

From the President

Foremost on the minds of many of us is Hurricane Katrina, which has devastated a large part of the Gulf Coast. Once again, our compassion and experience dealing with victims of trauma will serve us and our patients well. Thanks to the establishment of our listserv after 9/11, we're now able to communicate and send information about resources to one another almost instantaneously. Our hearts go out to the victims of this disaster, as we struggle to understand and explain to ourselves, and our patients, how and why such things happen, and how to best cope, incorporate whatever lessons there are to be learned, and then move on. I feel truly blessed, especially in times like these, to be part of an organization such as NMCOP, which allows us to support one another and work together effectively to help alleviate the suffering of our fellow citizens.



NMCOP PRESIDENT
Judy Ann Kaplan

NMCOP —

rooted in the past, focused on the present, looking toward the future

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On a more positive note, 2006 is the 150th anniversary of Freud's birthday. The Austrian Embassy in Washington D.C. is organizing a conference that will commemorate this event, and NMCOP is one of the organizations they have asked to assist with the planning. We are excited and honored to be included, and will keep you informed as plans progress.

As President, I have truly learned that our organization stands or falls on the dedication and devotion of those who may not make the headlines, but who do, with their invaluable efforts, make our organization work. I want to express my deep gratitude to them here:

Barbara Berger, Past President, Liaison to the Consortium, and 2007 Conference Director, has been generous beyond belief with her time and knowledge. In addition to chairing the 2007 Conference, Barbara has been an invaluable, wise presence at board meetings and in the many, many phone calls she and I have had over the past four years. Barbara truly qualifies as "she without whom this

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from the **Editor...**

Donna Tarver,
Editor



This is Judy Kaplan's last newsletter article as President of NMCOP. The newsletter thanks her for her work as President, her contributions to the newsletter, and her unfailing support during her tenure! Our soon to be President-Elect—Samoan Barish—has contributed a wonderful article on "Suffering and Its Vicissitudes," which she reminds us is a universal issue that we all confront and is an issue so timely in light of the ongoing war in Iraq and the two hurricanes that have disrupted so many lives and reminded us all that just below the surface of our daily awareness there so many vulnerable persons in our country living in poverty and poor health who are unable to fend for themselves. Surely, we will not soon forget their faces.

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.

Thanks to all contributors to this issue: Samoan Barish, Barbara Berger, Joyce Edward, Velia Frost, Kathleen Hushion, Judy Kaplan, Penny Rosen, Marilyn Schiff, Cathy Siebold, and Diana Siskind. ■

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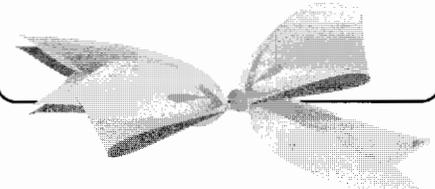
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The number of colleagues you may honor is unlimited. With members like you, NMCOP is well positioned to continue to grow, and we **definitely** are growing! ■

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Suffering and Its Vicissitudes: *My Brother, Myself, and My Patients*

By Samoan Barish, PhD

Not to know suffering means not to be human.
~ Midrash

Our recognition of life's abundant provision of pain.
~ Lionel Trilling

Who, except the gods, can live time through forever
without any pain? ~ Aeschylus, Agamemnon

In the spring off 2004, just six months after being best man at his medical student son's wedding, my younger brother was diagnosed with ALS (Amyotrophic Lateral Sclerosis). Commonly called Lou Gehrig's disease, this is a devastating affliction that attacks the nervous system, causing the muscles to waste away. There is no known cause for this disease, no remedy, and no medical treatments that can stem its relentless tide.

My brother's diagnosis was shattering and it plunged him and all of us who love him into a severe and instantaneous state of suffering. Steeped in this experience I began to think about this common human affliction and how it is ubiquitous to the human condition, in a sense bonding us to each other. Although I have just described a personal event, every one all of us knows something about suffering.

In all manner of degrees and types, we therapists and analysts sit day by day with psychic pain and suffering in symbolic and real terms. Yet, we do not have a body of literature of thought specifically devoted to the phenomenology of it. This paper is a beginning effort to address that gap. How we understand suffering, what it means to us, how we work with it in ourselves, our loved ones, and in our patients, is the overarching theme of my paper. In the process, I share some of the particulars of my own suffering, including some of my reactions to my brother's unspeakable disease, its effects on me and my clinical work with selected patients.

Life is not a pie; we cannot measure, sift, mix, and then come out with a creation that can be cut into perfectly proportioned pieces, evenly divided among all. Instead, it's a veritable mess. How we handle the "messes" in ourselves, in our lives, with our loved ones, and with patients is a matter of deep interest for us analysts. Suffering can be very messy indeed. Trying to consider psychoanalytic theory and practice along phenomeno-

logical lines, directs our attention to the psychodynamics of what suffering specifically entails.

As therapists and analysts we need to make explicit our existential appreciation of the universality of suffering. Using lenses that both abstract universalizing processes and particularize individual psychological meanings may provide a space within which we can find new ways of knowing and thinking about suffering.

I believe it is necessary for each of us to look at our own theoretical and philosophical positions concerning the nature of suffering, and how those views are informed by our idiosyncratic personal leanings and experiences (including our tolerance for pain and suffering). Although, both personally and professionally we might want to help alleviate, if not eradicate, the pain of suffering, we must acknowledge that this is not in the realm of human possibility. Therefore, how do we make space for suffering as part of existence? Just as we need to make room for suffering, indeed even invite it into our consulting rooms, so too do we need to make room for it in our lives.

When I speak of suffering, I speak of it in all its variations, ranging from that which originates from purely internal means to that which comes solely from the external world. Freud tried to distinguish neurotic suffering (e.g., suffering of one's own making as well as one's inability to face suffering) from common unhappiness that is endemic to the human condition. Presumably, we analysts know something about the internal and external conditions of our own pain, as well as for our loved ones and the people who come to see us. In addition, all of us have some degree of exposure to the sufferings of masses of people who are subjected to the larger inequities of geopolitical life and culture, including violence, starvation, abuses, deprivations and unspeakable horrors.

I am not suggesting for a minute that the internal and external vicissitudes of suffering fills the foreground and background of our consulting rooms. As we all know there are many riches, many struggles and conflicts, many intimacies, surprises, discoveries and new beginnings that are subsumed within the analytic encounter. I am suggesting, however, that we could gain from a heightened focus on the phenomena of suffering.

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What do I mean when I refer to suffering? Webster's Dictionary defines it as "to endure, to feel pain or distress, to sustain loss or damage, to be subject to disability or handicap." Partridge's *Etymological Dictionary of Modern English* tells us that middle French *sufrir* derives from low Latin *sufferine*, a modification of Latin *sufferne*, to bear (*ferre*), hence to support. Interestingly, the word passion, derived from the Latin *pati*, means to suffer or to endure. Indeed, Galdi (1996) points out that both in German and Hungarian there is a strong connection between passionate emotion and suffering; essentially they are homonyms.

Acknowledging that we need to consider suffering from a cultural context, the anthropologists Arthur and Joan Kleinman define it this way from "the historical and cross-cultural record as a universal aspect of human experience in which individuals and groups have to undergo or bear certain forms of burden, troubles and serious wounds to the body and spirit." They proceed to group these burdens into various categories such as: contingent misfortunes (e.g., serious acute illness); routinized forms of suffering (e.g. chronic illness, death deprivation and exploitation); and suffering resulting from extreme conditions (e.g., the Holocaust). They tell us that although the cultural meanings of suffering are elaborated differently, the intersubjective experience of suffering is itself a "defining characteristic of human conditions in all societies" (1991, 280; italics added).

What does Psychoanalysis have to say about suffering in a psychocultural sense, or the particular psychodynamics of suffering? Surprisingly, there is not an extensive body of elaborated literature devoted to the subject, although there are many passing references to suffering. In fact, a search of the PEP CD revealed there were 5463 articles containing the word "suffering" and only 16 with the phrase "phenomenological suffering." Of course, there is Freud's famous quote referred to earlier, that one of the goals of psychoanalysis is to "transform hysterical misery into common unhappiness" (1893-1894, 305).

In *Civilization and Its Discontents*, Freud considered some of the reasons for our suffering. Clearly, the most apparent source of suffering is our body and the various illness and pains we are all subject to, ultimately "doomed to decay and dissolution" (1930, 21). Freud tells us that the second source of suffering is the external world where all matter of natural and man-made disasters may occur. The external world, Freud says, "rages against us with overwhelming and merciless forces of destruction" (77; as in the colossal devastation of the Tsunami in the

Indian Ocean earlier this year and the devastating floods and aftermath in New Orleans in August 2005). Finally, Freud concluded that the most pernicious source of suffering, and the one source psychoanalysis could possibly have some effect on, is "the suffering that humans can experience in their relationships with each other."

Although we might argue there are manifold sources of suffering that bring patients knocking on our doors, we are all familiar with struggles in relationships and the desperation, frustration and despair they can engender. Further, in today's contemporary psychoanalytic world I think we can say that, although we cannot prevent illness, aging, dying and death or the overwhelming traumas of natural disasters, we can help people bear their suffering and come to terms with it.

Finally, Freud had a recommendation to make regarding the promulgation of suffering in the analytic situation. He posited a technical notion that most of us would not subscribe to in today's world, namely, that exacerbation of suffering is essential for therapeutic gains. Freud developed this idea against the background of his time and place. He apparently shared the cultural ethic of his time wherein suffering was viewed as a means of character building. (See Strupp 1978)

Ferenczi had something to say about suffering by way of a powerful metaphor, "terrorism of suffering." He first introduced this phase in his clinical diary in describing a seriously traumatized patient. (See Galdi 1996 for an elaboration of Ferenczi's notion of terrorism of suffering as it applies specifically to transference and countertransference.)

Michel Guy Thompson (2001), in his presidential address to IFPE entitled "Happiness and Culture," revisited Freud's ideas presented in *Civilization and Its Discontents*. In the process of engaging in such a review, he necessarily considers notions of suffering and suggests that "[s]uffering and happiness enjoy a complementary relationship" (4).

All major religions have something to say about suffering. Unfortunately, there is not adequate time and space for even a thimble-full worth of discussion of comparative religions position on suffering. Suffice it to say that, the Judeo-Christian myth of the Passion and the Fall accounts for the necessity of human suffering. Buddhism has much food for thought to offer on the topic of suffering, some of its ideas seem in concert with Existential psychology. For example, Buddhists say life is suffering. You can't willfully change that condition. Rather, the focus needs to be on how you relate to suffering and deal with it. One has to live with it as a condition of life and not seek to fight it or fix it. My brother has

been interested in Zen Buddhism and meditation for many years, and since his diagnosis, he has been working on selected Zen koans attempting to realize some Zen ideas. Some of the Zen “concepts” that have particular meaning to him are: impermanence (everything changes all the time)—the essence of things are “empty,” awareness of the present moment—paying attention to what is happening as opposed to getting caught up in discursive thinking—and realizing absolute reality, which can’t be verbalized or understood by thought, but only through meditation and koan training.

There is quite an extensive body of literature devoted to the analyst’s life situation and how it affects treatment (see end references A). The following is a sketchy vignette of one of the many ways my brother’s terrible disease accompanied me into the consulting room. It is personally idiosyncratic and particular to my situation.

Shortly after my brother’s diagnosis was confirmed, Mr. Gingold came to one of his regular multiple-time-per-week sessions. Mr. G is a middle-aged man whom I have seen for over 15 years. He is an aggressive, intense, and vigorous man, who looks and seems much younger than his chronological age. He is an architect, and during the course of our long years of work, Mr. G has achieved great success and received many external confirmations of his talent and native abilities.

Mr. G is a negotiator par excellence, and devotes much of his prodigious energy to reaching his desired goals. Although we have spent much time on his underlying sense of inferiority and lack of self-confidence, he can also be characterologically quite cocky. Before this particular session, his style had not especially been a problem for me, or offended me. This is a patient I continue to be very involved with, one I am very fond of, and someone of whom I have come to appreciate many of his positive qualities, particularly his desire to do good for others that he cares about. I have been very impressed with the fundamental depth of his changes and his persistence in tackling his many maladaptive and counter productive ways of being in the world.

Mr. G and I have gone through many significant changes in his life. He initially entered treatment because he was fired and unemployed for long periods of time while he reached great heights of acclaim. He went from being a compulsive womanizer to being able to get married, be monogamous, and have a child. He is a wonderfully involved and caring father. Unfortunately, he chose a very difficult woman to marry and she turned out to have a serious addiction and a borderline personality. Mr. G worked very hard to make the marriage work, but eventually it became impossible to continue. Currently he is at the tail end of a most acrimonious child custody and divorce proceeding. He recently, through dint of his intelligence and tenaciousness, has been awarded his goal of 50% child custody.

In the session we had just after I learned of my brother’s diagnosis, Mr. G came in full of his usual energy and began talking about the appointment he had recently made for his yearly physical. In his quite cocky way, he said, “Of course I know there’s nothing wrong with me!” At that moment, I found myself having a very strong reaction to him. How could he be so sure? Here was a man in his early mid-50s, who had no apparent anxiety about what might be found from a physical. I found myself comparing him to my brother and to my brother’s awful diagnosis and prognosis. He is also a man in his mid 50s, and his illness came out of the blue. I realized with a start that my patient was only a few years younger than my brother. I had never consciously thought of him in relation to my brother nor had I compared their age difference before that very minute.

Further comparisons came tumbling down like a landslide on a rocky hillside. Here was this man, not much younger than my brother, not only so assured about his physical health but on the cusp of starting other new beginnings in his life. He recently embarked on a relationship with a lovely woman, and the possibility of marriage and starting a second family was on the horizon. We had worked long and hard on his problems with intimate relationships and we were seeing

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According to Freud, the most apparent source of suffering is our body, with the various illnesses and pains we are all subject to, ultimately “doomed to decay and dissolution.” The second source of suffering is the external world that “rages against us with overwhelming and merciless forces of destruction,” where all matter of natural and man-made disasters may occur. Finally, the most pernicious source of suffering, and the one source psychoanalysis could possibly have some effect on, is “the suffering that humans can experience in their relationships with each other.”

A Handbook of Divorce and Custody: Forensic, Developmental and Clinical Perspectives

Co-edited by Linda Gunsberg and Paul Hymowitz

The Analytic Press, Inc., Hillsdale, NJ

(Reviewed by Kathleen Hushion, CSW)

As child therapists working with families of divorce, we are frequently caught in the middle of embattled parents and dragged into custody disputes that conflict with our clinical work. Divorce proceedings, custody disputes, and parental hostility are ever-present ghosts in the office as we continuously clarify our role to parents and attempt to remain impartial. While making it clear that I do not participate in any legal action, I often felt it would benefit my clinical work to be more informed about what actually goes on in courtrooms and attorneys offices. This handbook provides a wealth of useful information. In the first section, we are introduced to the process in the courtroom, from the point of view of a judge, lawyers, and psychologists whose collaboration is crucial to the rendering of an informed decision that is "in the best interests of the child." There is an outline for forensics evaluations, and terms like law guardian and the difference between a law guardian and guardian ad litem are defined. But overall, the real strength of this volume is in the depth and breadth of clinical issues presented throughout.

As several of the chapters note, divorce is now commonplace in our society, but the effects on children and families is insidious and complex. As I took stock of my own practice, I was shocked to realize how many of the children and adolescents in my caseload had separated or divorced parents. Some parents

Book Film

R E V I E W S



astutely bring their children for therapy as soon as marital problems start while others are so self-involved or simply overwhelmed that they don't consult with a professional until a school problem or other symptom arises, and the parental disharmony or divorce is presented as part of the background history. Divorce has been woven so tightly into the fabric of our society that we as individuals and clinicians lose sight of its constant presence. This volume loosens the threads of this problem and provides 27 chapters as varied and diverse as the problem itself.

*The newsletter welcomes reviews of books and films relevant to membership concerns, and members who author books and/or chapters are encouraged to contact Diana Siskind, book review editor, upon publication. Diana Siskind, MSW, 321 W. 78 St., Apt. 1E, New York, NY 10024
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Diana Siskind

BOOK REVIEW EDITOR



The phrases "soul murder" and "soul blindness" evoked powerful images in the Novick's chapter, which highlights the famous case of Jessica deBoer. In taped interviews with Jessica and her parents, the child appeared stable and happy, but the authors raised the critical question: was this an "adaptive transformation or a defensive submission"? The effects of divorce and the resulting custody and visitation arrangements often have insidious and far-reaching affects on the authentic development of the children. When parents are unable to see beyond their own needs and anxieties, children become victims of projection and externalization which is so damaging to the progression of a true self. An "apparently" healthy well-adjusting child can be presenting a false self that overrides the significant conflict underneath.

Even the most well-meaning parents will unconsciously manipulate their child for their own purposes. In the extreme, allegations of sexual abuse can be used as a weapon to interrupt the relationship with one parent and their child or children. B. J. Cling presents this issue and explores the suspicions of many experts that false reporting is on the rise. The serious and pathological implications of this kind of manipulation is "creating a false reality" and is discussed in M. Shopper's chapter on parental alienation. **Whether** consciously or unconsciously, all parents "involve" their children in the divorce and replace the child's perception of reality with their own. Shopper defines "[d]isorders of created reality" as situations in which a persons own autonomous sense of reality testing and reality appreciation are devalued and/or overwhelmed and replaced by a different reality through the actions of another." This

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Moving Beyond the Comfort Zone in Psychotherapy

By Nancy A. Bridges, PhD

Jason Aronson Publishers: 2005.

(Reviewed by Cathy Siebold, DSW, LCSW)

In her book *Beyond the Comfort Zone*, Nancy Bridges engages us in a discussion of some deeply felt struggles by therapists engaged in dynamic psychotherapy. One particularly useful aspect of this book is the way she demonstrates the application of relational and intersubjective ideas to the therapeutic process. Throughout the book there are numerous examples of her work with patients and with supervisees. Her focus is on the various ways that therapists and patients struggle to connect rather than foreclose connection. Her willingness to provide multiple examples of her work was impressive and useful. Bridges also integrates cognitive techniques with dynamic processes and gives the reader ideas about a more active style of practice. Recently, authors such as Allen Sugeran, Peter Fonagy and Mary Target have also demonstrated the utility of greater activity on the part of analytically oriented therapists.

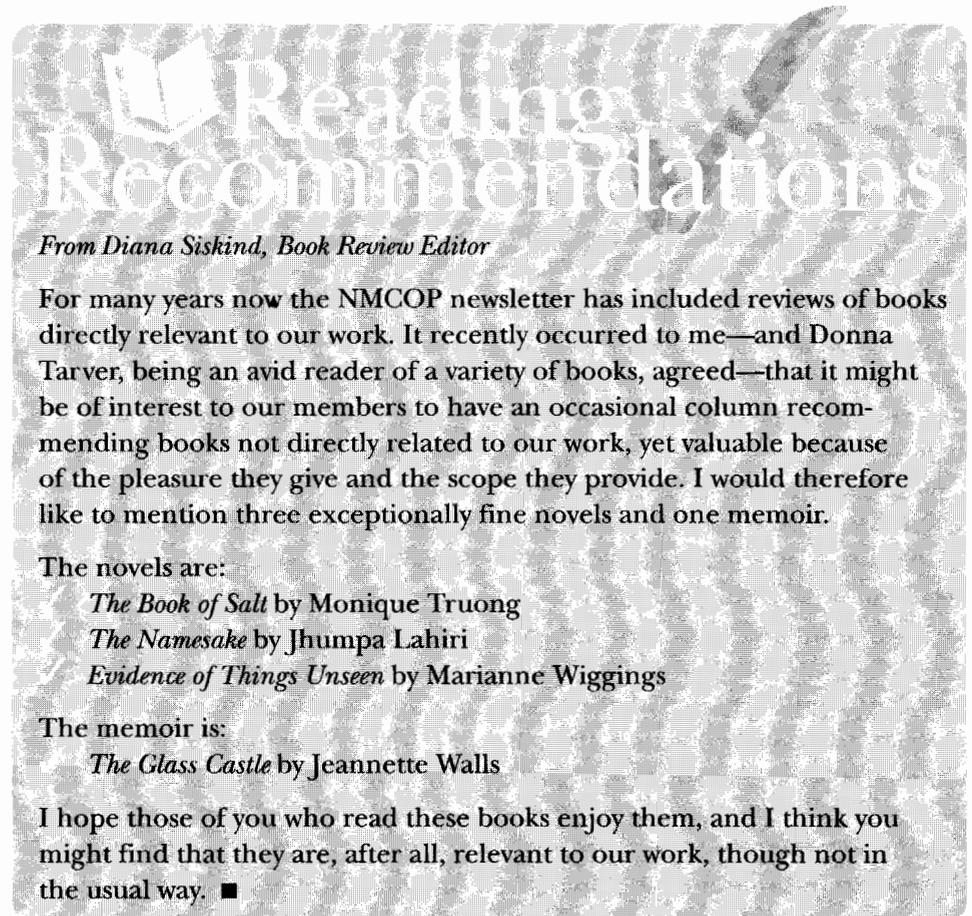
The strength of the book is that it depicts the therapist at work. Repeatedly, Bridges focuses on clinical issues related to enactment, impasse, boundaries, and disclosure and the therapist's feelings as he or she traverses these clinical moments. In her examples of clinical encounters, she emphasizes the myriad ways that she thinks about a patient's needs. Her description of her perceptions of the professional's role in participating with the patient is clear and grounded in practice values and ethics. As with any work, maintaining a focus means that some areas may be less well articulated. In my reading of the text it seemed that although

she draws from a number of analysts who recommend differing perspectives, there is little presentation of alternative points of view. As the chapters progress, the author increasingly emphasizes aspects of a relational and intersubjective perspective that are consistent with her style of applying these ideas. Depending on the reader's interests, this focus can be useful in that it clearly demonstrates the author's thinking and use of these perspectives to inform her clinical practice.

The first chapter presents a brief but clearly elaborated description of clinical concepts such as enactment, projective identification, and boundaries from a relational perspective. In this chapter's section, "Internal Boundaries," Bridges introduces what is a continuing focus of the book, the transference and countertransference pulls that can occur

between patient and therapist. Both parties can have feelings and responses that are in part derived from personal history and in part derived from the therapeutic dyad. The therapist's ability to manage this complexity is an important focus of this book. Within the context of describing these concepts, she also sets a tone for creating a safe, ethically bounded space for patient and therapist. The theme of creating intimacy in the therapeutic dyad while preserving safety for patient and therapist is further elaborated in chapter 2. Here the author begins to treat us to extensive clinical material demonstrating not only her interventions with her patients but also why she does what she does. The integration of relational ideas such as those described by Mitchell or Benjamin further elaborate her thinking about

See *Comfort Zone* on page 8...



Reading Recommendations

From Diana Siskind, Book Review Editor

For many years now the NMCOP newsletter has included reviews of books directly relevant to our work. It recently occurred to me—and Donna Tarver, being an avid reader of a variety of books, agreed—that it might be of interest to our members to have an occasional column recommending books not directly related to our work, yet valuable because of the pleasure they give and the scope they provide. I would therefore like to mention three exceptionally fine novels and one memoir.

The novels are:

- The Book of Salt* by Monique Truong
- The Namesake* by Jhumpa Lahiri
- Evidence of Things Unseen* by Marianne Wiggings

The memoir is:

- The Glass Castle* by Jeannette Walls

I hope those of you who read these books enjoy them, and I think you might find that they are, after all, relevant to our work, though not in the usual way. ■

difficult clinical moments.

In chapter 3, Bridges takes up the difficult and less commonly discussed topic of sexual feelings as expressed or experienced by patient and therapist. Again, I commend her courage in describing her internal thoughts and feelings. The descriptions of her interventions with patients are useful for both new and seasoned therapists. This chapter also explores aggressive feelings but in less detail. Although I agree with the author that much more has been said about feelings of anger than about sex, it might have been useful to some readers to have greater clinical elaboration of interventions where the patient or therapist are experiencing anger.

Although there are many ways that the author helpfully applies relational ideas and attitudes to the therapeutic process, at times she does not adequately define a particular author's point of view. For example, in chapter 3 she uses Benjamin's concept of the third, but she neither articulates what Benjamin means by this term nor contrasts this meaning with other analysts' use of the term. Similarly, in chapter 4, the author uses the construct of implicit relational knowing without describing the meaning of this construct. Those not well versed in contemporary relational ideas may find these omissions a bit challenging at times. In chapter 4, the author explores a number of thorny topics, touch being one of them. Acknowledging that touch is sometimes possible in the therapeutic relationship and that there are a number of analysts and therapists who have begun discussing ways in which touch can be helpful is an important aspect of this chapter. Moreover, the author exposes some of her experiences and guidelines

that she uses to respond to different patients. Bridges demonstrates the multiple ways that both therapist and patient experience self and other's needs. She further encourages the reader to think about his or her own subjective responses to complex issues such as touch or gift giving, recognizing that these are not right or wrong but that we each bring an individual perspective to these experiences.

The discussion as presented, however, is broad and at times may over-generalize the topic. For example, kissing a dying man on the cheek is a very different situation from hugging a patient at his or her request. The context of the dying process almost always **obviates** traditional rules that **focus on helping the patient to talk rather than act** (Redding, 2004). **Moreover, in the situation described, the dying man was the father of her adult patient with whom she had collateral contacts over the years. Perhaps in keeping with her intersubjective emphasis, it might have been helpful to elaborate on how collateral contacts impact the therapeutic dyad.**

Similarly, asserting **a rule that when the therapist senses that touch would induce erotic feelings, he or she needs to find a way to talk rather than acquiesce to a patient's request potentially oversimplifies sexual desire. If feelings are seen as part of a relational experience in the moment, then perhaps there is a way to distinguish a rule about when touch is helpful or not. If, however, sexual feelings or passions are seen as part of an innate unconscious wish, then erotic desire is probably always part of the process and such a rule is impossible to apply. The lack of a way to think about innate experience or passions is one of the difficulties faced by contemporary relational theorists** (Siebold 2005).

There are many other issues that the author addresses in this same chapter, among them gift giving and receiving, or attending special occasions with a patient. These are useful topics for discussion, but again it seemed to me that it might have been more helpful to distinguish differences in context between agency-based practices, termination experiences, or giving gifts to patients after many years of treatment. The author is conscientious in recommending that therapists obtain consultation regarding such controversial issues. She also reiterates her point from earlier chapters that boundary issues are important when discussing touch, gifts, or outside contact with patients.

In chapter 5, Bridges returns to a clearer articulation of issues related to dynamic psychotherapy. She focuses on the topic of self-disclosure and the way that she thinks about and uses self-disclosure with her patients. Although the reader may not always agree with her approach, these vignettes illuminate her thoughts and feelings and provide the reader with much to consider about similar interactions with patients. For example, Bridges suggests asking patients about their responses rather than waiting until the patient feels able to say something. Her vignettes also depict her thinking about ways to facilitate the patient's recognition of the fallibility or limitations of the therapist. Although the clarity of her descriptions is a strength of this chapter, there was little discussion of differing opinions about self-disclosure. Even within relational theory there are varying points of view. Some such as Pizer (1997) recommend open disclosure, whereas others suggest a modified approach. Cooper (1998) for example, has suggested that rather than a direct expression of feelings or experiences the therapist might

instead use what he has termed "virtual" disclosure. Instead of saying I will miss you, the therapist might say, what if I did miss you? This is not to suggest he is right and Pizer or Bridges are wrong, but to offer that there are multiple ways of thinking about disclosure within the relational approach.

In the final chapter, Bridges explores the topic of supervision. In some ways this chapter mirrors the first chapter, in that her approach to supervision is similar to the eclectic way she approaches psychodynamic therapy. At the same time, it seemed that she particularly advocates a respectful, didactic approach to the supervisory process. Arguably, respecting supervisees, sharing clinical experiences with them, and using a didactic approach are valuable components of supervision. At the same time, I thought that her recommendations could have benefited from including ideas about parallel process or the ways that aspects of the clinical encounter may be recreated in the supervisory dyad. Bridges is particularly concerned that the supervisor not engage in activities that will shame the supervisee. Certainly, this is a sound recommendation. Shame, however, is a deeply felt emotion that is often underestimated in therapeutic work (Morrison, 1986). Perhaps there could have been ways to think about and explore feelings of shame that occur in supervision in ways that would be constructive to the supervisory and therapeutic dyads.

Nancy Bridges has provided us with a text describing in rich detail the interactions between therapist and patient. The extensive use of clinical detail provides the reader with much to ponder. Her willingness to expose her thoughts and activities, including her mistakes with patients is refreshing. Readers seeking to

understand what it means to be relationally or intersubjectively focused will benefit from sharing in the author's experiences.

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Divorce, continued from page 6

issue is presented in more depth by Wallerstein and Resnikoff in their discussion of the "strange new reality" that can result in a child's inner world when the changing relationships in a child's external world are contaminated with the effects of the divorce. Tessman addresses this issue in her excellent chapter on the absent father. While reminding us how children identify with a lost parent as a way to defend against the pain of loss, this is problematic in divorce where the identification is "based on those memories that are most laden with exquisite affective pleasure or pain, magnified by their intensity and cut-off from growing along with the rest of the child." The internal image is further compromised by the opposing parents hostility and results in a differentiation of the father "in sight" and the father "inside."

Currently, I have two cases of

Redding, K. K. 2005. When Death Becomes the End of an Analytic Treatment: Necessary Parameters. *Clinical Social Work Journal* 33:69-80.

Pizer, B. 1997. When the Analyst Is Ill: Dimensions of Self-disclosure. *Psychoanalytic Quarterly* 66:450-69.

Siebold, C. 2005. "Sexual Inhibitions, Body Image, and Eating Disorders: Contemporary Psychoanalytic Theory of Female Psychosexual Development." Presentation at The New Jersey Institute for Training in Psychoanalysis. Teaneck, NJ, July 18.

adolescents whose parents have joint custody, and the fathers in each case have remarried. One mother is mildly depressed, the other is narcissistic and manipulative, but neither has pathology serious enough to question custody. And yet both fathers have expressed the belief that their teenage daughters would be better off living full-time in their newly created family complete with stepmother and stepsibs, and one is actually pursuing legal custody. On the surface, these fathers appear to have the child's best interests in mind, but, clearly, underlying motivations related to financial control and vindictiveness toward the ex-spouse are at play. These men are both relatively high-functioning individuals whose judgement is impaired, and their daughters are becoming victims of a split reality. Each is attempting to manipulate their daughter's affections from mother to stepmother in a presumed effort

See Divorce on page 10...

to offset the noxious effects of the mother's supposed pathology.

Klein, in his chapter on parental rights, highlights the critical task of the forensic psychologist to tease out these underlying motivations. He also takes on the roles of stepparents and their negative as well as positive influence in divorcing families. Several chapters are devoted to guidelines for forensic evaluations and outline the unique psychological variables that must be considered. Linda Gunsberg's chapter is particularly good at explaining the unconscious conflicts at play and the unique transference and countertransference issues that are aroused in families and evaluators. Elaine Schwager takes this a step further in her beautiful piece focusing on the inner creative world of the child. She discusses the importance of assessing the child's spiritual and artistic development to assure that each parent is recognizing the child's needs for creative expression.

An entire section is devoted to the very thorny problems of visitation. It was not that long ago that the standard custody arrangement involved one full-time custodial parent, usually the mother, with visitation with father every other weekend and one night a week. In my experience, that has been replaced with the more equitable but exceedingly complicated joint custody arrangement where the children spend equal time with each parent. Many families split a week in half and the kids spend Sunday to Wednesday with Dad and Thursday to Saturday with Mom. Or they alternate weeks or even months. And then there is the problem of relocation, which is presented in a very good chapter by co-editor Paul Hymowitz. But the salient point is that children are asked to lead a double life with two homes, two families, two sets of clothes, and two separate and different experiences of parenting.

While it is not possible to mention all the chapters in this book, it is worth mentioning a few others that develop important aspects of divorce and its affect on the developing child. Ava Seigler hones in on aggression and how the hostility and often violence in a broken home impair the normative development of a child's aggressive drive. Co-editor Linda Gunsberg writes about the parental affair which is so often a part of these families in reality and fantasy. She focuses on the incestuous affair which she defines as sexual relations between a spouse and a relative or family friend while it is clear that any parental affair has incestuous overtones for a child. This adds a heightened complication to the child's experience of divorce and exacerbates feelings of betrayal and further erodes the trust.

Most of the articles, written from a psychoanalytic/

developmental perspective, reinforce the need to be mindful of a child's developmental age at the time of trauma as well as in treatment planning. A chapter by Diana Siskind provides an outline for assessment and treatment of children and families in the throes of divorce and advises the reader to "take the time to carefully assess the child and his parents and the impact of the divorce on each of them and on the family unit." We can see a child like little Jessica de Boer, who appears healthy but may be in a state of heightened mobilization of defenses, while another can be in an obvious regressed state that may or may not be related to the divorce. As in all good clinical work it is important to establish a foundation to "understand both child and parents beyond, as well as within, the microcosm created by the crisis of divorce."

This book is an excellent resource that I highly recommend as a guide to help your patients navigate their way through the storm and stress of divorce. ■

Kathleen Hushion, CSW, is a psychoanalyst in private practice in NYC and in Huntington Long Island, NY; member and faculty of IPTAR; and supervisor of IPTAR's Child and Adolescent Training Program. She is a co-editor of a forthcoming book, Understanding Adoption.

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Returning a Psychoanalytic Perspective to Social Work Education

By Joyce Edward, LCSW, BCD

As some NMCOP newsletter readers know, I have for the past several years been involved in an effort to help promote the teaching of psychoanalytic theory at my alma mater, the Mandel School of Applied Social Sciences (MSASS), Cleveland, Ohio. To that end, I have funded a series of yearly case seminars developed by Dr. Jerry Floersch, Associate Professor. Dr. Floersch is the author of *Meds, Money, and Manners: The Case Management of Severe Mental Illness*, and he is currently conducting NIMH funded research on youth subjective experience of psychotropic treatment. He has a forthcoming (co-authored) book entitled *On Being a Case Manager*.

To address the underutilization of psychodynamic case study material in the curriculum, Dr. Floersch has for the past three years organized a five, two hour seminar which offers students the opportunity to follow the work of an analyst. This past year eight students completed a seminar conducted by Dr. Jeff Longhofer, Visiting Associate Professor at MSASS. Dr. Longhofer is a recent Smith College of Social Work graduate and a psychoanalytic candidate at the Cleveland Psychoanalytic Center. Dr. Longhofer created composite case studies from two ongoing adolescent psychotherapy cases and discussed with students the engagement, assessment, working with parents, goal setting, and termination processes, from a psychodynamic, case study perspective.

Let me quote from some of the student's year end evaluations of this year's seminar:

"[In this seminar I gained] a better understanding of what psychotherapy looks like in a real-life, clinical setting. . . . [F]or example, I gained a better understanding of the relationship between internal and external world and defense mechanisms. I also expanded my understanding of how a therapist might go about helping the client in a gentle and respectful manner One major complaint I have with my current education is that I have learned the theory but I have not been exposed to any type of social work methods or clinical techniques. I benefited from Jeff's descriptions of how he engaged with his clients and techniques he has found useful and not so useful."

"[F]rom the seminar I have an increased understanding of what it means to 'respect' someone's defenses, and the need to proceed 'gently' in uncovering these with a client, and to some extent keeping defenses intact while they are still needed."

"I have had some limited exposure and training in my classes so far regarding psychoanalytic theories, which led me to have very mixed feelings on the utility and validity of this perspective. Hearing about actual practice implications and the benefits in specific cases truly helped me to gain a better appreciation for the theories Thanks for this wonderful opportunity."

"The seminar was the best offering of a form of therapy I had little or no knowledge of. I think that psychodynamic psychotherapy should be a required course at Case, as it gives the student a comprehensive and detailed experience in the healing process. Dr. Longhofer showed hands-on use of this method. I'm very honored to have been able to attend. What I learned: skills in engagement techniques. Thanks."

The student evaluations of this project have been positive each year. The success of the project has also demonstrated that a significant number of students appreciate seminars or coursework in the psychodynamic method. The seminars have provided Dr. Floersch with baseline information to argue for the return of case studies to the general curriculum. For example, the Mandel School faculty voted (May 2005) to accept an important curriculum change (voted on May 2005) wherein all students will learn at least two social work intervention methods; however, each method must contain case study material. Group work will be one mandatory intervention method. Students will choose a second intervention among cognitive-behavioral, family systems, and interpersonal/psychodynamic perspectives. The change means that the MSASS direct practice curriculum will include a course that describes psychodynamic theory and a second course focused on psychodynamic theory in practice. The psychodynamic courses were not currently being offered nor had there been a focus on case study material. In sum, the seminars helped build confidence to argue for more case study presentations and psychodynamic perspectives.

Next year, Dr. Floersch is planning to develop an ongoing case study within the general curriculum. My contribution will be used to pay community practitioners an honorarium to offer a case study presentation of some aspect of psychodynamic work. Each practitioner will be asked to share a vignette from a case that demonstrates

See Social Work on page 12...

some particular aspect of theory, as it relates to practice. These seminars will take place every other week for two semesters, for a total of fourteen sessions. Dr. Floersch hopes that the success of such a pilot project will help field staff, faculty and students see the importance of connecting case studies to the student's own field experience and learning.

It has given me great satisfaction to help fund these seminars. I have been most appreciative of Dr. Floersch's efforts in developing this project. It is his creativity, his time and his effort that have made such a program possible. I am also very appreciative of the willingness and support of the Mandel School in this effort to return psychoanalytic theory to social work education. As we know and as the students above have discovered, contemporary psychoanalytic theory has much to offer to today's social workers particularly those on the "front lines" of practice. Any effort we make to help schools of social work today to understand this, will I believe be to the advantage of the students, to their clients, and to our field in general. ■



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The *Psychodynamic Diagnostic Manual* (PDM): Overview

By Stanley I. Greenspan, MD; Nancy McWilliams, PhD; and Robert Wallerstein, MD

The *Psychodynamic Diagnostic Manual* (PDM) is a diagnostic framework that describes the whole person—both the deeper and surface levels of an individual's personality and that person's emotional and social functioning. It emphasizes individual variations as well as commonalities. This framework opens the door to improvements in diagnosis and treatment of mental health disorders and to a fuller understanding of the functioning of the mind and brain and their development. The PDM complements the DSM and ICD efforts of the past 30 years in cataloguing symptoms and behaviors.

The PDM is based on current neuroscience and treatment outcome studies (discussed in the research section) that demonstrate the importance of focusing on the full range and depth of emotional and social functioning. For example, research on the mind and brain and their development shows that the patterns of emotional, social, and behavioral functioning involve many interconnected areas working together, rather than in isolation.

Treatment outcome studies point to the importance of dealing with the full complexity of emotional and social patterns. Blatt and colleagues demonstrate that the features of the psychotherapeutic relationship, which involve many components of the mind and brain working together in an interpersonal context, predict outcomes far more robustly than any specific treatment approach per se. Westen and colleagues demonstrate that treatments that focus on isolated symptoms or behaviors (only one part of the mind and brain), rather than larger personality and social and emotional patterns, are not effective in sustaining even narrow behavioral or symptomatic change and do not address more complex personality patterns. In addition, Shedler and Westen, Dahlbender, and many others show that it is now possible to measure complex personality patterns, emotional and social patterns, and the interpersonal processes that constitute the active ingredients of the psychotherapeutic relationship. Reviews by Leichsenring and Fonagy, as well as others, demonstrate that psychodynamically based therapeutic approaches not only alleviate symptoms, but also improve overall emotional and social functioning.

The PDM was created through a collaborative effort of the major organizations representing mental health

professionals concerned with in-depth approaches to emotional, social, and behavioral functioning. These organizations are: the American Psychoanalytic Association, the International Psychoanalytical Association, the Psychoanalytic Division [39] of the American Psychological Association, the American Academy of Psychoanalysis, and the National Membership Committee on Psychoanalysis in Clinical Social Work. Their presidents formed a Steering Committee and recommended members to serve on work-groups to construct this diagnostic classification system

The diagnostic framework formulated by the PDM work groups systematically describes:

- Healthy and disordered personality functioning;
- Individual profiles of mental functioning, including patterns of relating, comprehending and expressing feelings, coping with stress and anxiety, observing one's own emotions and behaviors, and forming moral judgments; and
- Symptom patterns, including differences in each individual's personal or subjective experience of his or her symptoms.

In summary, the *Psychodynamic Diagnostic Manual* adds a needed perspective to existing diagnostic systems. In addition to considering symptom patterns described in these systems, it enables clinicians to describe and categorize personality patterns, related social and emotional capacities, unique mental profiles, and personalized experiences of symptoms. It provides a framework for improving comprehensive treatment approaches and understanding both the biological and psychological origins of mental health and illness.

Rationale for the PDM

A clinically useful classification of mental health disorders must begin with an understanding of healthy mental functioning. Mental health involves more than simply the absence of symptoms. It involves a person's overall mental functioning, including relationships, emotional regulation, coping capacities, and self-observing abilities. Just as healthy cardiac functioning cannot be defined simply as an absence of chest pain, healthy

See PDM on page 14...

mental functioning is more than the absence of observable symptoms of psychopathology. It involves the full range of human cognitive, emotional, and behavioral capacities.

Any attempt to describe and classify deficiencies in mental health must therefore take into account limitations or deficits in many different mental capacities, including ones that are not necessarily overt sources of pain. For example, as frightening as anxiety attacks are, an inability to perceive and respond accurately to the emotional cues of others—a far more subtle and diffuse problem—may constitute a more fundamental difficulty than a few episodes of unexplained panic. A deficit in reading emotional cues may pervasively compromise relationships and thinking and may indeed itself be a source of anxiety.

That a full conceptualization of health is the foundation for describing disorder may seem self-evident, and yet the mental health field has not developed its diagnostic procedures accordingly. In the last two decades, there has been an increasing tendency to define mental problems more and more on the basis of presenting symptoms and their patterns, with overall personality functioning and levels of adaptation playing a minor role. There is increasing evidence, however, that both mental health and psychopathology involve many subtle features of human functioning. These include, in addition to surface behaviors and symptoms, a person's experience, awareness, and expression of a wide range of positive and negative emotions; coping strategies and defenses; capacities for understanding self and others; and quality of relationships. Mental functioning, whether optimal or compromised, involves not only the surface but also the deepest levels of the mind. Mounting evidence from neuroscience and developmental studies supports this perspective (see the PDM research section). To ignore mental complexity is to ignore the very phenomena of concern. After all, our mental complexity defines our most human qualities.

To describe accurately the mental condition of any human being, a classification of disorders of mental health must involve all relevant dimensions of human mental functioning. The psychoanalytic tradition, or what is often called depth psychology, has a long history of examining overall human functioning in a searching and comprehensive way. Nevertheless, the diagnostic precision and usefulness of psychoanalytic approaches have been compromised by at least two problems. First, in an attempt to capture the full range and subtlety of human

experience, psychodynamic accounts of mental processes have been expressed in competing theories and metaphors that have, at times, inspired more disagreement and controversy than consensus. Second, there has been difficulty distinguishing between speculative constructs on the one hand, and phenomena that can be observed or reasonably inferred on the other. Where the tradition of descriptive psychiatry has had a tendency to reify "disorder" categories, the psychoanalytic tradition has tended to reify theoretical constructs.

In recent years, however, having developed empirical methods to quantify and analyze complex mental phenomena, depth psychology has been able to offer clear operational criteria for a more comprehensive range of human social and emotional functioning (see the PDM research section articles by Westen, Shedler, Blatt, and Dahlbender). The challenge became to systematize these advances with a growing body of rich clinical experience in order to provide a widely usable framework for understanding and specifying complex and subtle mental phenomena.

In addition to describing symptoms, the goal of the PDM is to describe systematically the mental functioning of the whole person. As indicated earlier, it is intended to complement the existing DSM and ICD systems, which focus heavily on symptom groupings. Psychoanalytic and psychodynamic practitioners require this additional diagnostic system for an adequate conceptualization of the phenomena they deal with daily in their clinical assessment and treatment work.

Over the past 20 to 30 years, in the hope of developing a fully empirical basis for diagnosis and treatment, the mental health field has progressively narrowed its perspective, focusing more on isolated symptoms and less on the full range of human mental functioning. The whole person has been less visible than the various disorder constructs on which researchers can find agreement. Recent reviews of this effort raise the possibility

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that such a strategy was misguided. Ironically, emerging evidence suggests that oversimplifying mental health phenomena in the service of attaining consistency of description (reliability) and capacity to evaluate treatment empirically (validity) may have compromised the laudable goal of a more scientifically sound understanding of mental health and psychopathology. Most problematically, reliability and validity data for many disorders are not as strong as the mental health community had hoped they would be. Allen Frances, MD, Chair of the DSM-IV American Psychiatric Association Task Force, commented in *The New Yorker* magazine that the reliability hoped for has not been realized and that, in fact, the reliability among practicing clinicians is very poor. In moving towards DSM-V, the APA Task Force is consequently shifting towards a more dimensional, rather than purely categorical, approach.

In a recent article in the *Journal of the American Medical Association* (reference), the author pointed out that medicine has moved beyond simply describing symptoms to categorizing disorders according to the nature of the functional impairment and, where possible, etiological factors. The author contended that current

classifications of mental health disorders may have gone so far in the purely descriptive direction (overlapping categories, excessive co-morbidities, etc.), that they are compromising the search for better understanding and treatment of mental health disorders.

The PDM is organized around an understanding of the processes that contribute to emotional and social functioning. Early in its history, psychodynamic theories emphasized etiological factors. As in all fields of medicine, clinicians and researchers quickly learned that the etiology of all disorders was more complex than the initial observations and theory had suggested. For this reason, psychodynamic models have moved in the direction of functional understanding of mental health disorders, with the expectation that such understanding will guide the identification of etiological patterns. For example, the PDM approach to personality disorders is built around identifying patterns that capture the quality and degree of impairment in such basic emotional capacities as forming and sustaining relationships; regulating affects, moods, and impulses; and carrying out essential human functions in family, educational, and work settings. The profile of mental functioning in the PDM examines in great detail the components of these functional patterns. The approach to symptom patterns in the PDM is to add to the descriptive level of the DSM system an understanding of the patient's unique internal experience of those symptoms and their functional role in the patient's overall experience of the world.

The PDM uses a multidimensional approach to describe the intricacies of the patient's general functioning and ways of engaging in the therapeutic process. It begins with a classification of the spectrum of personality patterns and disorders found in individuals. It then describes a "profile of mental functioning" to look in more detail at each of the patient's capacities. This is followed by a description of the patient's symptoms, but with a focus on the patient's internal experiences as well as surface behaviors. The PDM covers adults, as well as infants, children, and adolescents.

To order a copy of the *Psychodynamic Diagnostic Manual (PDM)*, visit our website at <http://www.pdm1.org> for ordering information and more details. Or send a check or money order to: Psychodynamic Diagnostic Manual (PDM), 10125 Colesville Road, Suite 194, Silver Spring, MD 20901 (Phone: 301-789-1660). \$35.00 USD, plus shipping and handling (Domestic add \$6.00; International add \$10 [2-4 wks] or \$20 [10-12 days]) \$45.00 USD for Special Hardback Edition, plus shipping and handling as above. Available Winter 2005-2006. ■

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From fall of 2004 through spring 2005, we offered a group of compelling, informative, and entertaining programs that evolved from the interests expressed by our members. Clinically relevant innovated work was requested as the primary focus.

The presentations more than fulfilled the expectations of the group.

Billie Lee Violette, MSW, PsyD, began the year by sharing her paper called "Continuing a Successfully Psychoanalytically Oriented Therapy during a Patient's Psychic Break," and Dori Dubin followed in January with her presentation of "The Mind Body Space: Creating the Psychic Skin for the Analytical Couple." Both papers were theoretically sophisticated, demonstrating keen therapeutic skills that generated a lively discussion among the group members.

In the spring, Joan Hammerman Robins, LCSW, presented her paper, "A Psychotherapist Retires." Her vivid thought provoking descriptions of her experience opened the way for members to candidly share their own feelings not only about their retirement but also about taking sabbaticals and absences due to illness.

In June, Rita Karuna Cahn, LCSW, offered a unique presentation, "Compassionate Listening: Social Activism in the Middle East." A seasoned therapist, Rita talked about the challenges of applying her therapeutic skills in politically charged situations that trigger profound emotional biases. She felt the experience was transformative, as her presentation was for the participants, especially in response to Rita's evocative photographs.

We have worked to generate an atmosphere that offers our members a forum for open discussion something we all need in the face of the challenges we meet in our work with patients.

This upcoming year promises to be equal last year's program. We begin our presentations November 5 with Dr. Laurel Samuels' program called "Dr. Malfi's Knee." She has studied and written extensively about the portrayal of female therapists in film since the 1980s. This promises to be a most unique and entertaining experi-

ence. Central to this presentation will be the use of film clips illustrating her core ideas. Billie Lee Violette, MSW, PsyD, will be the discussant. I look forward to giving you my report on this original program.

I am happy to report that we have been working very closely with the California Society of Clinical Social Work which has been very supportive. The society has enabled us to successfully reach the social work community. Currently, we are solidifying our connection with the Sanville Institute for Clinical Social Work. On January 24, 2006, the three organizations are jointly sponsoring a program called "Trauma as Seen from a Cross-Cultural Prospective."

We are encouraging our group to participate in the 2007 conference and hopefully you will be able to hear some of these papers at that time. ■

~ Velia K Frost

New York State

Penny Rosen, MSW, Chair
212.721.7010 or rosenpmsw@aol.com

On October 30, a local meeting on Long Island, organized by Joyce Edward and held at the home of Monica Rawn, will feature Sheila Felberbaum. Presenting her paper "Life Threatening Illness, Death and Countertransference," Sheila will illustrate one practitioner's experience as she shares not only the voices of her patients but also her own struggles involving the joy of connection and the pain of loss inherent in doing this work. Accompanying a patient on a journey from diagnosis to death intensifies one's reactions exponentially when self or family illness are concurrent.

On February 11, 2006, NMCOP joins the Psychoanalytic Psychotherapy Study Center (PPSC) in co-sponsoring a half-day panel discussion. The topic is "Hide and Seek: When Secrets Haunt the Treatment." The planning committee consists of Laurie Sloane, Executive Director of PPSC; Arlene Litwack (co-chair); Trish Tidwell (co-chair); Libby Kessman; Margo Lundell; Cathy Siebold; Carol Stangby; Ashley Warner; Fall Willeboodse; and myself. Stay posted for more details of this exciting event which will take place at the NY Blood Center, 310 East 67 Street, in Manhattan.

Other small gatherings are also being planned. ■

~ Penny Rosen

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Watch the Winter 2006 issue for more Area reports.

**Tenth NMCOP Conference
March 8 through 11, 2007**

The Unexamined Life

"The Examined Life," the 10th annual NMCOP conference, will take place in Chicago from March 8 to March 11, 2007, at the Swissotel overlooking the Chicago River. Featured speakers include Salman Ahktar, Stuart Twemlow, Philip Ringstrom, Kimberlyn Leary, and cartoonist Lynda Barry.

When Socrates declared, "The unexamined life is not worth living," he made a powerful statement about the process of inquiry that leads to the achievement of a personally meaningful life. For Socrates, this process of inquiry was a special type of conversation through which meaning and self-knowledge could be discovered. Implicit in this idea is the value of the process itself as a creative act that contributes to this meaning. The psychoanalytic endeavor is a similar type of creative, transformative conversation that leads to self-knowledge, personal growth, and a sense of well-being.

To help us explore the various ways that we as therapists examine the lives of the people we work with as well as the ways in which we examine our own professional activities, the conference committee is organizing an array of speakers, panels, papers as well as surprising fun experiences. We have invited several distinguished psychoanalysts to contribute to this exploration. Salman Ahktar is one of the most eloquent analytic thinkers, a published poet as well as psychoanalyst, with a special interest in emotions. Stuart Twemlow represents the best of "applied" psychoanalysis as he has worked to develop community and school programs that address the problems of violence and bullying in contemporary society. Like Ahktar, he is an articulate voice of the special ways that psychoanalysis can creatively transform lives. Philip Ringstrom is an analyst in the relational school with a particular interest in what he calls the "improvisational moment" that occurs in the course of the psychoanalytic conversation. The luncheon speaker, Lynda Barry, is a Midwestern author and cartoonist who writes autobiographically inspired pieces about race, childhood, adolescence, war, and family, and teaches writing as well.

The conference will also feature the best of local and national social work and psychoanalytic clinicians. You should receive announcements shortly about early registration for this not-to-be-missed meeting and a Call for Papers. ■

Our Contributors...

National Membership Committee on Psychoanalysis (NMCOP) is pleased to present its first *Annual List of Contributors*. We are very grateful to those on the list; their tax-deductible gifts will be used to strengthen NMCOP's stature and influence in the mental health field and to further our goals.

We will be happy to receive any additional gifts at any time. Checks should be made out to the National Institute for Psychoanalytic Education and Research in Clinical Social Work, Inc. (NIPER) and sent to:

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We encourage you also to send a contribution with your 2006 Membership Dues in Spring 2006.

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would not have been possible."

Marsha Wineburgh has, in her period as President-Elect, added her political astuteness and rich leadership experience to the Board's deliberations, and brought fresh insights, leading to new ways of perceiving and framing our challenges as an organization. Marsha has generously shared her expertise and experience with the Board, and with me in our weekly phone calls.

I also want to praise Marsha's landmark work in her role as our Legislative Chair. Over the last twenty years, Marsha has been unflinching in her ultimately successful efforts to develop, pass, and shepherd into reality, a New York State law regulating social work. All psychoanalytic social workers are in her debt, and I am pleased that she will continue to serve as our representative to the Consortium Legislative Committee.

Karen Baker has served admirably well as our Secretary, and the record keeper of NMCOP. It has been very reassuring to know during Board meetings that Karen is alert and on the job; that I can trust that part of the

meeting to her. Karen has also continued her **outstanding** work as Michigan Area Chair.

Terrie Baker has continued her excellent **support** work as Treasurer, providing ongoing reports to the Board on NMCOP's financial state. She has **foreseen** potential negative trends and made many **useful suggestions**, as we work to stabilize and increase our **financial** well-being. Terrie also continues her excellent **work** as the North Carolina Area Co-Chair.

Ellanor Cullens, as small area (Georgia) Board Member-at-Large, has contributed her Southern graciousness, organizational skills, and willingness to serve the Board in many ways. As Public Relations Chair, leader of our Ad Hoc Website Committee, member of the Continuing Ed Committee, and coordinator of the Area Chairs' Corner in our Newsletter, Ellanor has established herself as an indispensable resource, always willing to do a job that's needed, in the best way possible.

Penny Rosen, as large area (New York) Board Member-at-Large, has, in her six months on the job, and in her previous stint as Area Co-Chair, has brought with her the vigor, intelligence and creativity that she brought to

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her earlier position as 2004 Conference Director. Penny also serves on the Ad Hoc Website Committee.

Cathy Siebold, from her former position as Maine Area Chair, has jumped into Board activities as Chair of both, the Education Committee, and the Continuing Ed Committee, bringing an intelligence and freshness that is a joy to work with. Cathy has made connections, set up programs, and, in general, added an important dimension to our major goal of education.

Marilyn Schiff has followed her outstanding service as large area (New York) Board Member-at-Large by filling the long-dormant position of Chair of Development/Funding Resources. This issue of the newsletter carries ample evidence of Marilyn's industriousness and understanding of our critical organizational need for income, beyond membership dues and conference fees.

Anne Gearity, as Membership Chair, has performed the duties of her job so well we have come to take her many talents for granted. Beyond this, Anne has in many ways been the conscience of the Board, bringing daunting trends to our attention, always with well thought through recommendations for resolving them.

Bob Adams, our New Professionals Chair, has brought vigor and determination to our effort to make NMCOP a more attractive organization for young social work analysts and therapists to affiliate with. Along with Cathy Siebold and Ellanor Cullens, Bob is increasing the number of year-round offerings of NMCOP to our members, going well beyond our nationwide Conference presence.

Donna Tarver, in addition to anchoring our Southern presence as Texas Area Chair, only continues to grow in her position as Editor of our newsletter. Her always-gracious experience and expertise have been a beacon to all of us who believe NMCOP should have an outstanding publication.

David Phillips and **Eda Goldstein**, as National Study Group Chairs, have brought on new members, instituted regular conference phone calls, and arranged a simultaneous meeting with the Board at the March in-person meetings, which provoked a very stimulating exchange of ideas for future plans. They write, "It is our intention to continue the important work that this Group has accomplished for almost fifteen years: To further conceptualize how social work values and concepts may affect psychoanalysis, as clinical social workers emerge as the major group practicing this specialty in the United States, and to continue to illustrate ways in which the concepts and techniques of psychoanalysis can enrich the training and practice of clinical social workers in all settings."

There are two groups whose major contributions to NMCOP I would like to gratefully acknowledge:

1. Our *Area Chairs*, led by President-Elect **Marsha Wineburgh**, have each in his or her own way made valuable, ongoing, grass roots contributions:

California (Northern): **Velia Frost**

California (Southern): **Ellen Ruderman**

Colorado: **Cathy Krown Buirski**

Connecticut: **George Hagman**

Greater Washington DC/ Baltimore: **Sarah Pillsbury**

Florida: **Ellyn Freedman**

Georgia: **Ellanor Toomer Cullens**

Illinois: **Sidney Miller** (who also served on our Nominations Committee)

Massachusetts: **Margaret Frank** and **Emery Gross**

Michigan: **Karen E. Baker**

Minnesota: **Hilde Gasirowicz**

New Jersey: **Ellie Muska** and **Janice Victor**

New York: **Penny Rosen**

North Carolina: **William Meyer** and **Terrie Baker**

Texas: **Donna Tarver**

Washington State: **Betsy McConnell** and **Sal Ziz**

2. Our *Organizers*, led by our Administrator **Deborah Dale**, have proven so valuable, that without their unflagging, reliable and loyal services we simply could not function:

Joel Kanter—our Listserve Moderator and member of the Ad Hoc Website Committee;

Gale Meyer—our Webmaster, whose contributions grow more important and notable with each passing day;

Ellie Muska—whose years as New Jersey Area Chair and her service as the first small area chair Board Member have been followed by her work in the most vital position of Treasurer of NIPER. Ellie can never truly know how much gratitude she has earned by doing so well in this absolutely essential job;

Sarah Pillsbury—as our Greater Washington DC/ Baltimore Area Chair, Sarah will be our local Washington DC Representative to the Committee at the Austrian Embassy, which is planning the 150th Anniversary Celebration of Freud's birth in 2006. Sarah also sits on the Ad Hoc Website Committee;

Penny Rosen—our New York Area Chair, serves on the Ad Hoc Website Committee as well.

I have added two ad hoc committees to our organization, which are hard at work. One is the Standards for Psychotherapy Committee, and the other is the Standards

See President's Message on page 22...

yet additional signs of his growth. However, I found I could not feel good about our hard won accomplishments. I simply could not stand the comparison between his good state and my brother's horrible state. It felt unbearable.

Following the sessions, I had the intense and painful feeling that I could not go on with this type of work anymore. There was no fighting it off or trying to convince myself to think or feel differently. I was completely immersed in this state. I had never experienced such strong feelings of this nature in all my previous years of clinical practice. There was intense passion in my suffering for my brother. I think I was very much in the state powerfully echoed by the great existentialist playwright Samuel Beckett (1959, 418) when he wrote something I have thought about from time to time through many years: "Where I am, I don't know, I'll never know, in the silence you don't know, *you must go on, I can't go on, I'll go on*" (Italics added).

I did continue to practice, and I found my feelings easing, and, to my surprise, that I felt more involved and invested in my work with patients than previously. I became more capable of receiving each person I saw on their own terms, struggling with their unique constellation of problems, wishes and dreads. I felt a renewed value in each person trying to make the most of his/her life, however trivial or mundane it might appear on the surface. I was, after all, engaging with each of them in the stream of their life and mine. This felt very worthwhile and important to me. In the context of my renewed conviction of living life as fully as possible, potential hazards and all, I came upon an interview Studs Terkel did with the opera singer Catherine Malfitano. She said, while talking about welcoming risky moments, "I think that one has to always have the sense that death is right next to you" (2005). Certainly, my brother's illness helped catapult me to looking at the brevity of our lives and to keep on trying to get a better focus on how to face my mortality. This confrontation led to renewing my appreciation of life and the comparisons with some of my patient's circumstances and my brother's plight quieted down.

One might wonder why it was this patient that stirred me up so. Maybe it was that Mr. G labored so mightily against accepting any limitations. In his view, there was nothing that couldn't be overcome with enough intelligence, creativity, resourcefulness and energy. I too have had my experience of grappling with accepting my limitations; always bent on improving, changing for the

better, persisting against the odds, and so on. In fact, Judith Vida and I wrote a paper subtitled "Discovering our Limits and Finding Ourselves" (1998).

My brother's illness, of course, confronted him and the rest of the family with the extent of our utter helplessness and inability to rectify a stark physical reality. Indeed, we all have our own brand of difficulty facing our human limitations. It is an ongoing life challenge for most of us to sort out what we can change and improve and what we can not. I believe that Mr. G symbolized this never-ending dialectic for me.

My brother and I are in very close contact and have regular daily phone calls, as well as cross country visits, as often as I can arrange it. Serving as a resource and source of support has been enormously gratifying and enriching for me. Emanating from my "center of gravity" (see Ferenczi 1923), there is something mutually rewarding and vitalizing in our contacts for both my brother and myself. We have had many deeply moving talks about his growing up, our family, and in a sense have done an overall life review. I have gotten to know my brother much better, especially considering he was barely 13 years old when I moved from New York to

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California to go to graduate school.

In the process of dealing with my brother's illness, I have had to confront my lifelong tendencies towards survivor guilt. Why am I going on living and his life is being cut cruelly short? I have learned many lessons from my brother, including what is and is not worth fighting for, and I have come to admire his lack of rancor at his situation. He and his wife are absorbed in resourcefully trying to cope with his illness and the innumerable practical challenges that must be met. My brother has the capacity to be self observant and expressive, yet I do not feel his resentment at me or others, nor do I feel he is flooding me by the range of feelings he expresses. In fact, on the contrary, I welcome them, although this is very painful at times. I appreciate the opportunity to serve as a sounding board and anchor during the times he requires it. And I continue to grow in my capacity to just be with him, when that's what suits him. These of course are skills we have honed in the consulting room and ones that hold me in good stead in helping me keep my brother company as he copes with his situation. Recently, he is finding it more difficult to speak, and I have come up with the idea of reading to him. This is something he very much enjoys, and distinctly prefers to hear books on CD. Knowing how much he likes me reading to him gives me a real sense of pleasure. In a recent article, Frommer (2005) calls our attention to our mortality and the "role of the psychoanalyst as well as intersubjective aspects of the psychoanalytic process as central to helping patients (and ourselves) grapple with mortality" (479). He suggests that if we can develop the ability to acknowledge our evanescence, we can be freed up to appreciate the vitality of our lives. Being aware of the moment and acknowledging impermanence is precisely what my brother is actively trying to work on and I am groping my way along with him.

I conclude with a poem by Jack Gilbert entitled "A Brief for the Defense." In the poem, Gilbert talks about the utter necessity of our balancing joy with suffering, arguing that we are obliged to seek out delight. ■

*We must risk delight. We can
do without pleasure.
But not delight. Not enjoyment. We must have
The stubbornness to accept our gladness in the ruthless
furnace of this world. To
make injustice the only
measure of our attention is to
praise the Devil.
If the locomotive of the Lord
runs us down,
We should give thanks that the end had magnitude.*

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Reference A

See, for example:

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Winter Issue...

Deadline for submissions is January 15, 2006

The Legacy Project

Since its inception in 1980, the National Membership Committee on Psychoanalysis has been focused on the following aims and purposes:

- 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 and 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 ethical standards of practice and for quality mental health care for all.

In 1995, keeping pace with our growth, we created a sponsoring organization, the National Institute for Psychoanalytic Education and Research (NIPER), to enable us to better implement those goals in a tax-exempt, structured manner.

Now in 2005–06, the 150th anniversary of Freud's birth, again in recognition of our organizational growth and our increasing stature in the mental health field, we are initiating a fund-raising program to enlarge our resources beyond membership dues and conference income.

If you would like to help us achieve any of these modern goals, you may make 1) individual contributions beyond the regular membership dues and 2) legacy/testamentary gifts.

If you would like more information about our fund-raising program, please contact:

Marilyn G. Schiff, Development/Funding Resources Chair
212.255.9358 • 212.255.9070 fax
c/o Deborah Dale
Administrator, NMCOP
140 Meadow Lane
Chapel Hill, NC 27516

We look forward to your participation in our growth efforts.

If you are interested in the Legacy-type gift, here is a sample form for you or your lawyer.

I give, devise and bequeath the sum of \$ _____ to
the National Institute for Psychoanalytic Education and Research
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formed under the laws of the State of New York.

President's Message, continued from page 19

for Social Work Psychoanalyst Parity Committee, chaired by David Phillips, which was formed in response to the requests of many members of our listserve. NMCOP Members will be kept informed about the activities of these committees in future issues of our newsletter.

Looking to the future, in order to insure that NMCOP remains a vital, healthy organization, I believe that we must be actively open to the inclusion of the many different schools of thought, philosophies and orientations, which at times distract us by their differentness, but which, looked at from the perspective of different paths toward the well-meant goal of helping others live better lives, forms an extraordinarily rich road. While we must not lose sight of Freud, we cannot allow our understanding of his insights to become a barrier against contributions of many others, and we need to continue to integrate or change those aspects of our theory or practice that do not prove to be useful in generating clinical, organizational or developmental insights. At NMCOP, we are interested in keeping our relationship with psychoanalysis and social work a healthy and vibrant one.

It has been a privilege and an honor to serve as President of such a fine organization, and I look forward to continuing to work with the Board, our new President, Marsha Wineburgh, and our new President-Elect, Samoan Barish, to ensure that NMCOP will continue to expand its membership, its advocacy, its resources, and its offerings for psychoanalytic social workers long into the future. ■

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

2005 MEMBERSHIP FORM

Last Name: _____ First Name: _____ Degree: _____
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Would you like your email included on our list serve? Yes No (If left unchecked, you will NOT be included)

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What is your client population (check all that apply)? Children Adolescents Young adults Adults
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With which modality(ies) do you work (check all that apply)? Individual Group Couple Family
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Membership runs from January 1 through December 31 of each year. Please visit our website at: www.nmcop.org.

Members joining by March 31st will be included in the 2005 Membership Directory.

Mail this form and dues/donation to:

Deborah Dale, NMCOP Administrator
1403 Meadow Lane, Chapel Hill, NC 27516
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Questions? Contact:

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