that one does not necessarily have to adhere to one point of view.

"a feeling of being one with Jesus". Druck points out that this could be seen as an attachment to idealized figures, which reflects a lack of holding introjects and an attempt to obtain comfort from outside objects. He suggests, alternatively, that this could be understood from a Kernbergian perspective as reflecting an omnipotent, grandiose "good" self which defends against a "bad" self through projection.

This case, further, provides a dramatic picture of the difficult beginning phase of treatment in which the patient demands concrete help and is unable to join in therapeutic self-observation. Dr. Druck has an imaginative, sensitive manner of developing and phrasing interpretations which address the patient's feelings and strengthens the alliance. Since this is one of his strengths, more space could have been given to different ways of looking at the material and of making particular interpretations.

In discussing the transitional object, Druck gives a sympathetic description of the rationale for the use of a transitional object, but then issues a number of cautions against overuse. For example, countertransference, such as the therapist's fear of the patient's anger and fear of separation projected onto the patient, may lead to inappropriate interventions. "It should encourage impulse control and reflection rather than, as often happens, seduce the patient, encourage merger or make the therapist, not the therapy, the patient's goal."

Countertransference . . . may lead to inappropriate interventions.

Kernberg's Theory

The two chapters on Kernberg are refreshingly clear and concise as they examine and bring alive borderline defenses. However, I wondered at first why the theory was so beautifully spelled out, yet the clinical material quoted from Kernberg — and in Druck's own case examples — did not persuasively support Kernberg's theory. A simple answer. Druck seems to have no argument with Kernberg's theory for the most part, but he has questions as to the overuse of confrontation.

The therapist again and again is placed in the position of confronting a character defense which is ego syntonic. The patient becomes resistant, especially since he sees only disaster and loneliness as the gain in giving up his wish . . . . [Yet] Through confrontation, Kernberg acknowledges and is empathic to the patient's angry, orally hungry self. If this approach is right with a given patient, the patient will respond to confrontation and interpretation by feeling understood and held . . . . We are discussing tact, pace of interpretations, technique of resistance analysis and, perhaps, awareness of the working alliance and impediments to this alliance.

The Right and Left of Childhood

The final section of the book compares what Druck labels the "left" and "right" wing of classical thought. According to the right wing, the child learns to modify and control his wishes and to accept the demands of reality through fear of loss of the object, of love, etc., while the left wing, as articulated by Loewald, holds that frustration is not central to the child's acceptance of reality. He/she learns "to retain the original mother-child psychological field at higher levels of abstraction . . . [and] not only submits to reality, but embraces it and makes it his reality in a manner that gives it zest and meaning." From the perspective of the right the patient is motivated by unconscious conflicted wishes which threaten the work and which must be analyzed. For the left the working alliance is sustained by transference wishes and at certain times by "background gratification. The analyst is the object through which reality comes to have affective meaning for the patient."

"The therapist's character is the most important determinant of the success of an analytic treatment."

Freud states in *The Future Prospects of Psychoanalytic Therapy*, ". . . everything still awaits definitive settlement and much is only now beginning to come clear." Dr. Druck has certainly added to analytic clarity. There is here something even more important. He says, "The therapist's character is the most important determinant of the success of an analytic treatment." One cannot help but feel the character in this work.

Thrae Harris, CSW, an advanced candidate at IPTAR, has a private practice in Brooklyn Heights.

tion of the concept from its impetus in the application of psychoanalytic ideas to understanding the development and treatment of children. She discussed Anna Freud's contribution to the theory, and referred to *The Technique of Child Analysis: Discussions With Anna Freud,* in which the concept is broadly addressed. Anna Freud believed the "working through" involves extension of interpretation, especially with children, because of their tendency to "lose" interpretations.

Expanding on the differences between adult and child psychoanalysis, Elliott-Neely noted that, while structural change in both child and adult patient takes place as a result of "working through" of gained insights from interpretation, the child's structural change also occurs via ongoing *normative* developmental processes. For children then, the process of "working through" occurs both within and outside the analysis because the child's primary objects are a major part of current life. The "working through" process is more difficult in child treatment because of the child's limitations in tolerance of pain and understanding of the long-range benefit of enduring it.

Different degrees of cognitive capacities affect "working through" for children and adults. The child patient needs interventions in addition to those involving interpretation of unconscious conflict; these interventions Elliott-Neely sees as an integral part of the "working through". As an example she cited the need for explanations of reality to diminish anxiety stemming from the infantile understanding of the world.

For children the process of "working through" occurs both within and outside analysis; the child's primary objects are a major part of current life.

Elaborating on the analysis of a 13-year-old girl, she documented the "working through" of a disturbance based on the young girl's response to an ankle injury in early childhood. The "working through" process consisted not only of repeated interpretations of unconscious neurotic conflict but also of clarifying distorted theories about the experience which had persisted beyond the infantile period. Effective interventions helped the patient construct a more reality-based understanding of confusing childhood events.

The concept of "working through" as applied to and understood in the child psychoanalytic process offers an opportunity to move beyond the narrow scope of interpretation of conflict. Limiting our view of "working through" to the idea of neurotic conflict resolution also limits thinking about the variety of curative factors of the therapeutic relationship.

After the presentations, the audience and the panel members engaged in discussion of case material and concepts, with special interest centered on the treatment of children. Issues further elaborated were the child's motivation, characteristics and use of material, and the involvement of parents. Last but not least, the characteristics of therapists were explored in terms of their special suitability for work with children. □

Surviving in Tough Times (Learn How at Annual Meeting)

By Carole Ring, PsyD, RCSW, BCD
Co-Chair, Education Committee

The 1991 Annual Meeting will take place May 11 at the Association of the Bar, 42 West 44th Street, NYC, from 8 a.m. to 4 p.m. It is a collaborative effort of the education committees of both the NYS Society and the Met chapter.

Addressing "Surviving in Tough Times," the event will include an institute and book fair. The morning business meeting will include President Philip Banner's address, committee reports and presentation of diplomate awards.

The "cutting edge" in clinical social work application to managed patient care will be discussed by John Chiaramonte, NYS vendorship chair, and keynote speaker Gary M. Unruh, NICSWA consultant and president of Provider Network, whose topic is "Impact of Economy on Health Care." Issues surrounding practice in the climate of cost containment and managed care will be addressed by Dolores McCarthy and Nancy Bernstein during the morning.

After lunch a series of workshops are available to participants. □

Executive Director

John N. Odom tendered his resignation as executive director of the NYS Society, effective February 15, 1991. The position of executive director has reopened to suitable candidates, who are invited to apply. Society members as well as nonmembers are eligible.

The successful applicant will have experience in administration, fiscal management and public relations; an MSW is preferred but not required.

The position will begin on a part-time basis and is expected to become full time at a later date. All correspondence to: Search Committee, 2517 Avenue "O," Brooklyn, NY 11210. □

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