NEWSLETTER
Committee on Psychoanalysis
A National Membership Committee of The National Federation of Societies for Clinical Social Work

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Psychoanalysis - A Clinical Social Work Subspecialty

The Federation's national membership Committee on Psychoanalysis has made it possible for clinical social workers to advance psychoanalytic training and practice within the clinical social work profession. Until now, clinical social workers have had to look to other professions for their identity as psychoanalytic practitioners. Psychologists and M.D.'s see their psychoanalytic practice as a subspecialty of their professional discipline. In contrast, clinical social workers have had to assume such titles as psychotherapist, psychoanalyst, etc., in order to define their subspecialty practice to the public.

This disavowal by clinical social workers of their professional discipline has had obvious repercussions for both the profession and the individual clinical social worker. Ken Adam's advocacy report in this issue highlights the difficulties we now face as a result of the lack of organizational support given by our profession to its psychoanalytic practitioners. A recent mailing by a major social work psychoanalytic organization highlights the despair that some clinical social work psychoanalytic practitioners have in achieving psychoanalytic parity with other professions as clinical social workers. It was reasoned that parity for social workers would be enhanced through accreditation of those who practice psychoanalysis because: "In psychoanalytic institutes *we would be psychoanalysts first, social workers second.*" I know of no other mental health profession which would evaluate its own profession as secondary. We cannot hope to achieve parity with other profesions until we claim our own subspecialty expertise.

Crayton E. Rowe, Jr.
Chairman

Psychoanalytic Training for Clinical Social Workers A Position Paper*

Committee on Psychoanalysis, National Federation of Societies for Clinical Social Work

Since the beginning of the formation of nonmedical psychoanalytic training institutes in the early 1950's, clinical social workers have comprised a sizeable body of the students. By 1975 (Rowe, 1975) a survey conducted by the New York State Society of Clinical Social Work Psychotherapists showed that over 50% of the total student body in a wide sampling of freestanding institutes in the New York area were clinical social workers. A 1981 follow-up survey indicated that clinical social workers made up an even higher percentage of the student body. Both surveys further revealed that a relatively small percentage of clinical social workers was in staff positions. It was apparent that other mental health disciplines were in control of the psychoanalytic training of clinical social workers.

By 1980 the long debated question of whether or not psychoanalytic practice (psychoanalysis and psychoanalytic psychotherapy) should be considered a separate professional discipline or as a subspecialty within the existing professions emerged as another crucial issue affecting clinical social

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Advocacy for Psychoanalysis - And Psychoanalytic Psychotherapy

As the Washington Representative of the National Federation of Societies for Clinical Social Work, it is my responsibility to help protect and advance the interests of clinical social workers and their patients. This includes protecting the right of clinical social workers to practice within the scope of their expertise. Sometimes that means educating legislators and third party payers about the training and expertise of clinical social workers; sometimes it means challenging the efforts of other professions to claim exclusive turf rights over areas of practice such as psychoanalysis, which are within the scope of practice of clinical social work as well.

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Clinical Conference Planned for 1988 — Dale Meers To Chair ... Call for Papers

All members of the national membership Committee on Psychoanalysis are invited to submit unpublished theoretical and clinical papers on the treatment of adults, children and/or families. Please send papers to:

Marsha Wineburgh, M.S.W.
315 East 68th St., Apt. 16T
New York, NY 10021

Papers will not be returned unless requested along with a stamped return envelope. Contributors will be informed only if papers are accepted by the Conference Committee. Conference area coordinators are Beverlee Filloy, Ph.D. (California), Eve Mayer, Ph.D. (Arizona), Irmgard Wessel, M.S.W. (Connecticut), Marsha Wineburgh, M.S.W. (New York). National Coordinators are: Walter Alvarez, M.S.W. (New York) and Irmgard Wessel, M.S.W. (Connecticut)

Papers must be submitted by Jan. 15, 1988. Specific date and location of conference is currently being determined.

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Membership Committee Report

It is our pleasure, dear friends and colleagues, to undertake the Membership Chair of this Federation National Membership Committee, as well as to contribute financially to sustain its purposes of existence. It is your vital presence as a member of this Federation National Membership Committee, and by contributing as substantial a sum as possible, that will enhance this Committee's visibility and functioning among other mental health groups such as Division 39 (Psychoanalysis) of the American Psychological Association and its section one (Psychologist-Psychoanalyst Practitioners). Combined annual dues for dual membership in these groups are currently 160 dollars. These dues are in addition to the general membership dues for the APA.

As you already know, organized psychiatry and psychology are in the process of defining who shall be eligible to practice psychoanalysis and psychotherapy. This is tantamount to legal regulations for those of us who are practicing psychoanalysis or psychoanalytic psychotherapy. It is most important that we organize ourselves to stand as an official body along with such organizations as the aforementioned Division 39, in formulating the eligibility requirements. IF WE DO NOT DO THIS OURSELVES, SOMEONE ELSE WILL DO IT FOR US!! All clinical social workers who are members of a state society in the NFSCSW are eligible for membership and urged to join.

We need to have a voice in negotiating national training and practice standards. Indeed, we need your voice - now - to join us in strengthening the credibility of our profession and our identity as individual clinical social worker practitioners in psychoanalytic psychotherapy and psychoanalysis. We look forward to your active participation with us.

Drs. Abraham and Carole Ring
Membership Chairpersons

Member Profiles

Dale R. Meers, D.S.W.

This special column is for the express purpose of continuing our efforts to network and highlight exceptional accomplishments and areas of expertise of our members. We would like to encourage our members to become acquainted with one another and will welcome all professional news about everyone of you. So take a moment to reflect and then describe: Academic and Professional Training; Professional Experiences; Specialty Interests/Goals; Society Activities; Awards and Distinctions. Remember, we want to hear from you! Please address your profiles, or those you think we should solicit, to: C. Ring, C.S.W., Psy. D. (Profiles), 1819 Avenue "K", Brooklyn, N.Y. 11230.

To lead off this new column on "Profiles," we are pleased to present Dale R. Meers, D.S.W., Fellow of the Greater Washington Society (D.C.), and much valued member of the Federation's National Membership Committee on Psychoanalysis. His high level of professionalism and dedication impressed us sufficiently that we have asked him to abandon some measure of his professional anonymity.

Dale earned his M.S.W. from the University of Minnesota, and his D.S.W. from the Catholic University of America. His other professional training included: four years of child psychoanalysis at Anna Freud's Hampstead Clinic where he was both a candidate and a research assistant (with Principle Investigators: Drs. A. Freud, J. Sandler and H. Nagera), followed by eight more years in adult psychoanalysis with the Baltimore-District of Columbia Institute for Psychoanalysis.

In addition to his private practice and teaching commitments, Dale has authored some twenty papers in addition to book reviews and panel reports appearing in The Psychoanalytic Quar-

Membership Application

COMMITTEE ON PSYCHOANALYSIS

Name _____

Address *(City, State, Zip)* _____

Highest Degree _____

University _____ State Society Membership _____

License or Cert. No. _____ State _____

☐ I would like to be a member of the committee

☐ I wish to contribute: ☐ 200 ☐ 100 ☐ 50 ☐ 25 ☐_____

(CONTRIBUTIONS ARE TAX DEDUCTIBLE FOR MEMBERS OF THE PROFESSION. Checks should be made payable to The National Federation Of Societies For Clinical Social Work, Inc.)

I WOULD BE INTERESTED IN WORKING ON:

A. National Standards _____

B. National Conferences _____

C. Legislation _____

D. Public Relations _____

E. Other

Please return to: CRAYTON E. ROWE, JR., M.S.W.
230 West End Avenue, Apt. 1D, New York, N.Y. 10023

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terly, The Psychoanalytic Study of the Child, The Annual of Psychoanalysis, the Social Service Review, and the Journal of The American Psychoanalytic Association. Dale's best known papers concern differential diagnosis of traumatized children, particularly those of the ghetto, and technical management of therapy. He is presently a consulting editor for the Journals of Preventive Psychiatry, Psychoanalytic Inquiry, and Child and Adolescent Social Work.

As a member of the Baltimore-District of Columbia Institute for Psychoanalysis, Dale has been a Teaching Analyst since 1973; he chaired their Research Committee (on Differential Diagnosis) from 1973-78; he was Director (1978-81) of the Washington, D.C. branch and President of the Consultation and Treatment Services of the Baltimore-D.C. Institute for Psychoanalysis, Inc. A member of the American Child Psychoanalytic Association from its founding, Dale was Chairman of the By-Laws Committee (1975-79) and a Councilor (member of the Executive Board 1978-82).

As for his teaching interests: Dale lectured, on his return to the U.S. from London, on ego psychology at the Graduate School of Social Work at the Catholic University of America (Washington, D.C.) and on child development (for some fifteen years) with the Baltimore-D.C. Institute for Psychoanalysis — but he most enjoyed his teaching child psychoanalytic technical management seminars and the Institute's advanced course on ego psychology. Other than that faculty appointment, Dale was first a Clinical Instructor and then an Assistant Professor in Pediatric Psychiatry at George Washington University — a title that went with his other faculty appointment at Children's Hospital, National Medical Center where he continues as a supervisor of psychiatric residents.

Political and social action are sometimes the unanticipated consequences of research, and Dale's research and presentation to (then) Senator Mondale's sub-committee contributed to the protective standards built in to Congressional day care legislation. We cite for your interest his Psychiatric Ombudsman for Day Care (in) the Joint Hearings of the Subcommittee on Employment, Manpower, and Poverty of the Committee on Labor and Public Welfare of the 92nd Congress.

Dale has been the recipient of many awards and honors: he was given a Research and Travel Award to study East European Adaptations of the USSR's Technical Innovations in Early Child Care by the Edgar Stern Family Fund and the Department of Psychiatry of Children's Hospital. Subsequently, Dale was the principle investigator and recipient of a U.S. Public Health Service, U.S.-U.S.S.R. scientific exchange grant to directly review Soviet child care programs in Moscow, Leningrad and Reiga. More recently, Dale had been acknowledged as a Distinguished Practitioner and Member of the National Academies of Practice.

In sum, we are very pleased and proud of Dale's tangible research and leadership contributions as well as those he would emphasize that interrelate clinical social work and psychoanalysis. We look forward to the richness of his further endeavors, and to his continued energetic presence as a valued friend, colleague, and member of our Federation's National Membership Committee on Psychoanalysis.

In conjunction with this profile, we are publishing, with minor editorial license, a letter Dr. Meers sent to the Maryland Board of Social Work Examiners. This letter refers to a major issue confronting our profession as to who shall be eligible to practice psychoanalytic psychotherapy/psychoanalysis. In his letter, Dale attempts to anticipate our licensing issues of the immediate future:

Dear Mr. Seymour:

There is a separate matter that may eventually concern the Board that I would like to call to your attention. I assume that you/the Board is aware that the National Federation of Societies for Clinical Social Work has recently authorized the formation of a Committee on Psychoanalysis. I would also assume that the Board is familiar with the unconfirmable contention that there are more social workers than psychologists or psychiatrists currently practicing psychoanalytic methods of psychotherapy. In this context, I would add that two weeks ago an attorney with the Justice Department called me and inquired at length concerning anything I might know that would bear on the psychologist's "restraint of trade" suit against both the American Psychoanalytic Association and the International Association for Psychoanalysis.

The American Psychoanalytic Association and the Academy for Psychoanalysis identify their membership requirements as medical and psychiatric. Their psychiatrist members are trained in the methods of psychoanalysis. Where credential exceptions have been made, as is true of me, non-psychiatrist members of the American Psychoanalytic Association continue to be identified by their academic credentials. That is, I, among others, am a social worker whose formal training led to Psychoanalytic Board Certification. Clinical social workers, not unlike their psychiatric and psychologist colleagues, are trained in and practice a disparate range of therapies, including behavior modification, dynamic psychotherapy and psychoanalysis.

The recent decision of the American Psychoanalytic Association to formally open training to non-psychiatrists is probably a response to the pending court suit on restraint of trade. More significantly, it is also an implicit acknowledgment of a nationally prestigious institution that clinically qualified non-physicians/psychiatrists are appropriately trained to practice psychotherapy/psychoanalysis. The political ramifications of the American Psychoanalytic Association's decision could be

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During the past several years there has been a growing concern within the National Federation over the attempts by psychiatry to exclude non-physicians from psychoanalytic training and practice. It was that concern which gave rise to the formation of the National Federation's National Membership Committee on Psychoanalysis, as a way of providing additional visibility, credibility, and force to the National Federation's efforts to protect the right of clinical social workers to be trained and to practice psychoanalytic psychotherapy and psychoanalysis.

In this column I would like to share with you some of the ways in which the National Federation, and its Washington Representative, have been engaged in the effort to protect psychoanalysis as a subspecialty for clinical social workers.

Several years ago we learned about a group that was seeking federal recognition as the official accrediting body for psychoanalytic institutes throughout the country. Had they succeeded, they would have had the power to establish accreditation requirements including course contents, credentials of instructors, and credentials of applicants for training. The National Federation joined a number of other groups in successfully opposing recognition of this accrediting group, on the ground that they did not reflect the full community of interests affected by the process of accrediting psychoanalytic institutes.

More recently we have been involved in making sure that the aggressive, well-funded efforts of organized psychology to gain equal access to psychoanalytic training and practice do not result in exclusion of clinical social workers. At one time there was a series of meetings between the American Psychological Association, the American Psychiatric Association, the American Psychoanalytic Association, and The American Academy of Psychoanalysis, to discuss the possibility of joint development of standards for psychoanalytic training. We persisted in reminding those groups that clinical social workers had a role to play as well in that process, that any effort to exclude clinical social work from the field would be vigorously attacked. Ultimately their efforts failed, and psychology ended up filing a class action antitrust lawsuit against the American Psychoanalytic Association, the International Psycho-Analytic Association, and two affiliated institutes, claiming that they are engaged in an unlawful effort to exclude competition by excluding qualified psychologists from institute training. We have followed that suit closely, and have maintained close contact with the lawyers for the plaintiffs who assure us their desire and intention is not to gain access for psychologists and then exclude other qualified disciplines, but rather to open up psychoanalytic training and practice to all qualified individuals regardless of discipline. Recent settlement negotiations failed to produce a resolution, and the lawsuit continues toward trial. We have offered to assist the plaintiffs with testimony from clinical social workers about the importance of access to good psychoanalytic training in order to compete successfully with psychiatrists in the practice of psychoanalytic psychotherapy and psychoanalysis and about the difficulty (especially outside New York City) of obtaining equal access to good psychoanalytic training if one is not a physician.

Finally, we routinely monitor the Congressional Record and the Federal Register for any federal government activity, by Congress or the executive branch, which impacts on the right of clinical social workers to equal access to psychoanalytic training and practice.

In all of our areas of activity — with Congress, with federal government agencies and departments, with third party payers, and with the other professions — our ability to have impact is significantly affected by the number and caliber of psychotherapists we are perceived as representing. In that respect, the activities of the Committee on Psychoanalysis are significant — they provide concrete evidence of the large number of highly qualified clinical social workers who are engaged in psychoanalytic practice and whose patients will be disserved if psychoanalytic training and practice is allowed to become the exclusive province of psychiatry or any single professional discipline.

Ken Adams
Advocate

THE COMMITTEE ON PSYCHOANALYSIS was formed as a standing committee of The National Federation Of Societies For Clinical Social Work in May, 1980, in response to the need for a national advocacy group for clinical social workers who practice psychoanalysis and psychoanalytic psychotherapy. While clinical social workers are a major provider group of psychoanalysis and psychoanalytic psychotherapy in the nation, they have been forced to look to psychology and medicine for standard setting and their clinical identity as psychoanalytic practitioners. The Board of the National Federation voted in October, 1985, to expand the scope of the Committee to organize all interested individual members of State Societies of Clinical Social Work to join the Committee directly and make membership contributions to be used exclusively by the Committee for its work.

International Psycho-Analytical Association Proposes Bylaws Change

The IPA will vote on a proposed bylaw change at the IPA Congress in Montreal in July, 1987. If passed, it will go for ratification in the fall by mail ballot to the whole IPA membership. The change will alter the relationship with the American Psychoanalytic Association and will allow psychoanalytic institutes in the United States not affiliated with the American to apply for affiliation with the IPA. Institutes applying for affiliation are subject to the policies and procedures of the IPA for the establishment of new training centers. We will provide you with further information in subsequent newsletters.

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workers. The National Association for the Advancement of Psychoanalysis, primarily a nonmedical organization, petitioned H.E.W. as the accrediting body for psychoanalytic training. This petition would have clearly established a separate profession of psychoanalysis and psychoanalytic psychotherapy. It met strong opposition from the American Psychoanalytic Association, The American Academy of Psychoanalysis, and Division 39 (Psychoanalysis) of the American Psychological Association. All were opposed to N.A.A.P.'s separate profession concept. These organizations testified that psychoanalytic training should be limited to those who first received an M.D. or Ph.D. degree. At this hearing the New York State Society of Clinical Social Work Psychotherapists and The Coalition of Social Work Psychoanalysts, a newly formed national organization, along with a number of other organizations, disagreed and supported N.A.A.P. in their position. Limiting psychoanalytic training to those who first acquire a doctoral degree already had been enacted 2 years before (1978) into California state law governing research psychoanalysts. This law in effect excluded all social workers with an M.S.W. degree from qualifying under this regulation.

It is clear that on both a state and a national level clinical social workers have allowed other organizations and mental health professions to exert uncontested control over all aspects of their psychoanalytic training. This condition prevailed though clinical social workers, judging by the New York area survey, composed a major body of psychoanalytic students as well as providers of psychoanalytic treatment.

This failure of clinical social workers to insist on having a voice in their psychoanalytic training and practice prompted the formation by the National Federation of Societies for Clinical Social Work and the New York State Society of Clinical Social Work Psychotherapists of Committees on Psychoanalysis. These committees, organized in 1980, were the first such committees formed by any national or state social work organization.

Concept of Psychoanalytic Training

The term "psychoanalytic" is used here to describe mental phenomena and a method of treatment based on the assumption of an unconscious in mental life (Fenichel, 1945). Guidelines for psychoanalytic training presented here are only for training in psychoanalysis and, while applicable for training in psychoanalytic psychotherapy, do not necessarily apply. It has long been recognized that clinical social workers have been the major providers of psychoanalytic psychotherapy and have received training through various routes. It is not the purpose of this position paper to qualify or disqualify any clinical social worker from the practice of psychoanalysis or psychoanalytic psychotherapy or to make any value judgment as to relative effectiveness.

It is the position of this paper that the clinical social worker who holds the M.S.W. degree should be eligible to receive advanced psychoanalytic training whether in psychoanalytic psychotherapy or in psychoanalysis in any free-standing institute or within any university system.

Psychoanalysis is viewed here as a therapeutic method which aims at the revival and resolution of the deepest layers of infantile conflicts and correction of structural deficits. It is broadly differentiated from psychoanalytic psychotherapy by the depth of the revival of unconscious core infantile pathology. Thematic to all psychoanalytic thinking is the making of unconscious phenomena conscious by means of the transference. It is important that training in psychoanalysis include personal analysis so that potentially interfering unconscious responses (countertransference), exacerbated by the patient's transferences, can be explored and resolved. A minimum of 450 hours with three individual sessions per week is recommended to insure the intensity of the experience of psychoanalysis.

A second major area of training should include control supervision with at least two analytic cases for a minimum of 1 year with different control supervisors.

The basic curriculum should include, but not be limited to, the following general areas:

1. Basic Psychoanalytic Theory: This should cover basic literature as well as developments in contemporary psychoanalysis. Some of the areas of focus would be theory of the unconscious and consciousness, development of the ego, object relations, and narcissism. The study of Freud's metapsychological formulations as well as more contemporary theory would be included.

2. Psychoanalytic Development. This should cover normal psychosexual and psychosocial development, development of the ego, and object relations.

3. Psychoanalytic Theory of Pathology. This should focus on the various disorders, including neuroses, psychoses, character disorders, the borderline personality, and the narcissistic personality. This sequence should include course work to provide the student expertise in distinguishing organic pathology from the functional.

4. Dreams, Fantasy, and Symbolism. This should include the study of the process of fantasy formation, primary and secondary processes, application of instinct and structural theory, and the application of transference phenomena in fantasy formation.

5. Technique of Psychoanalysis. This should include the study of transference and countertransference phenomena, resistance and defense, development of alliances and the proper uses of psychoanalytic interventions.

6. Continuous Case Seminars. Here the application of basic principles of technique can be studied for the purpose of synthesizing theory with practice.

7. Advanced Case Seminars. These would afford the student the opportunity to study the more difficult patient and the use of various parameters of treatment.

This position paper recognizes equivalency for all guidelines presented here for training in psychoanalysis. Equivalency recommendations will be determined by the Committee on Psychoanalysis.

REFERENCES

Fenichel, O. (1945) *The psychoanalytic theory of neurosis.* New York; W.W. Norton.

Rowe, C. (1975). Report of an evaluation of advanced training institutes and programs by members of the New York State Society of Clinical Social Workers, Newsletter for the New York State Society of Clinical Social Workers (also abstracted in "News of the Societies, New York State Society"). *Clinical Social Work Journal, 3,* 230-231).

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*This paper was approved by the National Board of Directors of the National Federation of Societies for Clinical Social Work as a national position paper in May 13, 1983. It was written by the Committee on Psychoanalysis of the New York State Society of Clinical Social Work Psychotherapists and approved by their Board of Directors on December 5, 1981. Published in the Clinical Social Work Journal, Vol. 12, No. 1, Spring 1984.

HERBERT S. STREAN, D.S.W.

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For over a quarter of a century I have been very much involved in trying to bring the findings of psychoanalysis to social work, and trying to bring some of the findings of social work to psychoanalysis. This is why I have consistently supported the idea of a psychoanalytic section in the National Federation of Societies for Clinical Social Work. Bravo to Crayton Rowe and to all my other colleagues and friends who have been instrumental in creating this important wing of the National Federation!

Clinical Social Work is barren unless it can incorporate notions like transference, countertransference, resistance, psychosexual development, id, ego and superego, to name just a few psychoanalytic concepts. By the same token, psychoanalysts all too often are insufficiently sensitive to their clients' and patients' social situations. For example, social workers know that it is ridiculous to ask a starving man or woman to free associate and they know it is equally absurd to ask a juvenile delinquent to quickly explore his transference reactions to the probation officer.

The following article, republished from Current Issues in Psychoanalytic Practice, is an attempt to help psychoanalysts become more sensitive to social issues — something that is part of the very web of social work practice and social work theory.

The Psychoanalyst: An Agent of Social Change

Herbert S. Strean

Most psychoanalysts do not enjoy a good public image. If the average layman is asked to describe an analyst, he usually has in mind an older eccentric man with a beard who says very little while he relaxes in his Park Avenue office with wealthy neurotics who indulge themselves several times a week talking about daydreams, fantasies, memories, and other trivia. In the mind of the layman, this eccentric old man is obsessed with sexuality, preoccupied with death wishes, and over-concerned with such matters as oedipal conflicts, latent homosexuality, sadism, masochism, incest, anality, and orality. Seeing just a handful of neurotics during his regular work-week, the modal analyst appears to be uninterested in bettering society and seems oblivious to such social problems as poverty, civil injustice, racism, discrimination against women, and nuclear explosions. This bearded "meshugeneh" (crazy one) ascribes most, if not all, of women's problems to penis envy, is convinced that the major etiological factor in men's neuroses is their wish to kill their fathers and fornicate with their mothers, and he never seems to recognize the importance of a patient's reality. Dr. Meshugeneh, according to the typical layman, gives his patients subjective, idiosyncratic,and biased interpretations to life-events and most of the time he is dead-wrong. He never seems to realize that a cigar can be a cigar. And, this selfish character keeps people in treatment for years, makes a fortune off them, and spends his patients' hard-earned money on his long and many vacations.

In effect, the modal psychoanalyst is often portrayed as a rich capitalist who is inhumane, egocentric, unscientific, and who cares little about people and their problems, but cares a great deal about himself and his own luxuries. If he were to be given a diagnostic label the modal analyst would be called a narcissistic character disorder with borderline features whose prognosis is guarded.

There is probably at least a grain of truth to every stereotype, including the one of psychoanalyst. However, it is the thesis of this paper that the analyst is demeaned and derogated not only because he understands the unconscious, something which frightens many people, and not only because many men and women are threatened by psychoanalysis' finding concerning sex, aggression, psychosexual development, transference, resistance, etc., but also because few psychoanalysts appreciate how much they are changing society, and how much potential they have within themselves to do more.

Recently I participated on a panel of social scientists who discoursed on the subject of vocations. While my colleagues disagreed on many issues, they all concurred that psychoanalysis is an elitist profession that deals almost exclusively with the rich and in no way improves social conditions. During this discussion, which emerged into a fiery debate, I was challenged to demonstrate how my clinical work, in even the remotest way, helped better society. For reasons that were not and still are not within my consciousness, I was able to respond to my adversaries in a way which had the effect of partially reducing their hostility toward psychoanalysis and of partially pleasing me.

What occurred to me in the discussion is the tremendously positive impact helping one patient through psychoanalytic psychotherapy can have on dozens, and sometimes on hundreds of individuals. Let me give a few examples from my own practice:

Dr. A., a forty-two year-old college professor sought treatment because he was in an acute depression. He was very irritable with his wife, uninterested in sex with her, and constantly fantasizing a divorce. He felt distant from his three children, and

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found himself spending a lot of time in dejected solitude.

At work, Dr. A. was very insensitive to his students' educational needs, often criticized them unfairly, and had little compassion for them. His contempt for his peers masked a thinly veiled veneer covering his acute jealousy. Frequently, he engaged in intense arguments with colleagues and students but these fracases inevitably ended up with Dr. A. feeling guilty, depressed, withdrawn, and nothing constructive emerging from the arguments.

After three years of three times a week psychoanalytically oriented psychotherapy, during which Dr. A. was able to get in touch with acute oedipal conflicts, repressed homosexuality, and death wishes toward parents and siblings, he felt much better. As he analyzed his various transference reactions, his work and love relationships improved considerably. He began to enjoy his wife much more and she described herself as feeling like "a new woman." Dr. A.'s children noticed the difference in his behavior and for one Father's Day bought him a gift accompanied with a card saying, "To Daddy, whose smile always makes us feel good." His students' evaluations of him became very positive, he was elected to several important committees at his college, and he began to write scholarly papers for scientific journals.

If we consider the impact of Dr. A.'s treatment on his wife, children, students, and colleagues, we can certainly conclude that his therapy had a distinct social benefit. We should also point out that the positive feelings that Dr. A. induced in his family members, colleagues, and students probably benefitted many other individuals who were part of their social orbits.

Mrs. B., was a thirty-two-year-old divorced woman and the mother of two daughters. She sought treatment because she found herself in power-struggles with her daughters, was in a continual vendetta with her ex-husband, was unresponsive to and argumentative with men, and found it difficult to relate warmly to her customers at the retail clothing store where she worked.

Because of her limited income, I saw Mrs. B. for a reduced fee in three times a week analysis. After five years of treatment, she stopped fighting with her ex-husband, enjoyed her daughters, derived pleasure from her sexual and interpersonal contacts with men, and changed her job from a sales clerk to a kindergarten teacher. As a teacher she felt she was being "constructive," "creative" and "loving."

One of the major issues in Mrs. B.'s treatment was her strong competition with men. As she could better understand her wish to castrate her therapist and as she could reduce her self-hatred and improve her identity as a woman, her relationships with men began to improve tremendously.

Mrs. B.'s therapy had a positive impact on her daughters, on the men in her life, and on the many children she saw daily in her teaching. The youngters she taught probably brought some joy into their parents' lives when they became aware of their children's pleasure in learning. This was also true for her daughters and the men in her life, whose happiness, in all probability, brought pleasure to others.

Mr. C. was a twenty-six-year-old man who sought treatment because he was jilted while intensively involved in a homosexual affair. Depressed and despondent, Mr. C,. could hardly work, sleep or eat. His condition upset his family and friends, and partially because of his condition, Mr. C.'s mother's alcoholism became worse.

In therapy, Mr. C. talked about his sado-masochistic orgies with other homosexual men, his extreme belligerence on jobs, his pleasure in anti-social and criminal activities such as theft and arson, and his pervasive and continual hatred. After two and a half years of twice a week therapy, Mr. C. gave up his homosexuality and moved toward women. He learned in his therapy that he was carrying out an intense, but futile, battle with his father. As he studied his relationships with his parents and with me in the treatment situation, he could stop virtually all of his criminal activities.

In evaluating the treatment of Mr. C., its results had a very positive social effect in that many people were spared anguish and deprivation when his criminal, anti-social, sadistic activities ceased. Also, his friends and family became less agitated as he felt better and functioned more effectively.

Ms. D., a forty-five-year-old social work administrator, sought treatment because the many workers under her filed a petition advocating she resign. Her subordinates resented her persistent and consistent hostility, her constant contempt, and her cold, accusatory demeanor. The board of directors of the agency where she worked made a deal with her. If she agreed to go into psychotherapy, they would keep her on the job another six months and then reevaluate the situation.

Eager to keep her job though humiliated about entering treatment, Ms. D. found therapy very difficult. For many months she experienced me as a "pompous ass" who wanted to "control" her and to "look down" at her. I reminded her of her older brother who was the favorite in her family and she hated both of us for our "smug, holier than thou" attitude.

As Ms. D. became aware of the fact that she was treating her subordinates at work the same way she was treated in her home, and as she could begin to master some of the rage she felt toward family members, her attitude toward her colleagues, clients, friends, and family improved a great deal.

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She became more loving and more supportive. As a result, dozens of individuals had their lives enhanced by the positive results of Ms. D.'s therapy.

In the examples above, all of the patients moved closer to "the analytic ideal" (Fine, 1982). They all became more loving, more communicative, less hateful, more sexual, and could take more positive and constructive roles in their families and in society. Of tremendous import, as a result of their therapy all of the patients discussed above made life a lot more pleasant for hundreds of individuals in their social orbits.

Inasmuch as we have described the social change that can transpire when only four cases of one analyst are briefly reviewed, it would appear very probable that if every psychoanalyst in the United States and in Canada went through his caseloads, he would discover that the amount of social good that evolves from clinical work would be enormous. We can further speculate that as a result of succcessful psychoanalytic treatment, not only are hundreds of thousands of patients leading more constructive, more creative, and more loving lives, but the results of their treatment are probably enhancing millions of people in countless numbers of ways. Think of the many spouses, parents, teachers, therapists, physicians, administrators, writers, artists, and politicians who have benefitted from psychoanalytic treatment. Then, think of the hundreds of thousands of individuals who have had their lives enhanced because of the positive and constructive effects achieved by psychoanalytic treatment of these spouses, parents, teachers, therapists, etc.

Yet, the number of people in psychoanalytic treatment still remains a small minority of the population and the number of people affected by its positive results is also only a small percentage of the population. How can more people become the beneficiaries of good psychoanalytic treatment?

INCREASING THE NUMBER OF TREATMENT CENTERS

One of the simple truths about our society is that most people have serious neurotic problems. Study after study demonstrates that emotional disturbance is very high but most people deny and rationalize their emotional difficulties. T. Rennie (1962) and his co-workers, in their epoch-making Mid-Manhattan Study found that about 80 per cent of the American population are emotionally disturbed and 25 per cent markedly so. In other cultures the percentage of disturbance is probably higher (Leighton, 1963).

Although there is ample proof that marital stress, childhood pathology and teen-age homicide and suicide are at an all time high (Hendin, 1975), psychoanalysts and other therapists have been remiss in bringing these facts to the public's attention. Insufficient numbers of people in our society recognize that psychoanalytic psychotherapy should be viewed as similar to an education, i.e., a necessary prerequisite for a life on earth that will be constructive, creative, loving, sexual, pleasureful, and devoid of neurotic and psychosomatic symptoms. Most people, in order to love and to work comfortably and enjoyably, need psychoanalytic therapy. Without it their hatred is excessive, their pleasure is limited, their capacity to achieve is hampered, and their ability to engage in warm, intimate, committed relationships is weakened.

Resistances to the aforementioned statements are powerful and many, particularly from those in strong need of psychotherapeutic assistance. Most clinicians concur that those who knock psychoanalysis the most and the loudest, are those who need psychotherapy the most. Yet, despite the irrational hatred of and powerful resistance toward psychoanalysis, whenever psychoanalytic societies and psychoanalytic institutes have started low-paying clinics, these clinics have become busy quickly and also have been successful in helping people (Reissman, 1964; Homick, 1974). Clinicians at these facilities have been able to demonstrate that schizophrenics can be successfully treated through the psychoanalytic method (Meltzoff and Komreich, 1970; Fine, 1981), that in most instances the poor are responsive to psychoanalytic therapy (Strean, 1978) and that if the therapist is not ambivalent about what he is doing, psychoanalytic therapy is probably the best treatment on the market today (Brenner, 1955; Fine, 1982; Fenichel, 1945).

One of the very serious problems existing in most mental health clinics and in most social agencies is that psychotherapy is not sufficiently valued by those who administer it and by those who practice it. In what we have referred to elsewhere as "The Flight from the Client" (Strean, 1978) we have shown that in most clinics and agencies when a therapist does good work with patients or clients he is rewarded by being removed from practice and made a supervisor or an administrator. This demeaning of practice is most acute in the social work profession where clients who have the most severe emotional problems receive the least expertise help and where educators who know the most about practice (field work instructors) have the least status. Yet, it has been our observation that when a psychoanalyst is on the staff of a clinic or a social agency as a consultant, supervisor or administrator, the practitioners usually identify with the analyst, the status of practice becomes elevated, and more clients and patients are helped.

It would appear that psychoanalysts can be more successful social change agents if they made sure that psychoanalytic societies and psychoanalytic institutes have clinics that treat not only verbal, introspective neurotics, but engage in projects that stimulate psychotherapy with the poor and promote psychotherapy with schizophrenics. In addition, psychoanalytic societies should form liaisons with family agencies, welfare departments, child guidance clinics and mental health centers so

that psychoanalytic knowledge and psychoanalytic expertise can enhance practice by helping more practitioners to understand and utilize such notions as transference, countertransference, resistance, infantile sexuality. All too often clients and patients are not helped because they are forced to submit to short-term therapy and other treatments which ignore their histories, their unconscious wishes, their superego demands, their transference reactions. (Strean, 1982)

APPLYING PSYCHOANALYSIS TO OTHER FIELDS

As already implied, although psychoanalysts know a great deal about what is necessary to achieve the good life, they have been slow to transmit their knowledge to the general public. From the work of such writers as H. Hartmann (1964), Anna Freud (1965), and E. Erikson (1950) psychoanalysts can prescribe with confidence what children need in order to grow and to mature. We can proclaim to the world that, without doubt, infants need the consistency, warmth, and empathy from a full-time need-gratifying mother, and that failing this, the child may become depressed, can even die. We know that children also grow and develop the best when they have two parents who love and respect each other and can work cooperatively on their behalfs (Neubauer, 1960), (Strean, 1982).

Psychoanalysts have been able to demonstrate that all human beings need to love and be loved and that love without sex is incomplete and ungratifying (Fine, 1981). Psychoanalysts have been able to expose some of the reasons why marriages fail; spouses expect too much of each other; they make each other parental figures and then sex becomes anxiety-provoking; they have weak capacities to tolerate the frustration which occurs even in a successful marriage, and they have unresolved problems with homosexuality, to name just a few variables that interfere with smooth marriages (Strean, 1983)

In this *Journal**, articles have demonstrated how the psychoanalyst and psychoanalytic knowledge can enhance the classroom of elementary school youngsters (Condit, 1984), how it can help us understand the criminal mind (Freeman, 1984) and how it can liberate the creative process (Lane and Storch, 1984; Fine, 1984; Harrison, 1984). Although psychoanalysts have contributed a great deal toward understanding political processes and political behavior (Bromberg and Small, 1983; DeMause, 1984) they have not been outspoken regarding political events that conflict with psychoanalytic findings. Few psychoanalysts spoke out against the Gay Liberation Movement when it paid off the American Medical Association (Socarides, 1974) to distort the enormous amount of clinical evidence available showing that homosexual men and women have a lot of unmastered hatred and fear and need treatment. Only a handful of psychoanalysts have repudiated the actions of the Ronald Reagan administration even though most analysts are interested in enhancing the lives of the poor, the aged, the mentally ill, and the handicapped. Why did so many psychoanalysts around the world stand silent as the Soviet Union punished political dissidents by throwing them into mental hospitals? Why haven't more analysts spoken out against nuclear weapons?

In sum, psychoanalysts should view themselves as social change agents. Their therapeutic work with individuals does help hundreds of thousands in profound ways, but they also can and should lend their expertise to clinics, classrooms, the work situation, and other sectors of living more often and more intensely. As analysts view themselves as an indispensable part of society, by the year 2000 not only will we have sent a man or woman to the moon but it will be a requirement for every senator and congressman to be psychoanalyzed.

**Current Isssues in Psychoanalytic Practice*

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ED NOTE: In this first issue of the Newsletter of the Committee on Psychoanalysis and in subsequent issues, we will be bringing our membership information concerning the clinical social workers who practice psychoanalytic psychotherapy and psychoanalysis.

The Newsletter is also an important vehicle for members, nationwide. We invite members to send information concerning their professional activities to the Editorial Office.

Member Profiles ... *continued from page 3*

extended and complicated. I am all too aware of the profound resistance of institutional psychiatry to accept that qualified social workers do, in fact, practice psychotherapy. Given the gratuitous and generalized contempt that psychiatry has more recently entertained for the practice of dynamic psychotherapy and psychoanalysis, it is only surprising to me that institutional psychiatry, the American Psychiatric Association, does not totally disclaim psychoanalysis and gladly abandon it to psychology and social work. But for the resistance of those psychiatrists in the American Psychiatric Association who are psychoanalysts, I suspect the APA would in fact be pleased to abandon the issue - except for the pragmatic consequences that are inherent in issues of control of psychotherapeutic practice.

Clinical social work does not need more enemies, and I have hopes that the newly formed Committee on Psychoanalysis might manage the professional and political contentiousness of psychiatry with clinical understanding and patient determination. These developments will surely have an impact on each and every state that licenses clinical social workers. My best friends are psychiatrists/psychoanalysts who are gifted and sensible when their narcissism is not threatened. Their training institutes are the best ever, and if professional sensitivity is maintained, social work training and practice of psychoanalysis may benefit markedly from allied psychiatric and psychoanalytic contributions.

Eventually, the licensing requirements of such an evolution in social work training and practice will be laid at your door. Before then, it is more likely that you will hear political waves of protest from psychiatry.

With best regards.

Dr. Dale R. Meers

In essence, we agree with Dr. Meer's constructive approach, which anticipates how our National Membership Committee on Psychoanalysis may negotiate with organized psychiatry on the one hand, and organized social work on the other; and thus, bring about a political-professional integration of clinical social work and psychoanalytic psychotherapy/psychoanalysis.

Drs. Abraham and Carole Ring