National Membership Committee on Psychoanalysis in Clinical Social Work, Inc.

Affiliated with The Clinical Social Work Federation

Winter 2001

Social Work, Psychoanalysis, and "Kunta Kinte"

As readers of our newsletter are aware, our newly constituted Study Group had their first in-person meeting not long ago. As NMCOP president, I wanted to provide the group with some direction and a mandate. Toward this end I wrote them a letter that I wish to share in this newsletter's president's column.

An open letter to members of the NMCOP Study Group: Jerry Brandell, Ph.D., Chair

PRESIDENT'S MESSAGE

William S. Meyer, MSW, BCD

Dear Jerry and Study Group Members,

While I want to use this letter to welcome you into our newly reconstituted National Study Group, I also want to indelibly impress upon you the importance of your mandate. My fear is that I will not find the right words to impress upon you just how much I believe is riding on what you accomplish.

As I write this, my memories are fresh from a discussion that took place with various members of the NMCOP Atlanta Area Group, under the leadership of Ellanor Cullens, MSW. Barbara Berger, PhD, (NMCOP president-elect) and I had just co-presented a paper, "Object Relations Theory at Play in the Transference." During the question and answer period an especially bright social worker identified herself as a faculty member of a nearby school of social work. "I teach in a program where I am not allowed to use clinical terms," she said, "not even a word like 'ego'." A few gasps were heard in the room. I was immediately reminded of the unforgettable Kunta Kinte of Roots — the man who never wavered in knowing who he was even though he was not permitted to utter his real name.

I told this faculty member that she had a worthwhile, even interesting, challenge ahead of her. Yet, the problem she was facing was brought on, in part, by those of us who have taught psychoanalytic theory. I said that we bear some responsibility for the backlash against the contributions of psychoanalysis, because we have taken this rich, relevant, all-too-personal theory, and have too often taught it in language that was esoteric, remote and unnecessarily rigid. If, as I believe, students who grasp the basic tenets of psychoanalytic ideas will hunger to learn more when they become acquainted with its broad and personal

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Getting to Know the Study Group Members, Part II

The members of the NMCOP Study Group are an outstanding group composed of prodigious writers, academicians and professors in schools of social work, tireless presenters of lectures and workshops, and consultants at the regional and national levels. Some of them have editorial experience as contributing editors, and a few as editor of professional journals. All are characterized by a strong commitment to sharing their knowledge and making it available to others. It is an honor to describe them and their many achievements.

For three essays from Study Group members, see pages 8, 16 & 18

Jeffrey Applegate, PhD, is a professor of clinical social work theory and practice in the Graduate School of Social Work & Research, at Bryn Mawr College. He is also a consulting editor for *Child and Adolescent Social Work Journal,* and *Clinical Social Work Journal,* in addition to maintaining a private practice and supervision. Post masters training includes The Menninger Foundation Training Program in Psychiatric Social Work, and a three-year Training Program in Psychoanalytic Psychotherapy at Family Counseling & Guidance Centers, Inc., Boston, MA. One of his several honors and awards is the Christian R. and Mary F. Lindback Foundation Award for Distinguished Teaching (1999). Applegate is the co-author of two books — **The Facilitating Partnership: A Winnicottian Approach for Social Workers and Other Helping Professionals** (1995), and **Men as Caregivers to the Elderly: Understanding and Aiding Unrecognized Family Support** (1990), a variety of book chapters, articles and book reviews. His publications, presentations and workshops indicate a variety of interests concerning work with the elderly, men as caregivers, intersubjectivity, postmodernism, and neurobiology and affect regulation.

Judith Batchelor, PhD, received her doctorate from Smith College School for Social Work in 1998. Her dissertation examined the adaptation to separation and loss in institutionalized children and its psychological influence on them as adults. Batchelor, who lives in Sioux Falls, SD, is currently in private practice with individuals and couples, in addition to organization consultation and training for health care and social service institutions. Her knowledge on issues of urban trauma has led to consultation with diverse agencies such as the Baltimore, MD, State's Attorney Office to assist with development of post trauma assessment and clinical intervention services; development of an educational text and video on trauma and loss in children for a community mental health agency in Detroit, MI; State Bar of Michigan on the needs of families as surviving homicide victims, and a monthly seminar and debriefing of clinical staff for battered women and their children in Sioux Falls, SD. Batchelor has been an adjunct professor with the University of South Dakota School of Medicine, Medical Staff Associate for Sioux Valley Hospital & University Medical Center; and a field instructor/lecturer for several universities.

William Borden is a Senior Lecturer at the University of Chicago's Department of Psychiatry and the School of Social Service Administration. His master's and doctoral degrees are from the University of Chicago, and he is the author of the edited book, **Comparative Approaches in Brief Dynamic Psychotherapy**. Borden has also published many articles and book chapters on relational perspectives, the contributions of Winnicott and the British Independents, narrative perspectives in brief treatment, and empirical research on stress, coping and development in the life cycle. In addition to his current position, Borden has also served on the faculty on the Institute for Clinical Social Work, Chicago; the Illinois State Psychiatric Institute, and the Jane Addams College of Social Work at the University of Illinois, Chicago.

Dorcas D. Bowles attained her EdD in 1983 from the University of Mass (Amherst) in Mental Health Administration, and an MSW from Smith College School for Social Work. Bowles has rich academic administrative experience as a dean and professor for several schools of social work including the University of Texas (Arlington), Atlanta University (where she was also Interim President), and Acting Dean at Smith College School for Social Work (where she also held a variety of other

*See **Study Group**, page 12...*

from the Editor...

Donna Tarver, Editor

Thanks to all for your rave reviews about our new look!! So many readers took time out of their busy schedules to contact me with great feedback and encouragement. It is exciting to know that you are reading and enjoying "your" newsletter and as always all comments are appreciated.

The Newsletter welcomes readers' letters, articles and opinions on topics of the day, clinical issues, book reviews, notices or reports of conferences, and news of interest to our membership. The Newsletter encourages social workers that have an interest in writing to use the Newsletter as a vehicle for converting their interest into the writing process.

We had our annual in-person Board Meeting in Durham, North Carolina in January. This is always a very intense experience with all members working hard to contribute to reviewing the past year, making both long and short term goals, laboring over decisions about how to best serve the needs of our membership, and always deliberating at length about how to increase the membership of our organization. It also always generates excitement about the opportunities and possibilities that our organization offers each of us and gives us a chance to get to know each other better and develop working relationships. I always leave both tired and with renewed energy and enthusiasm for the year ahead. Bill and Gale Meyer and Terrie Baker were gracious hosts and made sure that we had a great time along with our work. We had the opportunity to meet and get to know Marilyn Schiff our new Area Representative from New York, and Anne Gearity our new Membership Chair from Minnesota. They both brought fresh ideas and energy to our work. Also in attendance were Barbara Berger, President Elect; Deborah Dale, Administrative Assistant; Dale Dingledine, Secretary; Ellie Muska, Area Representative at large; David Phillips, Past President; and the aforementioned Bill Meyer, President; and Terrie Baker, Treasurer. We were fortunate to be joined on Sunday by Joel Kanter who shared exciting plans for the upcoming **Mini-Conference** to be held at **Virginia Commonwealth University School of Social Work, Arlington (VA) Campus on Saturday, March 31, 2001, 9:00 am - 4:30 pm.**

In this issue we are again pleased to be able to feature articles by three of our new Study Group Members: Jerry Brandell, Study Group Chair; Ellen Ruderman; and Roberta Shechter. Dale Dingledine presents the second in a series of articles about the new study group. Diana Siskind again has brought us two outstanding Book Reviews. Monica Rawn has reviewed **The Power of the Inner Judge: Psychodynamic Treatment of the Severe Neuroses**, by Leon Wurmser, MD. Patsy Turrini has reviewed **Ours, Yours and Mine: Mutuality and the Emergence of the Separate Self**, a collection of articles by Anni Bergman, PhD, representing and updating her most significant work over the years of her research, clinical work, and writing.

Thanks to all contributors to this issue: Barbara Berger, Jerry Brandell, Dale Dingledine, Bill Meyer, Monica J. Rawn, Ellen Ruderman, Roberta Shechter, Patsy Turrini, and Diana Siskind. ■

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See page 22 for more information.

FROM THE PRESIDENT-ELECT

Barbara Berger, PhD

In my last column I referred to the importance of ways that associations create community for professionals like clinical social workers who do psychoanalytic work. Another venue of importance that not only pulls us together as a discipline, but also affords professional self esteem is the publication of journals. We can be proud of a number of publications which provide outstanding articles discussing, exploring, and exemplifying issues of psychoanalytic relevance with a clinical social work underpinning. The *Clinical Social Work Journal,* edited by Carolyn Saari, *Psychoanalytic Social Work,* edited by Jerry Brandell, *The Child and Adolescent Social Work Journal,* edited by Tom Kenemore, and *Smith College Studies in Social Work,* edited by Gerald Schamess, are examples of excellence. In Jerry Brandell's words these journals, "offer the best evidence that psychoanalytic ideas do, indeed, matter to social work clinicians. "Moreover, in a practice climate tainted by the pharmaceutical-psychiatric-managed care complex, it becomes ever more important for psychoanalytic social work clinicians to raise their voices. Our scholarly journals "can afford us such opportunities and I believe it is through these venues that our future will depend."

The editorial boards of these journals are composed of a very dedicated group of top quality clinicians and academicians who believe strongly in the importance of their product. Carolyn Saari, Editor of the *Clinical Social Work Journal,* emphasizes the hard work to which she and the editorial board are committed in order to maintain a high degree of excellence. And, Dr. Saari adds, "If people are interested in working with people to develop papers, or if there are other concerns, there is an effort to help refine work for publication." In his dual role as both an editor and President of the Institute for Clinical Social Work, Dr. Kenemore underscores the need for the awareness not only of the importance of publication, but also the difficulties with which authors must contend. He says, "Creative and innovative developments are constantly being reported on, described and evaluated. Using professional journals to develop practice and research expertise involves a lot of work, not the least of which is making the leap from the knowledge presented to its application to practice."

Indeed, it becomes clear that while our professional journals are edited by an erudite group of respected professionals upon whom we rely for prestigious presentation of the outstanding thinking in our field, it is a situation of mutual dependence. Those editorial boards need the support of the members of the profession they represent. It is for us, the psychoanalytic social workers who do the work, who have the thoughts and ideas, to contribute in a scholarly form. It is only with our willingness to write and submit that these journals will flourish. It is if these journals continue to flourish, that they provide the psychoanalytic social work community a scholarly place among related disciplines. There is another way in which it is imperative that we support our professional publications. It is only with our willingness to subscribe and to read that our profession can share its extensive knowledge and experience with colleagues. As a community, these most outstanding journals afford us a place to exchange ideas with each other, and an opportunity to be represented as thoughtful, informed professionals. The chance to learn by reading and the opportunity to educate by writing, provided by professional journals, creates both a privilege and a responsibility. As members of the psychoanalytic social work community we must share a mutual commitment with the editors who stand ready to publish our theories, research, and case material. ■

Aims & Purposes of the NMCOP

- To further the understanding of psychoanalytic theory and practice within the profession of social work and to the public.
- To promote a unique and special identity for all social work professionals engaged in psychoanalytically informed practice.
- To work for equal recognition and professional parity for qualified psychoanalysts and psychoanalytic psychotherapists in social work with other mental health disciplines through education, legislation, and collaboration with other disciplines.
- To effect a liaison with other disciplines identifying themselves with the theory and practice of psychoanalysis.
- To advocate for the highest ethicalstandards of practice and for quality mental health care for all.

Membership Alert!

- As a result of our broad membership outreach, to all Federation members, we have increased our 2001 COP list by 119 members. Welcome... and we look forward to your company in our organization. You will be included in our directory and on our website.

- Renewal reminders are in the mail. Please remember: to be included in our directory, you must renew by March 31.

- Those who renewed early, in response to our brochure mailing: thanks!

- Please check our website: **www.nmcop.org** Members are listed with e-mail addresses. If you are not listed, please let me know and I will assure your inclusion. Quite amazing: by clicking on a member's name and address, you can immediately send an e-mail message.

- ***Please know:*** one of our membership benefits is access to discounted subscriptions to all of the journals published by Analytic Press, and JIPA. This information is available on our website, and in this newsletter. Once this subscription is initiated, the discount will continue yearly.

- Area representatives continue to meet, by phone, to discuss ways to assure access for members to other benefits from this organization. I am also open to ideas and comments, and look forward to talking to you.

- Anne Gearity,
Membership Chair

Area Representative's Corner

The Area Representatives are a little understood group of dynamic and dedicated people, some of whom have contributed years of service to the NMCOP. Not only does the general membership not have a good sense of the hard work these folks do in their individual regions, but, unfortunately, their collective relationship to the Board as a whole is also not understood. Believe it or not, despite the quarterly conference calls, which provide their main venue for meeting and connection, the area representatives themselves may not know what counterparts are doing in their own regions. But, these people are the tillers of the soil from which we grow — they are the people who make it happen. Because the Area Reps are so important in this organization, it seems imperative that the membership knows more about them and their roles in NMCOP.

The Area Reps, as a group, are the Advisory Board. In this capacity, the Executive Board looks to them for their collective wisdom and advice, their sense of the "state of the membership." Their individual connections within their own regions make them a great resource for knowledge about the ideas and concerns of each member, as well as the general needs of specific locations. There is such a broad spectrum of differing needs across the country, that the resourcefulness of each Area Rep is greatly challenged.

In the Seattle area, Betsey McConnell recently received a phone call from a member saying that it was the inspiration and support she provided as NMCOP Area Rep that encouraged her to write and publish her first paper. While Betsey has been successful in her work, Ellanor Cullens has been working to grow a new chapter that is only two years old. She began with two members, and now has 12 who attend programming as Ellanor has been able to arrange it. Using her own creative version of our Ambassador's Program, Ellanor has had Peg Frank, Dale Dingledine, Bill Meyer and Barbara Berger as speakers in a program series for Georgia. Ellen Ruderman has had a large Board with whom she has been working in Southern California for more than 10 years. Many projects and programs have made a growing and vibrant chapter in California. Ellen's Reflection Series, a series of presentations of papers presented at conferences, was especially successful.

The work done by these and other Area Representatives, whose work will be reported in upcoming columns, makes an admirable contribution to the psychoanalytic social work community and it is very greatly appreciated. I am hopeful that we will be able to communicate the depth and breadth of their contributions. In future newsletter articles, we will continue the introductions nationally — and celebrate together their great variety of accomplishments. ■

Ambassadors Program

If your area wishes to have a speaker, or if you wish to be a speaker (if you will be in an area where we have members and you are interested in presenting during your stay), please contact:

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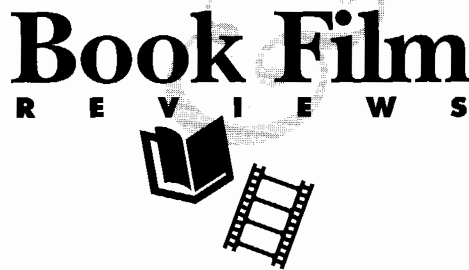


The Power of the Inner Judge: Psychodynamic Treatment of the Severe Neuroses

by Leon Wurmser, MD

Jason Aronson, Inc., 2000, 356 pages
Northvale, New Jersey

(Reviewed by Monica J. Rawn, CSW, BCD)

Leon Wurmser, our Distinguished Speaker at the NMCOP 2000 Conference, has long been a maverick in analyzing patients that the psychoanalytic establishment labeled unanalyzable. His research interests have included the psychodynamics of compulsive drug abusers and he has served on various government commissions, committees, and advisory boards concerned with addiction. He has received awards for his pioneering work in the field of mental health, anthropologic psychology and philosophy, and for outstanding teaching. He has written and co-authored several books and published 300 articles. Dr. Wurmser is multilingual, but not to worry — this work is in English!

In concluding this book, Dr. Wurmser makes a sweeping claim. He maintains he has contributed a theoretical reconceptualization "that gives a new understanding of pathology specific to severe neurosis" (p. 324). This is a tall order, considering the plethora of literature on the kind of pathology Wurmser describes — call it borderline, narcissistic, character disorder, or severe neuroses. What one can count on for sure is a systematic scholarly work, which synthesizes various psychoanalytic paradigms. It is informed and nuanced by Wurmser's familiarity with philosophy, mythology, literature, sociology, and biology. Wurmser's uncommon sense and unflinching staying power are clues to his forte in maintaining an alliance with his patients. He is masterful in taking on the challenge of their "inner judge." This is a "must read" — at least twice!

Wurmser offers twelve characteristics of "severe neuroses" that closely resembles standard descriptions of borderline disorder. His cases illustrate, among other things, frequent alterations of consciousness, chronic self-condemnation, and repetitive compulsive or addictive and often perverse behavior. However, he sees these patients as diverse and differentiated, not uniform, under the general rubric of "borderline." He would reserve a borderline diagnosis, not for a chronic characterological condition, but rather for a transitional state, one in relative proximity toward or away from psychosis. Wurmser faults current cliches and the traditional wisdom that take precipitous leaps from description to explanation in making diagnostic "indictments" of borderline pathology. He urges informed nonjudgmental assessment. Is Wurmser splitting hairs? Does the renaming to "severe neuroses" circumvent problems of unempathic, clinical and theoretical fuzziness, or is "a name by any other name...?" I think Wurmser does offer a very useful theoretical perspective, one which is not incongruous with others, such as the Novicks, Grossman, and Schengold. His treatment strategies are very well reasoned and deserve serious consideration. I will later comment further on this. Dr. Wurmser provides us with ample illustrations of his own work, invaluable to therapists on all levels of expertise.

Wurmser advances his own narratives to defenses that have become code associations to borderline and narcissistic pathology: splitting, denial, reversal, projective identification, repetition compulsion, and negative therapeutic reaction. He interprets these from a demystifying, humanistic, and experience-near perspective — a "kinder gentler" one that mitigates negative countertransference potential. I select repetition compulsion as an example, because it seems to be the focal organizer of Wurmser's clinical assessments and treatment protocol. This is what he says:

"Certain dilemmas, sequences, and equations kept emerging that had been present in the therapeutic work, yet which I had not been aware of with such clarity nor had known from the literature. Eventually, it was the power and importance of the 'repetition compulsion' that proved a kind of red thread through everything — but as a problem, not as answer." (p. 19)

As he sees it, repetition compulsion "consists in the avoidance of anxiety and in the quest for protection, namely in a series of compulsively succeeding feelings, actions, and interactions — a vicious circle of succeeding compromise formations" (p. 173). In the patient's struggle with opposing and competing intrastructural schisms of identification and ideations, he feels compelled to engage in (ultimately futile) repetitive sequences of behavior intended to regulate the intensity of intolerable global affects. Wurmser asserts that this behavior is not primary, not a derivative of instinctual drive. It is, rather, reactive to current derivatives of past trauma and adaptive efforts to

See Inner Judge on page 21...

Ours, Yours and Mine: Mutuality and the Emergence of the Separate Self

by Anni Bergman, PhD
in collaboration with Maria F. Fahey

Jason Aronson, Inc., 1999
Northvale, New Jersey, London

(Reviewed By Patsy Turrini, MSW, BCD)

Dr. Bergman and Dr. Fahey have written a valuable book. It contains 19 articles that were scattered in 11 different books, and in 7 different journals. Thus if one does not own each publication, one can miss these writings. This is one raison d'etre for collected papers of an author. Additionally, collected papers offer an immediate location to study an author's major efforts, and especially so in a collection like this that contains a good index and is updated with information from recent contributors.

I was very touched by Dr. Bergman's acknowledgments. She conveys such warm gratitude to her students, colleagues, mentors, supervisors, family, friends, and the parents of her child patients. It is a most enviable image of a warm inner circle. She ends her acknowledgments with an expression of gratitude to her analyst, Werner Nathan, "who was instrumental in my own psychological birth. I know he would be happy about this book." Her generosity of spirit in her acknowledgments is no doubt testament to her ability to appreciate the "other." And thus it is no surprise that she wrote a paper with Arnold Wilson, entitled, "Thoughts About the Stages on the Way to Empathy and the Capacity for Concern," located in Chapter 6 in this collection. This paper was published in 1984 in a book, entitled **Empathy II**, Analytic Press. One should not let the date fool you. The chapter is very up to date, and I wish I had known about it when I wrote a recent paper on guilt and caretaking. I think we need more sophisticated websites and data references for psychoanalysis that include the social work, and psychological journals, not in the mainstream databases. This chapter reviews the capacity of an infant and toddler to develop empathy, relating the acquired ability to the forces in ascendancy in the various separation-individuation phases. Dr. Bergman says, "the symbiotic phase and the period of early rapprochement are the periods in which the forerunners of empathy are most clearly distinguishable. By contrast, the practicing subphase, with its emphasis on mastery, autonomy, and narcissistic enhancement of the self, is a time at which there is a moratorium on the unfolding of the capacity for concern." Insights like the above are interspersed into the rich descriptions of the many other discoveries of the unfolding blue print of human dynamics. Another example of up to date material is located in Chapter 1, entitled *Separation-Individuation Theory and Ongoing Research.* This is an excellent review of much of the core findings from the research begun in 1959, but in addition, Dr. Bergman integrates Fonagy and Target (1996, p. 21). She includes Stern (1995, **Motherhood Constellation**). She welcomes a critique from Gergely (1997) who believes that well attached children do not suffer a rapprochement crisis, as she holds to her view that there is a rapprochement crisis that is resolved, and she suggests that the study of the rapprochement period with well attached children would be a fruitful area for future study. From my own view, I believe we do not yet have a complete picture of the multiple dynamics involved in the rapprochement experience, as well as the other developmental acquisitions and milestones, as for example, how much the individual toddler seriously experiences the recognition of smallness, vulnerability, the aloneness of self in the world, and the fall from invincibility during the rapprochement period. I once told Dr. Mahler I thought the wall of the child in rapprochement whose mother is leaving is the ubiquitous pain felt by adults at the death of a loved one. Dr. Mahler told me I was very smart, so I guess she agreed with me.

I think another reason this book is so welcome is that it brings us again into this important world of discoveries that can then prime us to investigate the variations of human affects, abilities, drives, longings, and basic needs. I have always found separation-individuation observations remarkably helpful to understanding the human condition.

The book is divided into two parts. The first section includes the two chapters mentioned above, and 10 other separate papers that include material on *The Use of Space: Ours, Yours and Mine,* that shows how a sense of how "mine" and "yours" grows out of an earlier sense of "ours" (p. xxix). *Speculations on Gender: Issue of Mother-daughter Interaction; Self-Other Action Play, a Window into the Representation World of the Infant.* The section ends with "three

See ***Ours, Yours and Mine*** *on page 14...*

Diana Siskind
BOOK REVIEW EDITOR

Focal Conflict Analysis: Teaching the 'Power of the Text'

Introduction[1]

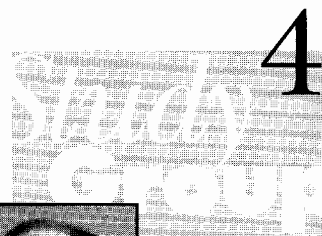
Psychoanalytically-oriented social work educators, clinicians, and researchers have long been interested in studying the treatment process or the transactions that occur between the clinician and patient during the clinical encounter. Perhaps the most obvious example of this is process recording, which historically held a prominent place in social work supervision and practicum instruction. It was not unusual for students to be required to prepare detailed process recordings on most if not all their clinical interviews, a time-consuming if not daunting proposition. Unfortunately, process recording has in many instances given way to other, less rigorous techniques of practicum instruction and supervision, such as the student's anecdotal summary or other kinds of more impressionistic observations on clinical process. Little more than a dozen years ago, I wrote confidently that process recording did "not seem to be in imminent danger of extinction" (Brandell, 1987, p. 300). That observation, of course, anticipated neither the continued erosion of the status of psychoanalytic thought in social work programs nor the corrosive influence of managed care on the practice and teaching of psychotherapy. Regrettable though this current situation may be, it does not alter the observations made a generation ago by Esther Urdang on the value of process recording for enhancing the acquisition of clinical skills. Process recording, Urdang wrote, aids in the development of the therapeutic dialogue; an awareness of interactional aspects of interviews; development and utilization of cognitive skills in clients; affective and latent aspects of communication; and development of diagnostic and treatment-analysis abilities (Urdang, 1979).

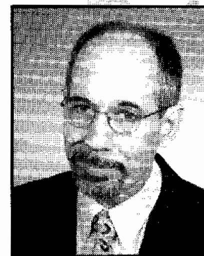
I would argue that the systematic investigation of clinical process can and should continue to be a meaningful part of the student's learning experience. It helps beginning therapists not only to listen carefully to their patients, but also reveals important psychodynamic practice principles with an immediacy and clarity far more difficult to achieve through other techniques of clinical instruction, be they impressionistic or more experience-distal in nature. The supervisory use of *process recording*, however, is but one means of investigating clinical process.

Research on Treatment Process

Research on process is generally conceived as a means for understanding how change is achieved and for learning more about the intrinsic nature of the therapeutic endeavor. Process analysis actually has a rather long history, dating as far back as the 1940s, when pioneers such as the late Frieda Fromm-Reichmann (Hornstein, 2000) began to use transcriptions of audio-recorded treatment hours to analyze various dimensions of psychoanalytic process.

Although literally scores of instruments and research methodologies for the analysis of treatment process currently exist (Kiesler, 1973; Shapiro and Emde, 1995), few adaptations for use in clinical instruction or supervision have been reported in the social work, psychoanalytic, or psychological literature, arguably for several reasons. These include: the time required to establish competence in using a process analysis method, typically affirmed through the degree of agreement or inter-rater reliability between two or more coders (Jones, 1995); the relatively higher rates of inference required in psychoanalytic frameworks for analyzing process data; and the data preparation itself. Clearly, these are significant obstacles in successfully adapting any instrument for analyzing process for use in the classroom or in the supervisory situation, though *focal conflict analysis*, a process analysis tool developed in the '70s and '80s, may offer several advantages to our more traditional armamentarium of clinical instructional methodologies.





by Jerrold R. Brandell, PhD

Study Group Leader-Facilitator

The Focal Conflict Model

The *focal-conflict* model is a concept firmly anchored in the structural hypothesis of psychoanalytic theory. The original concept was developed by Thomas French, who described the focal conflict as "the problem with which the patient's ego is preoccupied" (French, 1954, p. 378). Each focal conflict, French suggested, consisted of three parts: *a disturbing wish or motive*; a *reactive motive*; and an *orienting hope* designed to alleviate or resolve the conflict. *Disturbing wishes* were generally conceived of as possessing

[1] *A longer and more detailed version of this article was presented by invitation at the Annual Fall Meeting of The American Psychoanalytic Association, New York, NY, December 13, 2000.*

either an aggressive or libidinal cast, and gave rise to a specific emotional reaction, such as fear, guilt, or some other form of anxiety. These two components, *disturbing wish* and *reactive motive*, constituted the focal conflict. The third component in French's paradigm, *orienting hope*, was the problem-solving mechanism activated by the focal conflict. French focused his attention on adaptive (hope-oriented) solutions to the focal conflict, largely ignoring the role that defenses, symptoms, and solutions that are otherwise *conflict-ful* play in the ego's effort to resolve the focal conflict. Joseph Kepecs, who had been a colleague of French's at the Institute for Psychoanalysis in Chicago, successfully adapted focal-conflict theory into a research paradigm for the study of therapeutic process (Kepecs, 1977; Kepecs, unpublished manuscript). He retained the focal-conflict idea originally described by French, but expanded the *wish* category to include *mastery* and *assertion*, both of which further emphasize the ego-psychological nature of the focal-conflict instrument. Kepecs also dealt with efforts at conflict resolution that are unsuccessful or maladaptive, such as defenses, wishes used defensively, and symptoms. These were added to the original *orienting-hopes* category, which Kepecs renamed, simply, *solutions.* The rating system in the revised focal conflict model borrowed terminology from the Gottschalk-Gleser Content Analysis Scales (Gottschalk and Gleser, 1969) and was also influenced by Roy Schafer's action-language (Schafer, 1975).

Kepecs advocated the use of an arbitrarily selected, transcribed ten minute verbatim excerpt of an audiotaped session as a means of furnishing "focus and precision" to the clinical data and because it provides student and instructor with a representative piece of the treatment interview (Kepecs, 1977, p. 383). For these reasons, it is preferable to other instructional and supervisory methods, such as anecdotal reports or audio recordings used without benefit of transcription. Moreover, the use of sequential transcripts provides a "good map of the course of therapy" and can also demonstrate "empathy, parallel process...tracking errors of the therapist" and "the power of the text" (Kepecs, unpublished manuscript, pp. 13-14).

Kepec's coding scheme (reproduced with some modification in Figure 1) is used in the following manner: A transcription is made of a brief (five-ten minute) excerpt from an audio-recorded session; the transcript is independently scored by the student(s) and the instructor on a line-by-line basis; and a formulation of the focal conflict is made based upon the *wish(es)*, *reaction(s)*, and *solutions* identified in the transcript. Since ratings, when compared line by line, do not always show a high rate of concurrence, the final formulation of the focal conflict seems to possess more value as a measure of inter-rater agreement (Brandell, 1987)[2].

I have actually used the focal-conflict instrument in several different ways in my work as an educator and clinical supervisor. Over the years, I have conducted a number of seminars on process analysis using a continuous case format for which the focal conflict instrument has proven quite durable. I have also taught focal conflict theory in both psychopathology courses and advanced clinical practice courses as a way of introducing students to basic psychoanalytic concepts. I often ask students to reproduce a verbatim or reconstructed process excerpt and then analyze the content using a focal conflict approach. I have also used focal conflict analysis in both individual and small group supervision of graduate students and post-master's degree clinicians. Although not all students find this method of approaching clinical data appealing, many have found it to be a useful adjunct to their clinical education. Students have sometimes told me, in fact, that using the focal conflict theory to guide their analysis of process has helped demystify or elucidate various psychoanalytic ideas that had up until then proven rather elusive. The seminars were viewed as nonduplicative of other classroom, research, and field-internship experiences, and students also felt that focal-conflict analysis enhanced their psychodynamic understanding of patients as well as their overall understanding of the therapeutic process.

Many students also observed that the focal-conflict instrument contributed to their dynamic understanding in a manner that process recording did not. Indeed, changes in the nature of a patient's conflicts or defensive armamentarium could be observed and even *quantified*, were a given case to be followed over the course of

See ***Focal Conflict Analysis****, page 10...*

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[2] *Kepecs didn't provide inter-rater reliability statistics, although he noted a "very satisfactory degree of consensus" can be reached between independent coders (ibid, pp. 41-42). The possibility of chance agreement in the first two categories (wishes and reactions) must be eliminated, however, before one can confidently discuss the level of agreement between raters. In my own research, inter-rater agreement in both the wish category (k=.58, p<.005) and the reaction category (k=.41, p, .005) between trained raters lent some support to Kepecs's contention. Because the "solutions" category can involve a variable number of designations between raters, it is much more problematic to assess the level of inter-rater agreement in this component. My research data demonstrated that consensus existed on at lease half of the identifiable solutions in better than four out of five (82%) ratings. Although this is not exceptionally high agreement, it does suggest the existence of a substantive basis for recorded agreements in the coding of solutions.*

Focal Conflict Analysis, continued from page 9

treatment. Students seemed to find the seminars most useful when they had the opportunity to present a particular case at several different points in the treatment process. After preliminary discussion of the case material, the taped segment was played back for the students and each student then scored his or her copy of the audio transcription. All seminar participants then compared notes, and the typescript was read back again in order to see how global agreement (that is, the formulation of the focal conflict) compared with line-by-line agreement.

The focal-conflict model, unlike more sophisticated instruments for researching and studying process, does not involve a complicated scoring procedure. Although some training is required before competence in using focal-conflict analysis can be achieved, essentially all of the concepts and terminology are congruent with the language of dynamic psychotherapy, thereby making the student's task somewhat easier. Because the unit of study is the five-ten minute treatment segment, date preparation is generally not very time-consuming. Finally, since the focal-conflict instrument requires a substantial degree of inference, the data it yields serve to complement and deepen the student's understanding of her/his case, as well as how treatment might be more successfully conducted. In essence, it helps students to begin to think psychoanalytically.

One major limitation of focal-conflict analysis is that it is exclusively designed for analyzing patient verbalizations. Therapist verbalizations are not coded and focus on the therapist-patient dialogue is limited. However, this limitation may, paradoxically, serve as an advantage in the instruction of anxious beginning-level students. Insofar as the focus of focal-conflict analysis is not principally on the trainee's clinical acumen or technical competence, but on the nature and meaning of the patient's communications, students may be somewhat less defensive or guarded (Kepecs, 1979).

Conclusion

Current trends in clinical social work education have placed less emphasis on the study of clinical process, although the analysis of process remains a time-honored method for the teaching and learning of psychotherapy. In this brief article, the focal-conflict model, an instrument for analyzing the patient's verbal process, is offered as a means of illuminating important aspects of dynamic theory. This process analysis method also permits the patient's conflicting desires, defensive organization, and verbal style to be studied in a much more detailed manner than the trainee's anecdotal reports or process reconstructions generally permit. Whether used in direct supervision or in the context of a didactic seminar focal-conflict analysis appears to have the potential to enhance the beginning clinician's grasp of psychoanalytic ideas and of the dynamic clinical process in which they are anchored. ■

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Figure 1: Focal-conflict model checklist.

Wishes: Select one or two (if applicable)

____ PHR Positive human relations: statements that refer to the self supporting, praising, expressing desire for sexual/nonsexual intimacy, expressing need for dependency on others. Also statements that refer to others doing, expressing, or wishing to express similar interests, or performing similar actions.

____ HO Hostility out: Statements that refer to the self attacking, belittling, humiliating, criticizing, or teasing others, ranging from simple angry statements to murder. Can apply to therapist. Covert hostility (others wishing to act or performing similar actions on other individuals) is also coded HO; denial of hostility is coded HO and denial, if appropriate.

____ M Mastery: Statements that clearly represent the individual's desire to take adaptive action. Includes wish to be autonomous, achieve goals, achieve self-understanding, control own life, change, succeed. To be considered mastery the wish should be stated in a declarative form, which implies adaptive action. Statements of having overcome difficulties are coded as ADAC, not as mastery.

____ A Assertion: Statements that represent a wish, stated explicitly or implicitly, for power and control over others. Assertion is interpersonal, rather than intraindividual (as is mastery).

Reactions: Select one or two (if applicable

____ Fear of overstimulation	____ Fear of separation	____ Fear of loss of control
____ Fear of abandonment	____ Fear of rejection	____ Guilt
____ Fear of merger (dedifferentiation anxiety)	____ Fear of bodily harm	____ Shame or embarrassment
____ Fear of loss of autonomy	____ Fear of death	____ Nonspecific anxiety or fear

Maladaptive solutions: Check all that apply

____ INT Intropunitiveness: Statements characterized by self-criticism, self-blame, suicidal or parasuicidal thoughts, disappointment in oneself, self-initiated threats to self; self held to account for all failures and dissatisfactions in life; self seen as unworthy, depressed or in despair; also, statements that are reports of self-injurious or self-destructive behavior (drug or alcohol abuse, self-mutilation, accident proneness). Differs from masochism primarily in that self, not others, is making critical and/or denigrating remarks.

____ MAS Masochism: Statements in which self is harmed, threatened, criticized, misunderstood, abandoned, rejected, neglected, punished, abused, or otherwise victimized by others. *Note:* In cases involving statements of spousal abuse, care must be taken to differentiate chronic reliance upon masochistic defense from exceptional circumstances in which the report of abuse is not a solution, but an anxiety-generating situational precipitant.

____ HS Helplessness: Statements that reflect helplessness, confusion, weakness, inability to cope, sleepiness, impotence, inability to focus or succeed. HS implies the inability to act and does not clearly represent internal conflict.

____ IHB Inhibition: Some awareness of conflicting forces reflected in client's statements, in that helplessness or inability to succeed, for example, are connected with an anxiety state — a sense of something that causes him or her to feel inhibited.

____ DRV Drivenness: Statements referable to individual's feeling that he
or she ought to or should be doing something. An implied objection to the pressure and a feeling of constraint should both be present in order to code DRV. The implication is that should the drivenness be given up, dire consequences will result.

Other maladaptive solutions:

____	SOM	Somatization	____	AMB	Ambivalence	____	SUP	Suppression
____	DEP	Depersonalization	____	REG	Regression	____	DEN	Denial
____	DER	Derealization	____	RFM	Reaction formation	____	WTH	Withdrawal
____	ISO	Isolation	____	REP	Repression	____	UND	Undoing
____	Other ____________		____	Other ____________		____	Other ____________	

Wishes used defensively:

____ DHO Defensive hostility directed outward: Often used after a PHR statement but can follow other wishes. Any wish met by rejection or attack can lead to DHO. The attack of rejection should precede or be otherwise closely connected to the use of DHO. An HO wish requires that there be no identifiable precipitating attack or rejection.

____ DPHR Defensive positive human relations: Usually occur in connection with an HO or DHO statement.

____ DM Defensive mastery: A refusal to wish to refuse to submit to internal intrapsychic intimidation or criticism.

____ DA Defensive assertion: Refers to interpersonal action and is a refusal to wish to refuse to submit to any external influence, intimidation, or control.

Adaptive solutions: Check all that apply

____ ADAC Adaptive activity: This category includes solutions that are relatively conflict-free as in the following:

____ Maturation	____ Self-confidence
____ Neutralization	____ Self-calming and soothing
____ Liberation	____ Hope
____ Sublimation	____ Humor
____ Self-approval	____ Self-observation

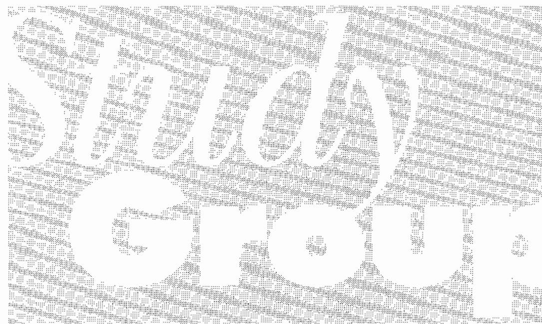
____ INS Insight: Statements characterized by a dynamic understanding of the self and one's own motives, including awareness of the focal conflict and the efforts made to resolve it.

Formulation of the focal conflict:
Wish(es) ____________________ vs. reaction(s) ____________________ ➤ solutions ____________________

Study Group, continued from page 2

administrative and teaching positions over a 20 year period). She is currently in Atlanta, GA as Dean and Professor at Clark Atlanta University School of Social Work and has a private practice. She has been a consultant for a variety of organizations such as the NAACP Legal Defense Fund, and Office of the State Public Defender for Los Angeles, CA. She has received numerous prestigious awards and has been active in community service at the city, state, and national levels. Bowles comes to the NMCOP Study Group with editorial experience for journals such as *Social Work, Smith College Studies in Social Work,* and *Practice Digest.* Her own publications and presentations have sought to expand awareness of ethnicity with a focus on the growth and development of black and bi-racial youth, especially in terms of developing an ethnic sense of self.

Jerry Brandell, PhD, is a Full Professor at Wayne State University School of Social Work in Detroit, MI, and Founding Editor of *Psychoanalytic Social Work* (formerly *Journal of Analytic Social Work*), and maintains a private practice in psychotherapy and psychoanalysis. He is also an Advanced Candidate in Psychoanalysis at Michigan Psychoanalytic Council. Brandell is a prolific writer and presenter. He has edited three books, **Theory and Practice in Clinical Social Work** (1997), **Narration and Therapeutic Action: The Construction of Meaning in Psychoanalytic Social Work** (1996), and **Countertransference in Psychotherapy with Children and Adolescents** (1992). Other writings include many book chapters, journal articles (both refereed and non-refereed). He has been Associate Professor at schools of social work at Boston University, Michigan State University, and a Visiting Professor at the University of Canterbury in Christchurch, New Zealand.



For three essays from Study Group members, see pages 8, 12 & 14

Joel Kantor, MSW, is a private practitioner in Silver Spring, MD, Senior Case Manager for Fairfax County Mental Health Services (part time) in Alexandria, VA, and a staff trainer for the District of Columbia Mental Health Commission. After attaining his undergraduate degree in Religious Studies from the University of Michigan, Kantor got his MSW from Smith College School for Social Work, and then a certificate from the Washington School of Psychiatry's Advanced Psychotherapy Training Program. In addition to being a Consulting Editor for *Clinical Social Work Journal,* Kantor has been a prodigious writer, especially on issues related to severe mental illness. His articles have appeared in *Clinical Social Work Journal, Smith College Studies in Social Work, Hospital and Community Psychiatry, Social Work, Bulletin of the Menninger Clinic,* and *International Review of Psycho-Analysis,* as well as our own NMCOP Newsletter. Several of his writings have also been on the work of Claire and D.W. Winnicott. Kantor has contributed chapters to several volumes in the *New Direction in Mental Health Services* series published by Jossey-Bass.

Caroline Rosenthal, PhD, has a strong academic background in understanding the human condition and mental health, with a PhD in Clinical Social Work (Smith College School for Social Work), an MSW (University of California, Berkeley, School of Social Welfare), and BA in Social Anthropology (Harvard University). She is also a 1999-2000 Fellow of the American Psychoanalytic Association, being the first social worker accepted into that program. Rosenthal has a strong interest in multicultural issues. Having been born and raised in Guatemala and Mexico, her doctoral research was on a better understanding of the use of psychodynamically informed treatment with Latinos. She has given many presentations on this topic and the need for cultural competency in clinical practice. Another area of interest for Rosenthal is that of ethical dilemmas in practice, which she has taught as an assistant professor at Smith College School for Social Work to high acclaim.

Ellen Ruderman, PhD, is a Training and Supervising Analyst at the Institute of Contemporary Psychoanalysis. She has served on the faculties of Cedars-Sinai Medical Center Division of Psychiatry, the UCLA Graduate School of Social Work, and as Consulting Faculty of the California Institute for Clinical Social Work. Ruderman's publishing endeavors include acting as Issue Co-Editor for two issues of *Psychoanalytic Inquiry* ("On Touch in the Psychoanalytic Situation," and "The Life Stage of the Psychoanalyst: Developmental Transitions and Epiphanies"). Her articles have also appeared in publications such as *Clinical Social Work Journal* and the *Journal of Orthopsychiatry,* and a book chapter in **The Social Work Psychoanalyst's Casebook: Clinical Voices in Honor of Jean Sanville**. Ruderman is currently co-editing **Women of the Millennium: Clinical and Treatment Perspectives**. She has been active with

NMCOP as a member emeritus of he Executive Board, the current Area Representative of the Southern California Chapter of NMCOP, and a Member-at-Large.

Caroline Saari, PhD, is a professor at Loyola University of Chicago School of Social Work, Editor of *Clinical Social Work Journal,* and a private practitioner. She received her PhD from Smith College School for Social Work where she worked for many years as a professor, Clinical Coordinator of the doctoral program, and as Associate Dean. Saari has also been director of the doctoral program at Loyola University, and was the Co-Director of Social Work at the Yale Psychiatric Institute, Yale University School of Medicine. As an educator and a prodigious writer, Saari has contributed to the field of social work through her many articles in journals, book chapters, numerous presentations, and three books — **The Environment in Theory and Psychotherapy** (in press), **The Creation of Meaning in Clinical Social Work** (1991), and **Clinical Social Work Treatment: How Does It Work?** (1986).

Roberta Shechter, DSW, wears many hats as a psychoanalyst, a faculty member and Senior Supervisor of the Psychoanalytic Institute of the Postgraduate Center for Mental Health. She is also an organizational consultant, Associate Editor for *Psychoanalytic Social Work,* and a clinical supervisor at The Washington Square Institute for Psychoanalysis. Shechter received her doctorate from Wurzweiler School of Social Work, Yeshiva University. She is the author of many articles and book chapters, and was the Coordinator of the PreConference Writing Workshops for the NMCOP 2000 Clinical Conference. She is a past-president of The Postgraduate Psychoanalytic Society, and is currently a Member-at-Large for that group. Some of Sketcher's clinical interests include transference, Oedipal issues, and analyst self-reflection, among a host of others.

Susan Sherman, DSW, is an adjunct professor at both Columbia University School of Social Work and Adelphi University Graduate School of Social Work. She also maintains a private practice, supervises psychotherapists, and works with the Jewish Board of Family and Children's Services Clinical Training Program. Sherman's publications have included chapters in edited books and book reviews for this Newsletter. She has presented numerous papers and workshops on a variety of subjects, especially on children's issues and treatment. She is a graduate of Bryn Mawr Graduate School of Social Work and Social Research (MSW) and Adelphi University School of Social Work (DSW), and certificate programs in advanced psychoanalytic psychotherapy, and psychoanalysis from The Society for Psychoanalytic Study and Research Training Institute.

Carol Tosone, PhD, is an associate professor at New York University's Ehrenkranz School of Social Work and maintains a private practice in New York. She is a graduate of Columbia University School of Social Work (MSW), New York University School for Social Work (PhD) and a certificate from the Postgraduate Center for Mental Health Fellowship Training Program in Psychoanalysis and Psychoanalytic Psychotherapy. Tosone's publications include **Love and Attachment: Contemporary Issues and Treatment Considerations** (1999), several journal articles, book chapters, book reviews, and conference proceedings on a variety of topics. She currently has two books in press. Tosone is on the editorial board for *Social Work in Health Care,* and is an associate editor for *Psychoanalysis and Psychotherapy,* and *The Journal of the Postgraduate Center for Mental Health.* Among her many presentations and papers, Tosone participated as a panelist at the NMCOP 2000 Conference ("Expanding the Myth: Is Psychoanalysis for the Privileged Few"), and at an NMCOP writing workshop prior to the conference. Areas of clinical interest include female masochism, eating disorders, and short-term treatment.

Billie Lee Violette, MSW, is completing her PsyD in Psychoanalysis from the Psychoanalytic Institute of Northern California. She is in private practice with adults and adolescents, with specialized knowledge in child sexual abuse, trauma, and alcohol abuse. Her clinical interests include dissociation, applied psychoanalysis, and literary criticism. Violette's articles and book reviews have been published in several issues of *Clinical Social Work Journal.* She has held offices as a board member of the Society for Clinical Social Work, National Area Chairperson for the Northern California Committee on Psychoanalysis, and as Chairperson of the Candidates Association of the Psychoanalytic Institute of Northern California. ■

- Dale W. Dingledine, PhD

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President's Message, *continued from page 1*

relevance, then it is up to us to convey the essence of dynamic concepts in common language. It was my hope, I told her, that she would find a way to do this.

But what are the consequences of policies at social work schools in which the use of clinical words is verboten?

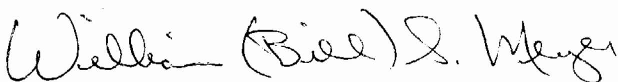
Earlier that same evening Dale Dingledine, NMCOP Secretary, was telling Barbara and me that she recently gave a lecture to a group of master's level social workers. Some time into her presentation she discovered that hardly anyone in her audience knew what she meant by the term "transference." After adjusting to this bit of unhappy news, Dale calmly proceeded to enlighten them. Wouldn't we all agree that it is tragic when master's level practitioners of our profession lack the knowledge of a concept so important yet so elemental?

There are many anti-clinical individuals among faculty and administrators of schools of social work who fail to see that a sound clinical education is indispensable to all social work practice irrespective of setting. They would like to keep us from transmitting what we know and have us fade quietly into the night. We are dismayed to witness the degree of their success. We must ensure that this is not allowed to happen further. Joyce Edward, in thinking about where we are headed, has asked, "Will anyone remember what good treatment is?" The answer depends on us.

As members of our Study Group you must be the storytellers from the village of our profession. Whether the lessons of psychoanalytically informed practice are passed from this generation of professionals to the next rests largely on what you do. You must tell our story and see to it that it is heard by as many in our profession — especially students — as possible.

A saying once displayed on a church in Washington, D. C. stated, "There is not enough darkness in the world to snuff out the light of even one small candle." Be our lights and glow brightly. Use your eloquence to be our messengers. Proceed with the knowledge that the future of our profession depends upon what you do.

With gratitude,



William S. Meyer, MSW, BCD
President, NMCOP

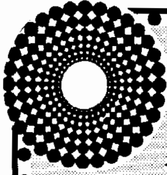
Ours, Yours and Mine, *continued from page 7*

papers co-authored with Maria Fahey, based on the most recent observations of some of the original subjects who are now adults. Because of the extensive observational data of the preverbal period, the adult follow-up study has offered a rare opportunity to see how elements of the unremembered preverbal past remain significant in adult life" (p. xxii).

The second half of the book begins with two case studies: *From Psychological Birth to Motherhood, the Treatment of an Autistic Child with Follow-Up into Her Adult Life as a Mother*, and *I and You, The Separation-Individuation Process in the Treatment of a Symbiotic-Psychotic Child With Follow-Up*. Another paper describes her work as co-director of a therapeutic treatment center at the City University of New York, which she co-founded with Gilbert Voyat and Linda Gunsberg in 1976. *Using Insights From Observational Research of Mothers and Babies in the Therapy of Preschool Children* describes the object relational treatment approach and the university setting of the center. The next three papers — *From Command to Request: The Development of Language in the Treatment of a Symbiotic-Psychotic Child* (with Chernack); *The Oral Deadlock: Treatment of a Psychotic Child*, (with Schwartzman, Sloate, and Wilson); and *A Model for the Day Treatment of Severely Disturbed Children* (with Arnold Wilson) — are important contributions to child treatment. The second section ends with *To Be or Not To Be Separate: The Meaning of Hide-and-Seek in Forming Internal Representations*. This last paper again demonstrates the excitement and universality of the observations about the discovery of the self, and the surviving tactics of loss, so much a part of all of the observations in the text. "Hiding and being found are exciting and pleasurable activities which begin with the earliest peek-a-boo games and last in ever more highly elaborated forms throughout early childhood and beyond" (p. 418).

I highly recommend this book. It is a great credit to Dr. Bergman that she updated the materials, and shares her personal and professional observations. She is distinctly her own person, and it is a pleasure to continue to learn from her keen mind. This volume offers all psychoanalytic practitioners pride in our intellectual and research heritage. ■

Patsy Turrini, MSW, is the author of many articles as well as co-author of the book **Separation-Individuation: Theory and its Application**. *She teaches, supervises and is in private practice in psychotherapy and psychoanalysis in Long Island, New York.*



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Selecting a Topic

We have come together today to discuss how to write a workshop proposal for a clinical conference.The anticipation of writing a proposal and presenting at a conference can trigger performance anxiety in any clinician. Performance anxiety is often begun during the initial stage of proposal writing, so let's begin our workshop with a story that addresses the psychological issues involved in selecting a workshop topic, our first writing task.

> John Smith, a senior clinician, a social worker with many years of experience, receives the clinical society call for conference papers in his office mail box and has a spontaneous series of connected thoughts:
>
> "Hey... this conference might be interesting to attend! (Pause.) Maybe it would be fun to do a workshop at this conference. I wonder? (Pause.) I certainly could use the professional exposure. My caseload in down. They say that patient referrals and supervisees can come from doing presentations. People meet you, like your ideas and see how you work. (Pause.) What should my topic be? (Long pause.) No, I'm too busy to do a workshop. I have too much on my plate already. (Longer pause.) Maybe another time...there is always a conference possibility..."
>
> Three months later John Smith takes the final form of the same conference program out of his mailbox and thinks again that the conference is interesting and wonders if he should attend. He looks through the program to select a workshop and is surprised to find the name of his supervisee, Ted, on the list of presenters. Now John's silent reflections run something like this:
>
> "If Ted can talk about that topic because of what he has learned from me, I certainly could. I should have tried to participate in this conference. (Pause.) The truth is, I did consider it, but I couldn't think of anything new to say, nothing original. Now, looking at the program I think the focus of this conference is exciting. After all, it is in my area of practice. But when I considered doing a workshop I couldn't think of a worthwhile topic, at least one that hasn't been done a hundred times before. If I had settled on a topic, just any topic it probably would have seemed repetitive or ordinary, and I would have felt foolish conducting the workshop."

This presenter believes that there is no "original" workshop topic. John's belief that *his* topic had to be original was the product of an underlying grandiosity. Vulnerability to low self-esteem and/or castration anxiety was stirred in John by the thought of publically airing his ideas. John Smith was struggling with the normal phallic-narcissistic issues that plague all of us at some point in our professional lives. John lost that struggle and did not write a workshop proposal. Everyone attending this gathering today is *ready* to do battle with his or her own performance anxiety and present a conference workshop. Some of you have topics ready-at-hand, others are still evolving ideas.

Selecting a topic and writing a workshop proposal is easily done when you accept the assumption that your workshop does not need to address a new idea in order to be considered worthwhile and acceptable to a conference. Clinical learning is the goal of most conferences, and colleague-led workshops are the means to that goal. Original ideas are admirable, but not necessary. Basic science has long accepted that there is no totally new idea under-the-sun, just variations on a theme and research expansions. Each variation and expansion has value. It pushes the knowledge base of science forward. The same is true in our clinical world. Schools of psychodynamic thought build on each other. There is a lot to learn, and most clinicians are in a state of perpetual learning. We never know enough. Going to conferences is a continuing education activity that addresses our need to know more. The best workshop clearly addresses that need. It teaches clinicians what they need to know in order to practice. So when you are planning to write a proposal, frame your topic by thinking in terms of teaching other clinicians one small part of what you know about in your area of practice. Read the conference call for papers with a limited teaching goal in mind, and your workshop topic will unfold.

Study Group 5

by Roberta Ann Shechter, DSW

When I read a call for papers and consider participating in a conference, my thoughts are guided by several questions:

1. What is the basic theme of this conference?
2. How does my work as a clinician intersect with that theme?

3. Is there anything that I feel equipped to teach another clinician that is connected to the conference theme?
4. Is there anything that I would like to talk about to a group of clinicians that they might find interesting?
5. The fit between my work and the conference topic may not be obvious. So how can I rephrase the conference theme to fit my practice experience, and in that new language what I would like to teach others?
6. Since I enjoy doing case-focused workshops, do I have a patient in my past caseload that fits the population addressed by the conference?

Limiting Your Focus

Once you have your topic remember most workshops are one hour or 90 minutes in length, so you will not have enough time to present all of your knowledge on the topic. Thus, it is probably a good idea for your workshop to be highly structured and clearly focused on one or two concepts with clinical case examples connected to those concepts. A good workshop allots time to audience participation or discussion. Many conference committees expect workshop leaders to use written papers in their presentations. Written papers, in my opinion, help a presenter structure a workshop. I always go in with a written paper. I may not stick to the page, but it helps timing and focus. If your workshop is 90 minutes in length, you might spend the first 25 minutes delivering a 10-page paper filled with your ideas, and then move on to a free-flowing discussion. Your paper sets the tone and the intellectual parameters of the workshop. Slow and clear verbal delivery of a paper is approximately 2½ minutes for every double-spaced typewritten page. So 10 pages will take 25 minutes. I begin many of my workshop presentations by defining a concept and using one or two brief case examples to illustrate that concept. I don't try to be brilliant. I simply want to present my work in a way that stimulates the thoughts of other clinicians, so that they take in my ideas and come forth with their own in our discussion. How case material is disguised for presentation, maintaining patient confidentiality could be discussed at a later point in this session. Let's move on now to the mechanics of writing a proposal.

Structuring the Written Proposal

There are many ways to write a workshop proposal. I would like to share how I write a proposal, structure it and fill in each section. I usually divide my proposals into four sections: Introduction, Theoretical Formulation, Case Illustration, and conclude with a 5 to 10 item Bibliography. The entire proposal is no more that three to five double-spaced typewritten pages. I structure my proposal like this because I want the conference committee readers to be comfortable with it. I want the readers to view it as scholarly and well organized, with clearly expressed ideas and definite presentation parameters.

In my ***Introduction*** (½ page) I state my workshop topic and suggest in what way my workshop will make a contribution to our clinical world. This statement may be general or somewhat political in tenor, i.e., I plan to focus on a much-overlooked dynamic in the fantasy life of many patients, sibling transference. The introduction section is meant to engage the interest and curiosity of its' readers.

A ***Theoretical Formulation*** (1½ pages) is all-important. In it I define the basic concepts that I will explore in my workshop. At the end of this section I refer to the case material that I will be presenting in the workshop. I do this in order to root the concepts that I have defined in a clinical context. My hope is that the proposal readers will become curious about my presentation and consider attending it.

A ***Case Illustration*** section can be part of your proposal, but it need *not* be a finished product. You might briefly describe the kind of patient that you will be discussing. Use identifying information that is colorful and somewhat dramatic or describes a situation that a reader and/or audience can easily identify with. The more polished this section, the more likely your proposal will be accepted. If you carefully make your case material illustrate the concepts in your theoretical framework section, then your proposal will have an overall consistency and seem scholarly, making it even more likely to be accepted by the conference committee.

Preparing for Presentation

This is the important task that is completed after your proposal is accepted. Now you write the 10-page presentation paper, a paper that you will trim several times in an effort to maintain your limited focus and remain within workshop time constraints. It is difficult to write a short paper. Most clinicians are highly verbal people who tend to be obsessionally all-inclusive, especially when they want to make an excellent presentation. In a workshop, less is always better. So save your castoff pages. Most workshop materials can be used as the basis for a published paper.

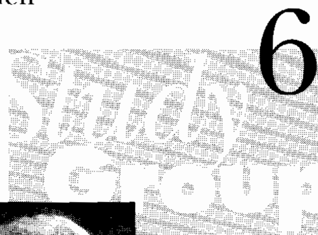
Audiovisual Aids

A slide projector is most often used when a paper is delivered in a large auditorium to a sizable audience.

*See **Proposal Writing Workshop**, page 19...*

The Link Between Early Clinical Social Work Theory & Contemporary Psychoanalytic Concepts: Returning to My Social Work Roots

[Editor's Note: The following is a synopsis of a paper to be presented at the 2002 conference of the National Membership Committee on Psychoanalysis. First presented in 1992 at the California State Society for Clinical Social Work Conference in Monterey, California, this synopsis was updated to its present form for the NMCOP Newsletter.]



by Ellen G. Ruderman, PhD

In this paper, a continuing "work in progress," I examine early clinical social work theory and its links to contemporary psychoanalytic concepts. I also contemplate the professional struggles of psychoanalytically-oriented clinical social workers, as they strive for recognition of their contributions to the disciplines of psychotherapy and psychoanalytic practice. Because of their early social work education and training, many clinical social workers are comfortable with the techniques in psychoanalysis, which emphasize the use of the therapist's inner processes in the therapeutic milieu. In contrast with their colleagues from other psychotherapeutic disciplines, however, many psychoanalytically-oriented social workers struggle with issues of professional self-esteem. The reasons for this are many. Certainly, in the hierarchy of psychotherapy and psychoanalysis, professional recognition seems to mirror payment structures. But there may be other reasons for prevailing perceptions, such as social worker's gender (largely female), and unwittingly collusion with views that under value their contributions to psychoanalytic knowledge, theory and practice. There is also considerable confusion by the general public about what social work is, because social workers have functioned in many capacities, i.e., community worker, welfare worker, medical social worker, clinical social worker, and social work psychoanalyst.

Using examples from my own professional journey from social work trainee to social work supervisor and from analytic trainee to analytic supervisor, I describe and illuminate many of the paradoxical realities for clinical social workers. For example, although clinical social workers have contributed much to the understanding of the patient within a framework of mutuality, when these teachings are introduced as part of the "new" or post-modern movements in psychotherapy and psychoanalysis, there is little awareness and acknowledgment of the contributions of social work in advancing these theories. Perhaps this has to do with social workers themselves, may of whom continue to accept the age-old triumvirate of the three disciplines, and keep themselves at the bottom rung of professional ladder.

The first "case in point" is my own experience at the Cedars-Sinai Mental Health Center (formerly, the Thalians Community Mental Health Clinic) in Los Angeles. There, under the encouragement of the Center director, social workers participated on an equal footing with their psychiatrist and psychologist peers in innovative clinical work, research and publishing of their work. Yet, despite their handling the majority of the caseload, and their partaking of the free exchange of ideas and unique training experiences, social workers at the Center were still, as formerly mentioned, at the bottom rung of the salary ladder.

The profession has witnessed many efforts to correct these imbalances. Pioneers such as Jeannette Alexander, Bernice Augenbraun, Shirley Cooper and Jean Sanville were instrumental in promoting the licensing of social workers in the state of California, while nationally the NMCOP has made considerable strides in furthering the recognition of psychoanalytically oriented social workers and their many contributions to psychoanalytic practice. With the burgeoning of new psychoanalytic institutes in the 1980s and 1990s, clinical social workers began to notice that tenets of post-modern psychoanalysis bore more than a passing resemblance to their own earlier teachings. While social workers in large numbers flocked to Institutes of all varieties for analytic training, theory also seemed to merge with their particular Institute culture, rather than emphasize and highlight the rich legacy of their early training and social work experience.

Concepts such as the importance of the relationship between patient and therapist, the use of self, respect for the patient's dignity and right to self-determination, and "starting where the patient is" have been hallmarks of social workers' psychotherapy practices. These concepts, derived from the early social work teaching of Hamilton (1958), Richmond (1917, 1922) and Perlman (1957), are now reflected in the post-modern movement. Relational Psychoanalysis (Mitchell and Greenberg, 1986-91),

Intersubjectivity (Stolorow, 1986; Atwood, 1990) and Self-Psychology (Kohut, 1977), are but a few of the post-modern movements which arouse a feeling of "déjà vu" in many clinical social workers.

The teaching of the use of the self extends quite naturally into today's concept of totalistic countertransference. As opposed to "classical countertransference" totalistic countertransference reflects the therapist as a total person in relationship to herself, the patient and the treatment process (Kernberg, 1965). I have included in my larger paper an example which elucidates how, as a consultant and supervisor of social work trainees, I was able to encourage my supervisees' "use of self" to help them break treatment impasses with their patients. Attentiveness to countertransference (Racker, 1968, Searles, 1979), Ruderman (1986, 1992), Casement (1986, 1992), can inform and guide practitioners in interactions with patients, and enables them to learn from and grow with their patients. From their earliest training, social workers are encouraged to view psychotherapy as a two-person process, each able to learn and grow within the treatment milieu.

In my dissertation study (1986), 20 psychoanalytically oriented clinical social workers in private practice supplied further examples of the conflicts within the profession. Eighteen of the 20 practitioners studied tended to undervalue their obvious skills and contributions a practitioners. Origins of these attitudes may be two-fold: all the social workers studied were women and many had probable internalized to some degree a devaluation of self imparted from their culture. These internalized societal attitudes may become amplified by the historical devaluation of social work as a profession. While this historical devaluation of social work is consistent with society's minimization of the person in the role of the caregiver, many social workers also collude with this position by devaluing, as did the female social workers in my 1983 study, their own essential contributions, and blurring their unique professional identities.

As schools of social work currently redirect their goals toward helping communities and veering away from clinical practice, the challenge, in my view, is to bring back the rich clinical legacy that can ensure clinical social workers will continue to contribute to the wide body of psychoanalytic knowledge.

It is imperative hat clinical social workers become the leaders in re-introducing psychodynamics and psychoanalytic thinking to those schools of social work which have continued to dilute the whole area of clinical concepts and clinical practice. For it is only the people within the profession who can understand what basic social work concepts are congruent with some of the newer ideas in psychoanalysis, and how these psychoanalytic concepts may be utilized constructively in both agency and clinical practice. Using their understandings of the framework of mutuality and their own awareness of countertransference, these analytically trained social workers can do much to advance the perceptions of their field, thus continuing to effect and enhance its true renaissance. ■

Los Angeles, California
(November, 1992; Revision: January, 2001)

[Editor's Note: Billie Lee Violette, LCSW, of San Francisco will be writing a response-discussion to Ellen G. Ruderman's Synopsis. As we wish to begin a Dialogue with NMCOP members, we are inviting you to respond to the Synopsis with your own feelings and professional points of view.]

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***Proposal Writing Workshop**, continued from page 13*

Most workshops engage in-group process and are limited to 8-15 people. Thus workshop audiovisual aids are usually chart handouts, blackboard diagrams, short films, and prepared bibliographies. I use diagrams that help my listener take in ideas and participate in discussion. I occasionally give a copy of my own published paper on a related topic or an additional bibliography as an "ending gift" to workshop attendees.

Any thoughts or questions about your workshop proposal ideas? ■

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Inner Judge, continued from page 6

avoid helplessness, rage, shame, guilt — the "too muchness" of diverse "affective storms."

Wurmser reminds us that defenses associated with severe neuroses are everyday armaments across the diagnostic spectrum. He gives us an aerial theoretical view of these manifest defensive maneuvers, but also takes us inside the gut experience of the patient's internal world and his adaptive efforts to cope. Speaking for the patient, he writes:

"The world consists only in disappointment. I feel like a locomotive that runs under full steam but whose brakes are fully throttled; it stands in place. Will and counterwill stand in full battle gear against each other, and I cannot do anything else but forgo the world and withdraw entirely upon myself. Although this does not bring me any peace, it diminishes at least my sense of shame in front of a sneering environment" (p. 269).

From a genetic frame, he sees these patients as traumatized victims of "soul murder" and "soul blindness." Their caretakers were chronically blind to their "selfness" and needs. While this particular view has a familiar Kohutian ring, Wurmser's theoretical and treatment scope are quite different. He remains grounded in a mainstream tripartite structural model.

Psychoanalysis, in its nascency, focused on the id. The emphasis shifted to the ego, especially during the middle of the last century. Wurmser places the superego in a supraordinate position as an inner regulating agency (p. 308). In this respect, his view bears some resemblance to Strachey's. Both depict the archaic, punitive, global superego of these patients and see thera-

*See **Inner Judge**, page 22...*

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peutic action in the potential for transmuting internalization. Wurmser emphasizes the intolerable pressure of severe and irreconcilable superego conflicts that evoke superego and identity splits. A protective denial maintains this "doubleness" in the service of blinding oneself, and keeping parts of the self or reality opaque. Shame and guilt are cornerstones of these patients' symptomatology and dynamics. Wurmser details "two basic structures of the superego" (p. 285) — "separation guilt" and "depression shame." One might question whether these are in fact basic structures, or whether Wurmser concretizes secondary idiosyncratic conflicts, affects, and behavioral sequelae. This dichotomy, at any rate, is reminiscent of Mahler's separation-individuation schemata, but Wurmser's superego is highly elaborated and textured. He depicts the superego as a powerful force to be reckoned with, and elaborates on the vicissitudes of defiance against submission to this tormenting "inner judge."

Wurmser posits seven dialectical polarities that are ubiquitous and manifest on many levels. They form the nodal points of themes he elaborates on throughout the chapters of his book, and they constitute the framework of his treatment strategies. He presents eleven guidelines for defense analysis. While some are familiar and useful as reminders, all are informative. Wurmser's focus is on the centrality of intrapsychic conflict, particularly the analysis of defense and defense against superego functions, both within the transference and the extra-transferential (p. 57). There is a caveat. He advocates flexibility in adherence to the frame. Traditional analysis, combined with ancillary treatment modalities (support, suggestion, intervention, hospitalization, etc.) must at times be utilized, if otherwise intractable patients are to be helped. As I write this review, I can hear echoes of voices questioning whether his treatment approach constitutes a "real" psychoanalysis, in the face of such mix of parameters. Perhaps this issue may be viewed as

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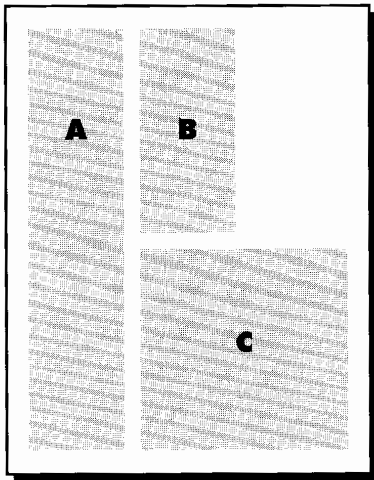

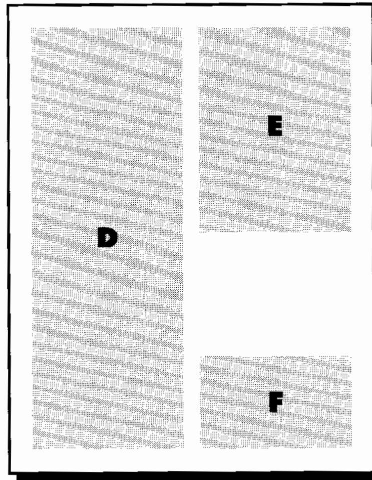

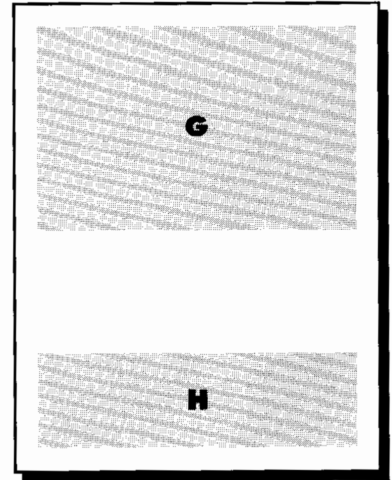

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a professional parallel to the "either-or" perspective of Wurmser's patients. The clinician confronts two paradigms here: the inner and outer worlds. What is needed, he asserts, especially in crisis, is the "complementarity of the interpretative and the interactive approaches." Superceding all, is his enjoinder to avoid a confrontational treatment approach and to foster a rational alliance with the patient, working toward the goal of greater self-observation.

Wurmser has produced yet another tour de force among his many publications. This is a detailed, densely packed encyclopedic exposition on theory and technique that leaves no stone unturned. He succeeds in narrowing the experiential gap between theory and therapy, between therapist and patient, and even between author and reader. Like a good teacher, Wurmser reinforces his main theses with helpful repetition, perhaps likened to that in the repetition of working through. You will feel enriched for having read this book. It is even better the second time around. ■

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