ASPP NEWSLETTER

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PRESIDENT'S MESSAGE

By Holly White Gotta, D.S.W.

A great deal has recently been written in the popular press about the quality and reliability of services provided by managed care. An article in *Vogue* entitled "Mismanaged Care" exposes the secret contracts that restrict medical care. (Sherman, Feb. 1996). *Time Magazine* (Jan. 22, 1996) had an in-depth look at managed care. An article in *The Nation*, refers to managed care as a "scam" and as "playing the denial game". (Slosur & Lettieri, 1996)

These articles provide the general public with important information. In general, the consumer seems delighted with managed care as out-of-pocket costs for health insurance decrease. Employers too, have been happy with managed care, as their costs for health care benefits have been reduced by 15-30 percent. What the public doesn't know is that their HMO is probably inadequate. They don't find this out until it's too late!

The American Psychiatric Association has instituted a special managed care phone line for psychiatrists to call and document the errors made by reviewers, thus qualifying the level of patient care interference. The American Psychiatric Association reports 7,000 complaints between 1990-1994. (Slosur & Lettieri, 1996)

The managed care revolution is clearly having a profound and effect on the treatment of mental illness. *The New York Times* (Jan. 24, 1996) reported that in the name of saving money, managed care companies were denying essential mental health services and that as a result, psychiatric problems worsened. The charges were serious enough that the consumer-affairs agencies of California and Rhode Island have begun investigations of how managed care companies handle psychiatric claims.

In Massachusetts, a group of Mental Health therapists and patients are suing the Blue Cross/Blue Shield plan over what Dr. Frederick Schiffer, a Harvard psychiatrist who has taken the lead in the suit, says is an "extensive, covert system of deceptions, disincentives and intimidations that effectively prevent many patients from receiving the advertised mental health benefits." People are recognizing that a conflict of interest exists for those who must decide how much therapy to authorize.

Consumer Reports (Nov. 1995) included a survey about psychotherapy and drugs in one version of its 1994 annual questionnaire. It found that more than 90% of people treated with psychotherapy reported that they had improved, most of them markedly, and that long term psychotherapy did much better than short-term therapy. These results are obviously good news for psychotherapy: the most credible consumer publication in America has strongly endorsed psychotherapy. Moreover, CR takes on the insurance industry and managed care, suggesting that long term psychotherapy is highly effective and woefully undercovered, if covered at all. Detractors of psychotherapy; drug companies, managed care companies and insurance companies have all begun to look for methodological holes in this study. Martin E. P. Seligman, Ph.D, was a leading consultant to the *Consumer Reports* study. Dr. Seligman states, "the main methodological virtue of the CR study is its realism: it assessed the effectiveness of psychotherapy as it is actually performed in the field with the population that actually seeks it, and it is the most extensive, carefully-done study to do this."

I wonder how the managed care industry is effecting the day-to-day work of the mental health professional? In speaking to friends and colleagues, some say they're busier than ever, some say they are working longer hours for less pay. *The National Psychologist* conducted a year-end survey revealing that 58% of the psychologists participating continue to be in solo practice, and are surviving economically. Many, however are disheartened, and disgusted with the current healthcare environment. Despite the general dejection and concern about survival, the predominant majority plan to "hang tough" and hope to prevail.

The nationwide survey also disclosed that psychologists are struggling to maintain an income level commensurate with past years. Figures indicate their incomes, on average, are increasing less than the national cost of living average, and that psychologists are working longer hours to keep pace. The survey revealed wrenching frustrations about managed care. Some of the psychologists in the 56-65 year age bracket wrote that they plan to opt for early retirement. Among younger professionals, one solution given by several was to move to other states or to switch from solo practice to a salaried psychology position. Others are thinking about entering the investment or real estate business. Some want to develop marketable products. A few want to write

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books. Although concerned about the future only 16.8% had answered yes when asked if they had taken steps towards leaving the profession, while 83.2% had given it little thought.

BESIDES the practical constraints of managed care, there are the serious ethical dilemmas for all health care professionals and the public. In the ongoing and intense discussion of utilization and managed care review, the entire larger issue of confidentiality is often ignored. Confidentiality is severely compromised, if not destroyed, by a third party review. This intrusion in the therapy process certainly affects and alters our course of treatment. Most patients express aggressive thoughts, wishes, and fantasies that often are an important focus of treatment. Some clinicans document aggressive or suicidal expressions to justify requests for further authorized sessions. Other clinicans raise serious concerns about this documentation and the confidentiality of the patients innermost processes. "Unfortunately, a serious examination of the problems and dilemmas created around the issue of confidentiality by the managed care delivery models is not under discussion because of a single-minded emphasis on cost containment and the perceived extreme financial crisis being confronted." (Slosur & Lettieri, 1996)

There are some courageous coalitions forming against managed care policies. Our own Karen Shore was cheered during a conference held in Atlanta, Ga., cosponsored by the National Coalition of Mental Health Professionals and Consumers, (for which she is President), and the Georgia Mental Health Alliance. These groups charged managed care as being, "immoral, unethical, corrupt, paternalistic, dictatorial, totalitarian and having established hierarchical bureaucracies."

As psychoanalysts we are taught to observe the frame and to keep to a structure in our treatment, in order to provide a safe environment for our patients. It seems impossible to observe these guidelines under the auspices of managed care. Don Milman (former Director of the Post doc) in a letter to Value Behavioral Health, printed in the Suffolk County Psychological Association Newsletter, discussed his unwillingness to become a provider and his concerns as an analyst. "Imagine, if you will, beginning treatment with the statement, 'your secrets are not safe with me.' Fundamental to any psychotheapeutic relationship is trust. Confidentiality is one of the foundations upon which this trust is built. When you open the door of my consulting room, you dilute the patient's willingness to share personal material. A therapist must be experienced as a reliable container for the patient's powerful feelings and thoughts. These clauses in your agreement effectively open the door of treatment to an outside observer and punches so many holes in the therapeutic container that the leaky therapy boat will not go very far nor float for very long."

Christopher Bollas, a British psychoanalyst, and David Sundelson, an American lawyer, echo many of the same sentiments. In their recent book reviewed in the *New York Times Book Review*, *The New Informants - The Betrayal of Confidentiality in Psychoanalysis and Psychotherapy* they discuss the problem of confidentiality in the managed care system. Their point is that managed care is more interested in

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BOOK REVIEW

By Suzanne B. Phillips, Psy.D.

The Impact of New Ideas: Progress in Self Psychology Vol. 11; Edited by Arnold Goldberg. Analytic Press, 1995. 313 pages.

The only really forward move provided by self psychology is its expansion of psychoanalytic theory, specifically its theoretical elucidation of the whole area of the reactivation of thwarted developmental needs in the transference via the discovery of the self-object transference (Kohut, 1984, p. 104).

ARNOLD Goldberg's (1995) edited book, *Impact of New Ideas: Progress in Self Psychology Vol. 11* moves this thinking forward. With textbook scope, the book is divided into four parts: I. Self Psychology and Intersubjectivity, II. Treatment: Clinical Studies, III. Dying and Mourning, IV. Theoretical and Applied. The book is at the same time thought provoking and predictable, frustrating and expansive.

In the five chapters chosen for Part I., Goldberg portrays in content and format the tension and controversy that underscores the progress in self psychology. The format is one of interactive confrontation and critique among contributing authors. It is almost paradoxical given the anticipated "empathic" selfpsychological stance. Perhaps more in the spirit of the disruption restoration process, the authors provoke engagement by the reader who finds herself/himself in the midst of controversy. It is difficult to stay affixed to a preconceived thesis as the sequence of movement includes assertion of theory, deconstruction, re-assertion, disavowal, and re-clarification etc. Close scrutiny and expanded understanding of constructs becomes inevitable, as the urge is to situate oneself somewhere in the fray.

Robert Stolorow begins his chapter, "Introduction: Tensions Between Loyalism and Expansionism in Self Psychology" by recognizing the controversy in self psychology and dividing the contributors into two camps, loyalists and expansionists. The loyalists hold Kohut's writings as the authoritative statement and expansionists, like himself, tend to be integrationists who bring to self psychology ideas from other sources like object relations, infant research, systems or field theory, and studies in the psychology of knowledge and the subjective origins of personality theories.

Stolorow exemplifies the disagreement between the Kohutian perspective and the intersubjective perspective of expansionists with a comparison of the self-object concept. The intersubjective perspective sees self-object longings as one of several types of principles that unconsciously organize a person's subjective world. Alluding to their tendency to reify the self-object, Stolorow notes that loyalists like Paul Ornstein refute this demotion of the self-object concept. For them, the term "self-self-object relationship" refers to the entirety of a patient's transference experience (Ornstein, 1991).

This Introduction is clearly not a neutral overview. While Stolorow offers a paragraph listing the chapters and positioning their authors along the loyalism - expansionism continuum, the remaining pages are used to rebut the arguments that will follow in Donald Carveth's chapter, "Self Psychology and Intersubjective Perspective: A Dialectical Critique." Stolorow notes that Carveth chastises him and Atwood (1992) for failing to be empathic toward the theorists they criticize, while Carveth uses deconstruction (the exposure of inconsistencies) to render a blistering attack on their theory and writings. Stolorow is particularly intent on defending the focus on subjective reality as not simply a total disavowal of objective reality, but a recognition that "objective reality is in accessible and unknowable by the psychoanalytic method . . ." (p.xvi).

The controversy alluded to in Stolorow's Introduction is fully realized in Part I of *The Impact of New Ideas* which includes Carveth's critique of self psychology and intersubjective perspective, Trop's comparison of self psychology and intersubjectivity theory, Paul Ornstein's criticism of Trop's comparison, and Trop's rebuttal to Ornstein.

CARVETH'S chapter is the most provocative. While deconstructionistic to the point of being at times antagonistic, his tenacious critique does invite a reconsideration of concepts. In face of the broad spectrum of theoretical and technical stances dividing the psychoanalytic community, Carveth outlines three patterns of psychoanalytic reasoning: monism, dualism and dialectics. In a monistic framework there is no conflict, there is single principle, as Kohut's theory of motivation. In dualism the clash of opposition is fundamental and cannot be transcended, as in Freudian drive-defense theory. Dialectical thinking holds conflict as a necessary but intermediate stage in a process in which initial monism gives way to dualistic clash and then is transcended into higher order synthesis. Ascribing to a dialectical point of view, Carveth recommends deconstructing differing theoretical and technical stances to afford synthesis. He asks: Can the Tragic Man of Self Psychology also be the Guilty Man of Freudian perspective? Can one reject the drive model and preserve a conflict model?

Carveth is most critical of the intersubjective perspective. He notes that its advocates claim an advance over self psychology because they have expanded their focus to the discovery of organizing principles as central in structuring a patient's subjective experience. While Carveth considers this a clinically valuable contribution, he derides the intersubjectivists for failing to situate themselves within the tradition of psychoanalysis. According to him, they fail to dialogue with, recognize or even correctly cite the work of predecessors as Jacobson, Kohut, Kernberg etc.

With respect to concepts, Carveth directs considerable attention to the intersubjective rejection of the idea of objective reality. He maintains that "Stolorow and Atwood assume that if the notion of an objective reality is allowed into the therapeutic discourse, the analyst will necessarily claim to enjoy a privileged access to it and will dismiss the patient's differing views" (p. 22).

According to Carveth, such thinking is an over-reaction to authoritative misuse and ignores the possibility that analyst and patient share a belief in the existence of an objective reality, one that is extremely difficult to perceive and of which the best one can have are approximations (Popper, 1972). What threatens

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patients is not the questioning of validity of their perceptions but the "spirit" in which this is carried out i.e., an authoritative way or in a mutually corrective dialogue. This alternative viewpoint is consistent with the "perspectivalist epistemology" which is claimed, but according to Carveth, not sustained by the intersubjectivists. It is strikingly similar to the perspectivism of interpersonal psychoanalysis.

IN Chapter 2, Trop compares and contrasts "Self Psychology and Intersubjectivity Theory." He notes that whereas they are similar in that they are both relational theories that reject the concept of drive as a motivational source, they differ in their views of motivation, definitions of empathy and theories of cure. Although identified as an intersubjectivist and presenting clinical material to illucidate this perspective, Trop's comparison is fairly objective.

According to Trop, self psychology holds that patients will be motivated to mobilize and seek out self object experiences to transform developmental deficits, while intersubjectivity theory focuses on the unconscious striving to organize and order experience. Whereas Kohut (1984) defined empathy as "the capacity to think and feel oneself into the life of another person" (p. 82), intersubjectivity theory redefines this as "empathic inquiry" i.e., a method of investigating and illuminating the principles that unconsciously organize a person's experience," (Stolorow, 1993).

In self-psychology cure involves a "disruption restoration" process in which archaic self-objects are replaced with an empathic resonance with the therapist such that the patient is able to seek out appropriate self objects. In inter-subjective theory, cure is conceptualized as resulting from the clarification and understanding of the unique unconscious organizing principles that "shape" disruptions of the bond with the therapist. It is not the restorations of the tie, but the understanding of the principles that organize disruption of the tie that is curative. According to Trop self-psychology underemphasizes this self awareness of one's role in shaping one's reality.

IN Chapter 3, "Critical Reflections on a Comparative Analysis of Self Psychology and Intersubjective Theory," Paul Ornstein critiques Trop's thesis and clinical material. Clearly a rebuttal to intersubjective thinking from the loyalist self psychology position, Ornstein notes that intersubjectivity theory as proposed in the works of Stolorow, Atwood & Brandchaft (1984, 1987, 1992, 1994) became controversial when it claimed originality, and fundamental difference from the theory out of which it arose. For Ornstein, the new theory offers little that is different or valuably expansive. He dismisses, for example, the proposed difference of conceptualizing transferences as an "unconscious organizing activity" as this does not contradict the nature of self-object transference to embody what is wished for, as well as what is old, repetitive and invariant. For Ornstein, attendance to the self-object transference does not, as Trop maintains, underestimate self-reflection. It increases self-cohesion which makes self-reflection possible.

What Ornstein finds different and problematic in intersubjective theory is the primary focus on organizing principles and the concept of empathic inquiry. Both violate the self-psychological approach which calls for attention to the subjective experience and seeks understanding before explanation. While critical of Trop's clinical examples, Ornstein reveals himself to be open to expansion that does not violate self-psychological perspective.

CHAPTER 4 is Trop's "Reply to Ornstein" and while it implies the wish to find useful ways to integrate various vantage points, it does little more than re-state his tenets. In Chapter 5, however, Craig Powell integrates variant theories by proposing "Internal Object Relations as Intersubjective Phenomena." Powell notes that patients frequently experience themselves as internally divided and look for ways to articulate this. He considers that Kohut's original formulations were object relational in that "transmuting internalization" takes place in the context of a self-object relationship (Kohut, 1971, p. 49). Accordingly, Powell proposes that self psychology recognize the acquisition of self-object functions that are not just self regulatory, but self-sabotaging, even self-destructive. Whereas an object relational view sees the internalization of the bad object as a way to control it, self psychologists may see the need for self-objects as so compelling that, even if destructive, they will be attached to. Powell proposes that familiar self-objects that can be soothing as well as painful will be concretized as part of the "organization of a person's experience" (Atwood and Stolorow, 1984).

PARTS II, III, & IV of Goldberg's book consist of 12 independent chapters organized under the headings of Treatment: Clinical Studies; Dying and Mourning; and Theoretical and Applied. Neither the order nor content of the chapters reflect the controversy in self psychology articulated in Part I. While the chapters vary in their reflection of a more loyalist Kohutian or expansionist intersubjective perspective, they are consistent in demonstrating the applicability of self psychology to different clinical issues and diverse diagnostic groups.

The five chapters of Part II include: "Why Can't a Woman Be a Man . . . in the Transference?" by Lachmann and Kiersky; "Complementary Function of Individual and Group Psychotherapy in the Management and Working Through of Archaic Selfobject Transferences," by Baker; "Jacquie: The Working Through of Selfobject Transferences with a Latency Aged Girl," by Lewinberg; "The Termination Phase in Psychoanalysis A Self Psychology Study" by Muslin; "A Self Psychological Perspective on Multiple Personality Disorder" by Palef. Whereas some chapters are predictable applications of self-psychology, others as Baker's on Group and Palef's discussion of Multiple Personality Disorder are more innovative.

Baker, for example, delineates four distinctions among selfobject experiences (transforming, restorative, maintaining and chimerical) that may be available in group treatment, to the extent that the concurrent individual treatment response to archaic self-object transferences is facilitated and expanded. In Palef's chapter, she considers that Multiple Personality Disorder represents not only dissociation in face of failed attunement by childhood self objects, but the need to maintain the organization of subjective experience by concretization in the form of

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individual personalities. Her clinical case is a vivid example of the analyst's work in the face of the tenacity of such organization.

THE Chapters of Part III organized under the heading Dying and Mourning, make a contribution to the reconceptualization of difficult issues. Abramowitz's chapter "Killing the Needy Self: Women Professionals and Suicide (A Critique of Winnicott's False Self Theory)" is written in response to two female physicians' suicidal crises. The author presents us with the question of why a capable female radiologist with her personal and professional life seemingly in order resorts to bloodletting. On a broader scale, she addresses the disproportionately higher rate of suicide in women professionals as compared to the female population. Abramowitz's thesis is that Winnicott's (1960) False Self/True Self Split is flawed and does not define the dichotomized self-destructive self. This destructive self is better understood in terms of Kohut's (1977) description of compensatory self-structures which are authentic and must be addressed as true aspects of self. It is failed integration that leads to self-destructive attempts at self cohesion.

In the chapter "Death of a Self-object: Toward a Self Psychology of Mourning Process," Hagman re-interprets the stages of mourning by Bowlby (1980) and Parkes (1987) and proposes that mourning must involve the transmuting internalization of the structure and function of the lost object. Knoblauch in "The Self-object Function of Religious Experience: The Treatment of a Dying Patient," considers the role of ideation as a powerful self-object experience. In this case ideation is religious belief. Knoblauch underscores the role of the therapist in recognizing and facilitating such ideation as a self-object experience, one that provides cohesion and continuity even when the patient is alone in face of death.

PART IV of the book includes five chapters under the heading, Theoretical and Applied. Differing from previous chapters that applied self psychological perspectives to diverse areas, the first four of these chapters draw upon outside models and constructs to expand self psychology. They include: "The Use of Sequential Personality Testing in Analysis to Monitor the Uncovering of Childhood Memories of Abuse," by Geller; "On the Capacity to be Creative: A Psychoanalytic Exploration of Writer's Block," by Tuch; "The Guilt of Tragic Man," by Droga and Kaufman; and "Looking at Patient Responses: Judging Empathic Attunement," by Shapiro.

Of particular interest, Droga and Kaufman examine the concept of guilt from Freudian, Kohutian and intersubjective perspectives. Their thesis is that the experience of guilt during development and treatment is a more important factor in determining psychopathology than has been accounted for by self psychologists. They maintain that Kohut underemphasized the guilt of "Tragic Man" because he associated it with Freudian theory. They hold that guilt, as any feeling emerging in the intersubjective field, should be explored with empathic inquiry.

Concluding, *The Impact of New Ideas* is a scholarly and comprehensive chapter by Hans Kilian which considers "Psychohistory, Cultural Evolution and the Historical Significance of Self Psychology." Delineating the impact of economic and social history on sense of reality, development of human relations, changes in mental illness, history of psychoanalysis and movement through its paradigmatic stages, Kilian sees the development of self psychology as both necessary and inevitable. He holds Kohut's use of empathy as scientific method as contributing to the "restoration of human values and sense of human self . . . (p. 300)." Underscoring the need for present day analysts to synchronize their tools and theories to the ongoing development of an autonomous self that must transcend the requirements of modern times, Kilian proposes "psychohistorical empathy." By including a grasp of cultural evolution and social reality in empathic understanding, Kilian suggests a way of competently recognizing and dealing with the asychronism that may well exist between us and our patients.

Arnold Goldberg's edited book *The Impact of New Ideas: Progress in Self Psychology Vol. 11* succeeds as a comprehensive and informative consideration of contemporary thinking in self psychology. Goldberg's choice of authors and their contributions make clear the progress of self psychology by examination of original formulations, expansion of ideas, open controversy, deconstruction of arguments, attempts at integration, and application of original and expanded perspectives to diverse arenas. This book is well worth reading. Whatever one's preconceived metapsychology, this book forces re-examination. In a sense, it exemplifies and provokes comparative psychoanalysis.

Given the passion with which we adhere to our models and the intensity with which we debate reformulation, it is valuable to recognize comparative psychoanalysis as difficult because it is as personal as it is professional, as emotional as it is intellectual, and as unconscious as it is conscious. Whether we conceptualize psychoanalytic concepts as idealized self-objects, organizing principles, or mental objects (Bollas, 1989) etc., to recognize them as aspects of self, to embrace their diversity and to draw upon them is to broaden the scope of understanding we bring to ourselves and our patients.

REFERENCES

Atwood G. & Stolorow, R. (1984), *Structures of subjectivity*. Hillsdale, NJ: The Analytic Press.

Bollas, C. (1989), *Forces of destiny: Psychoanalysis and human idiom*. Free Association Books: London.

Bowlby, J. (1980), *Attachment and loss*, Vol. 3. New York Basic Books.

Kohut, H. (1984), *How does analysis cure?* ed. A. Goldberg and P. Stepansky. Chicago: Chicago University Press.

_____ (1977), *The restoration of the self*. New York: International Universities Press.

_____ (1971), *The analysis of the self*. New York: International Press.

Ornstein, P. (1991), Why self psychology is not an object relations theory. In: *The Evolution of Self Psychology. Progress in Self Psychology*. Vol. 7, ed. A. Goldberg. Hillsdale, NJ: The Analytic Press, pp. 17-29.

Parkes, C. (1987), *Bereavement: Studies of grief in adult life*. Madison, CT: International Universities Press.

Popper, K. (1972), *Objective knowledge. An evolutionary approach*. Oxford: Claredon Press.

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How To Respond To A Professional Complaint

By Bruce V. Hillowe, Esq.

THIS is a necessary topic to know about, however unpleasant. A good number of psychologists during the course of their professional careers are notified that a complaint about their conduct has been received and is being investigated by a disciplinary body. It might be by the American Psychological Association or some other professional society, or by the New York State Office of Professional Discipline, which is the prosecutorial arm of the State Education Department that oversees State licensed professions. These bodies can warn or reprimand, or if misconduct is more serious, suspend or revoke membership or licensure. In years past, many psychologists tended to see disciplinary actions that did not restrict their ability to practice as a private embarrassment. But in these days of managed care and higher insurance rates, any finding of unethical or unprofessional conduct, however minor the infraction or punishment, can result in being dropped from provider panels or group polices, with severe financial consequences. Here are some do's and don'ts.

1. Don't delay. You must respond within the time given you, even if that response is to request additional time to examine records, prepare an answer, or consult an attorney. Most of the time if your request is reasonable you can get an extension. Don't ignore the complaint. It won't go away. And don't wait until the last minute because that will cause unnecessary haste, mistakes and anxiety.

2. Don't try to convince the patient or other complainant to drop the complaint. They probably won't anyway. If things have gotten to this stage, there's probably little you can do no matter how good your powers of persuasion or conciliation. Also, you could say or do something that will be seen as an admission of guilt, or an attempt to coerce the complainant or interfere with an official investigation. The last thing you need is to make things worse for yourself.

3. Consult an attorney. Don't try to handle it yourself. Coming from an attorney, this may sound self-serving. And sometimes an investigator will imply that your consulting an attorney is a tacit admission of wrongdoing. But having knowledgeable counsel is essential to your being treated as fairly and leniently as possible. Concretely, I am recommending that before you draft a written response to an APA complaint or before you respond orally, in writing or through questioning to an OPD investigation, you first consult with a knowledgeable attorney. Be sure the attorney has experience with disciplinary matters. Some knowledge of issues in mental health treatment is very helpful. You do not necessarily want a litigator who plays "hard ball," whose approach may hurt your cause and cause unwanted friction, delay and expense.

4. Carefully review your records before responding. Don't just trust your memory. Your records will help you remember accurately what happened and are the most reliable evidence you have to offer in your defense. If you have adequate records, your response will likely expand on what is in your notes and explain what is not. If you don't have records, that will cause an additional problem and you then will have to rely on your memory. If that is the case, it is wise to begin immediately to try to remember and write a narrative description of the events in question.

5. Don't lie or fabricate records. None of us like to think we would do this, but if there is one occasion to be tempted, this is it. Truly. But it can only cause more and greater problems.

6. Don't attack the complainant. Such as the patient bilked me, is borderline, is spiteful, crazy, etc. First of all, it's irrelevant. The investigators are interested in facts not personalities. Secondly it is overly defensive. A well planned defense based on the record and your sensible explanation will speak for itself on the credibility and motivation of the complainant.

7. Don't attack the disciplinary process. The investigators see themselves as hard working, responsible, honest, and doing a necessary job. You can't really insult the system without insulting them. They may not take it personally, but then again they might. In any case, it can't help you. If you are getting good advice and representation, the system will work as well as it can, which is adequately most of the time.

8. Don't tell more than you have to. This is tricky and best left to you and your counsel to decide in its particulars. The idea is to tell the truth but not be confessional about it. For example, you may have to admit that you did not keep adequate records for a certain patient for a certain period of time, but to then admit that you didn't keep any records on any patient at that time would be unnecessary.

I hope you never have to use this information. In essence, the advice is the same as when dealing with any potentially serious practical problem: be informed, get good advice, use your head, and try to gain some perspective. For most psychologists, a complaint brings fear, anger, a sense of betrayal, guilt and self recrimination. Don't be ruled by these. Whatever you are charged with, it will not be the end of your world.

Bruce V. Hillowe is an attorney and psychologist, and a member of the Adelphi community, who practices law in Mineola.

ASPP Newsletter **deadline for the Summer 1996 (July) issue is first week in May** for articles, reviews, and letters which should be sent to Dr. Linda S. Bergman, Editor, 83 Stony Hollow, Centerport, NY 11721; Fax: (516) 754-4567. May 15th is the deadline for seminar announcements, News and Notes, and Classified listings ($25 per issue) which should also be sent to Linda Bergman at the above address. All copy should be submitted in duplicate, typed, and **double-spaced**. Usage and reference citation must be in accord with the APA *Publication Manual* (3rd ed.) Manuscripts are accepted subject to editing and review. *ASPP Newsletter* welcomes manuscripts for publication but assumes no responsibility for statements advanced by the authors.

One-Person versus Two-Person Psychology: Toward An Integration Part Three; Clinical Material

By David O. Belser, Ph.D.

THEORETICAL and technique matters aside (having been discussed in previous issues of the *Newsletter*), the issue becomes; how in fact can a one-person and two-person psychology be integrated? The following case offers a conceptual scheme and represents an attempt at integrating the one-person and two-person positions. In fact, based on resistance and transference issues, this case made integration a necessary and productive endeavor. What follows is a brief presentation of the case with an examination of some aspects of the treatment, particularly transferential, that are approached from both viewpoints.

Mr. S. is a 30 year old patient who was referred for treatment when his current therapist took another clinical position and had to leave him. He presented with complaints of intense anxiety and depression and expressed general dissatisfaction with his life. He stated that he had never had a romantic nor sexual relationship but that he wanted one. Additionally, he had no significant social relationships and felt isolated and lonely. He experienced intense anger and rage towards himself and others. Constantly preoccupied with his perception of himself as underweight, he felt "hideous and repulsive looking; I'm inferior to other people." His extreme discomfort with himself led him to say, "I'm not able to be myself; I can't be who I am." He lived with his parents and had a conflictual and hateful relationship with his father and a symbiotic relationship with his mother. He worked at a blue-collar job that he hated and he was often angry with his boss and co-workers.

Over time, Mr. S's diagnostic picture emerged more fully. To his anxiety and depression were added severe obsessiveness and paranoia. His anxiety was mostly generalized but there was social anxiety as well. His depressed feelings constantly preoccupied him; he rarely smiled. His obsessiveness consisted of extreme rigidity and perseveration. There was an organic-like quality to his thinking: He would fix on something and could not seem to move on to something different. He had extreme persecutory fears, feeling like everyone was against him and out to attack him; he was defensive, withdrawn, and retaliatory. In fact, these obsessional and paranoid elements suggested underlying delusions and psychosis. Overall, there were both symptomatic as well as characterological features to Mr. S.'s diagnostic picture.

Viewed from a one-person perspective, the following theoretical material emerged. Mr. S's character had been fixed at an early developmental time-period, i.e., preoedipal, since his pathology was severe and dyadic in nature. Based on the paranoia and withdrawal in his interpersonal relationships, his personality functioning could be described as paranoid-schizoid (Klein, 1946).

Mr. S.'s object world (Jacobson, 1964) consisted of aggressive internal self and object representations, thus, the extreme anger toward self and others as well as the paranoia. The external world was perceived as bad and persecutory insofar as "others see me as repulsive." Since others in the external world were seen as threatening and attacking, they must be defended against. As a result, Mr. S. expended great effort trying to control others and to force them to be positive objects. Mr. S.'s bad internal objects took the forms of: "I am bad, others are bad, and others see me as bad." There were also good object representations for Mr. S . but these were unrealistic and wishful. Both good and bad objects functioned in a symbiotic and merged manner so that Mr. S. and the object were united (Mahler, Pine and Bergman, 1975; Silverman, Lachmann, and Milich, 1982). There was extreme splitting and rigid categorization: the good object was identified with Mr. S.'s mother and the bad object with his father.

Mr. S. displayed a deficient sense of self (Kohut, 1971). He felt inadequate and inferior and believed that others experienced him in exactly the same way. Others are hated and envied for what he perceived as their superiority. He constantly stated, "I can't be myself; others will hate and reject me." Winnicott's (1965) concept of true and false selves comes to mind as does Erickson's concept of identity (1959).

IN ego psychological terms, Mr. S. had the classic "weak" ego; he was unable to take a full and responsible role for his own functioning. He was inhibited, could not express or assert himself and was withdrawn, angry, and helpless. He could not balance the internal and external worlds in an adaptative way (Hartmann, 1958). His severe superego was extremely condemning of self and others. His predominant defenses were withdrawal, identification with the aggressor, projection, and externalization. His impulses were generally under control although he occasionally acted out in a passive-aggressive manner and had a past history of acting-out behavior.

Mr. S.'s interpersonal relationships were narcissistic and one-sided. People existed solely to meet his needs. Caring and liking for another person occurred only if he was guaranteed the same. His interpersonal relationships were also characterized by sadomasochism. While he exhibited strong aggressive and sadistic urgings toward others, he also assumed a helpless, masochistic position, presenting himself as blameless in his relationships. Sometimes victim, sometimes victimizer, he alternately attacked the object and defended the self.

The two-person psychological perspective was based on the here-and-now interactions and their manifestations as transference and countertransference phenomena (Gill, 1982). From the first session, Mr. S. displayed an intense transference reaction to me that appeared almost psychotic. He immediately began expressing his dissatisfaction and anger with me and was critical, hostile, and accusatory. He stated that I was neither caring nor interested in him and that I "only do this work as a job and for the money." I was astonished at Mr. S.'s reaction toward me, having rarely been accused of all of this in an initial interview.

Over the next few months and well into the first year, Mr. S. continued his characterizations of me as "cold, unfriendly and

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One-Person . . . *(Continued from page 7)*

unemotional." Session after session, he insisted that I was of no help to him. He often withdrew during sessions, refusing to talk because of "the way that you are." He felt that I couldn't be trusted and that I didn't give him enough feedback or advice. He frequently told me how bad I was. I often felt that by focusing on me and telling me how I should change he was forgoing his own responsibility for himself. The exclusive focus on me appeared to be in the service of his rigid character style, paranoia, anger, and fear.

He attempted to control every session even to the point of telling me what I should and should not interpret. I recall that whenever I made a genetic transference interpretation he told me, "Don't bring that in. It doesn't belong right now." I remember feeling trapped and immobilized. He tried to force me to be what he wanted.

In contrast to his negative perceptions of me, Mr. S. characterized his previous therapist as a warm, friendly and caring person who gave him what he wanted and needed. She had been ideal and had met his every need. I tried to understand what his previous therapist actually did and what it was that he so positively responded to. It appeared that there were both real and distorted aspects to his perceptions of her just as I later found with regard to me.

STARTING from a one-person psychology, I began to make interpretations that addressed what I saw as splitting. I was his bad, critical father and his previous therapist was his good, nurturing mother. I persisted with these interpretations and he appeared to respond to them. However, just when it seemed that he had stopped obsessing about how bad I was, and had started talking about himself and his own behavior, he resumed his previous position.

In addition to interpreting the transference, in both current and genetic forms, I began to interpret his object relations. That is, I interpreted his good and bad self and object representations in the paranoid projections. I tried to help him to see how his perceptions of me were split-off part-objects of himself. Thus, the cold, unfriendly therapist with the bad attitude was both himself and his dreaded fear of others who would reject and persecute him. In fact, virtually everything that he said about me could be easily said about him. He was cold, negative, unfriendly and uncaring. As such, his "attitude" toward others was essentially the same as his father's attitude was toward him. The angry, critical introjects of his father became his angry criticisms of me. Again, he appeared to respond to these interpretations but would inevitably return to his accusations of me.

Countertransferentially, the twice-weekly sessions with Mr. S. were extremely frustrating and difficult. He had made up his mind about me from his first impressions and had put me into a rigid and fixed category from which there was no escape. I was terrible and there was nothing that I could do to change his perceptions. If I was friendly or caring he could not perceive it. In fact, I felt there was ample evidence of my being more than just the bad object. This included my empathic stance and my interest and concern for him as well as my being available for an occasional extra session. The work became more difficult as I tried to break through his rigid defenses and resistance. Feeling helpless and angry, I sought refuge in my interpretations and hoped they would have an effect.

WHAT was the way out of all of this? Was I the helpless son, the critical father, or both? Was he the same? Moving to a two-person psychology seemed to provide a way of addressing these questions. We were both in the grip of an extremely difficult interpersonal relationship. I had first thought of his transference as a distortion of the past in the present. It did not have a reality basis in our relationship. However, as our work progressed, I turned to a more reality-based explanation for our interpersonal relationship. I began to examine what he accused me of being and acknowledged my own "coldness and unfriendliness." I admitted the plausibility to his perceptions; indeed, I now understood how he perceived me as cold and unfriendly. In fact, my analytic technique, which typically vacillates from reserved to active, was probably quite distant with him. His "cold, unfriendly, attitude" did not help matters any.

I then integrated two-person interpretations into what I had originally conceived of as one-person projections. Previously I had interpreted along the lines of "You see me as if I am your cold, unfriendly father," and "You treat me as your cold, unfriendly father treated you" (Tarachow, 1962). I now added, "It is understandable that you see me this way. Your perception of me is part of what is going on. I am like this. Why do you think this is so?"

The treatment now moved into another phase. The work was freed up and I began moving between one-person and two-person conceptualizations. We spoke of how he reacted to me and I reacted to him. Thus, he and I were both cold and unfriendly toward each other. In one session he and I asked, "But who started it and why?" We both were reenacting his interpersonal relationship with his father. He saw me as the bad father and I was the bad father. Additionally, he was the bad father and we were both, at times, the helpless son.

The integration of both one-person and two-person perspectives contributed significantly to a fuller understanding of Mr. S. This was especially notable with regard to transference manifestations which were worked and reworked along one and two-person dimensions. The initial one-person approach of "transference-as-distortion" was supplemented by the two person notion of "transference-as-plausible-and real." There is no doubt that Mr. S.'s transference had a strong, distorted aspect to it and that the inappropriateness and intensity of it (Greenson, 1967) brought the specters of the past into the present. However, the interpersonal relationship that was created by both of us was also real and valid. We reenacted something in the interpersonal sphere that was not a distortion. Thus, his perceptions of me were both distorted and real just as they had been of his previous therapist. The transference was a distortion and was not one. Both approaches led back to Mr. S.'s early intrapsychic and interpersonal history and to his mother and father. Both parents were the parents of intrapsychic fantasy as well as the real parents of his childhood.

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One-Person . . . (Continued from page 8)

The combination of one-person and two-person approaches helped to free this treatment from the rigid confines of an either-or approach. Integration of both perspectives allowed both participants to challenge and, ultimately, to change their convictions. Thus, I was freed from theoretical one-sidedness and Mr. S. was validated and liberated somewhat from his perceptual rigidities. What transpired during this treatment occurred out of theoretical and practical necessity. There were significant transferential and countertransferential resistances at work that demanded other perspectives to counteract them. Clinical impasses required novel and flexible solutions. In this case, the integration of one-person and two-person psychologies assisted the process of treatment and impacted the intrapsychic and interpersonal psychologies of both participants.

REFERENCES

Erickson, E. (1959). *Identity and the life cycle.* New York: International Universities Press.

Gill, M. (1982). *The analysis of transference: Vol. 1.* New York: International Universities Press.

Greenson, R. (1967). *The technique and practice of psychoanalysis.* New York: International Universities Press.

Hartmann, H. (1958). *Ego psychology and the problem of adaptation.* New York: International Universities Press.

Jacobson, E. (1964). *The self and the object world.* Connecticut: International Universities Press.

Klein, M. (1946). Notes on some schizoid mechanisms. ***International Journal of Psychoanalysis*, 27, 99-110.**

Kohut, H. (1971). *The analysis of the self.* New York: International Universities Press.

Mahler, M. Pine, F. & Bergman, A. (1975). *The psychological birth of the human infant.* New York: Basic Books.

Silverman, L. Lachmann, F. & Milich, R. (1982). *The search for oneness.* Connecticut: International Universities Press.

Tarachow, S. (1963). *An introduction to psychotherapy.* New York: International Universities Press.

Winnicott, D. W. (1965) *The maturational processes and the facilitating environment.* New York: International Universities Press.

President's . . . (Continued from page 2)

the quick-fix cure. The complicity of the psychoclinical professions in the breakdown of therapeutic secrecy amazed Bollas and Sundelson. They say that "psychotherapy depends utterly on the patient's confidence that he or she can reveal to the therapist the most intimate thoughts, and fantasies in a privacy that is inviolate. They further state, "Remove confidence and not only will psychotherapy fail but the psychotherapeutic professions will die." (Bollas and Sundelson).

In the best of worlds, we as analysts protect our patient's confidentiality at all costs. Practically, we need to survive economically in this managed care era. This dilemma causes most of us a great deal of concern. Each of us has to tackle this problem in his/her own way. It is now up to us; to APA, NASW, American Psychiatric Association, to communicate the findings of the CR study and to encourage other outcome studies to demonstrate the effectiveness of long-term psychotherapy. Morris Eagle in his Presidents Message (Psychologist/ Psychoanalyst - Winter 1996) says it well. "I think that there is

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ADELPHI UNIVERSITY POSTDOCTORAL PROGRAMS

Advanced studies in Group, Family, and Couple Treatment

ON January 21, 1996, the Executive Board of the Postdoctoral programs voted to approve a new program: The Advanced Studies in Group, Family, and Couple Treatment. Below is the description the organizing committee prepared for the Executive Board.

General Educational Orientation and Philosophy

The Advanced Studies Program in Group, Family, and Couple Treatment adheres to the principle that all human beings organize relationship structures for their growth and development. The treatment modalities of group, family and couples therapy are designed, with the leadership of a therapist or co-therapist, to help larger numbers of clients. By developing an interpersonal context for the resolution of emotional difficulties, therapists and clients are offered more choices.

The Advanced Studies educational focus is to bring to the clinician, the cutting edge of interpersonal treatment modalities, so as to increase familiarity, usage and application. More importantly, the various aspects of the program, such as, curriculum, supervision, conferences, and its evaluative mechanisms, are designed to reorient the candidates' thinking and perceptions toward an interpersonal psychology.

The basic learning tool for the two year program is the experiential group composed of candidates and only one leader per semester. This group will experience and process the needed information and skills that replicate the treatment modalities. The group will also function via peer feedback to identify the learning issues of its members and their remediation.

Regular weekly faculty presentations on a variety of didactic subjects will complement and supplement the experiential group's learning. Over the two years, these will cover the various generic concepts that are applicable to all three modalities, as well as the specific information applicable to each modality. Faculty will also demonstrate how didactic material can be applied to the treatment process. In addition, meetings, seminars, and other educational functions will be sponsored and organized for the benefit of the public and the professions, in the matters of health, prevention, and social well-being.

The curriculum follows the basic philosophy of establishing an interpersonal structure for learning that simulates the interpersonal treatment structures. Unlike treatment, however, the learning goal is the development of a professional interpersonal self that is adaptive to the varying interpersonal modes of clinical evaluation and treatment.

The Advanced Studies Program expects a psychotherapy requirement from its candidates. During the two year program, candidates will be required to undergo one year of a psychotherapeutic experience, beginning in their second year. It is anticipated that during the first year, a familiarity with the candidates develops, and the candidates become able to integrate into the learning process, recommendations for psychotherapy can be geared to their developmental assessment.

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ADD (Attention Deficit Disorder): Another Diagnostic Disaster

By Gary Bruschi, Ph.D.

IT'S gotten way out of hand, this ADD. Everybody and his brother has ADD. And it IS the boys who get it, right? You don't see too many little girls getting referred for it. Nine out of ten referrals are boys. There's Childhood ADD, Adolescent ADD, Adult ADD. It's become big business. It's become a socially acceptable kind of thing. There are ADD organizations, ADD Clubs (Le Club ADD!), twelve step ADD groups, ADD Societies, ad nauseam. It's become quite the thing!

Recently, some parents brought their 12 year old boy to me for help with his ADD. They wanted therapy for the kid whose problems included poor achievement, distractibility, excessive motor activity, forgetfulness, and interrupting. After some questioning, they also included oppositionalism, defiance, cursing, torturing his siblings, fighting with his mother, locking himself in his room, etc. Quite a handful this kid! The school psychologist had diagnosed him ADD, much to his mother's relief. Now at least, she knew what she was dealing with; she had something to hang her hat on! Mom was one of those overbearing, self-centered, intrusive mothers who just had to have things her way. You might call her the stereotypical Jewish mother were it not for the fact that she exists in every culture and religion. Dad was in orbit around the planet Mars, in that he worked, worked, worked, and made piles of money. She complained incessantly and wanted him to just DO something. So Dad would bribe the kid, promise him the moon, if only the kid would lighten up on Mom. Puulease don't give Mom a hard time cause you know how she gets and then what are we gonna do. Ben? I swear I'll get you that Porsche on your sixteenth birthday! And so it became Dad and son, in concert against mother.

A classic ADD kid right? These parents were desperate and I had come highly recommended as a no nonsense, straight talking shrink who specialized in kids like Ben. They wanted to put Ben on Ritalin, and would I puulease DO something with him and leave them alone thank you. See you when he's fixed! He was just ruining their lives. It's a long story so I'll shorten it. I told them that any kid's symptoms are a reflection of his parents' individual psychologies (their family histories) as well as their marital conflict. I told them that all behavior serves a purpose in the family and that it was our job to figure out what it was. Straight talking, right? As I spoke, they began to stare off into space. Mom got highly perturbed and fidgety; I swear Dad started dozing off (he worked many hours!) "Are you saying that it's our fault, that we have something to do with Ben's behavior?", Mom asked me aggressively and incredulously. Dad said, "Huh?, Yeah, are you saying that?" To which I replied that I wasn't assessing blame, there's no one to blame, it's not something to blame anyone for. It's just that Ben's problems are family problems and they can only be solved within the context of the family. Now Mom was really getting agitated, rattling her jewelry and fussing with her makeup. This is NOT what she had expected at all! Dad had that glazed, befuddled look, not sure what to do. In a flash I knew what it was like to be married to each of them, and what it was like to be Ben. And with that, I began to feel angry, helpless, and depressed!

And that was just the first session! Fortunately, or unfortunately, depending on whose shoes you were wearing, Mom showed up for Session Two without Dad and accompanied by a sullen Ben. She stated that she really liked me, that I seemed like a nice guy, but that she was taking Ben to a REAL doctor, thanks but no thanks. She had been reassured by this psychiatrist that Ben had a neurological condition that could best be helped with medication. Ben stared at me plaintively, as if to say. DO something ! But it became clear that I wasn't going to be allowed to do anything; me or any other man who had an opinion other than her own. Oh and by the way. Dr. X would be calling me and would I please consult with him and let him know my opinion! Oy Vey!

TEN or fifteen years ago, it was known as MBD, Minimal Brain Dysfunction. Then it became LD, Learning Disability (in the Associative Areas of the Left Side of the Brain Thus Causing Discriminatory Differentiation Problems Which Made Ben Highly Distractible and Produced Low Self Esteem!). Then it became Dyslexia, or inability to read due to neurological dysfunction. Now, it's ADD, and all these diagnoses have been confirmed with EEGs and sophisticated psychological tests! It's the diagnosis of choice, the one that gets you extra help in school, the one that supplies the grist for special education, the one that's neurological, the one that has absolutely nothing to do with family relationships and dynamics. How convenient and simple! It's the one given when medical and mental health professionals have no idea what they're talking about, don't know how to handle parents, and are afraid to say the tough things that come with the turf. It's the one where scientific research is joyfully and prodigiously funded by the major pharmaceutical companies in their never ending search to find a population to medicate. It's the one promoted by the acquiescent family practitioner, psychiatrists, social workers, and most distressingly, by my fellow psychologists. It's the Perfect American Diagnosis: superficial, biological, blameless, and readily cured by drugs. And most important, it's got absolutely nothing whatsoever to do with the parent-child interaction. Thank You And Leave Me Alone With All Your Freudian Theories! It's this, well, this thing that swoops down on our boys and just makes them impossible to deal with, like a kind of pedophiliac stranger in a trench coat who molests our children and has nothing to do with us. Yeah, a truly American Diagnosis!

The typical ADD case goes like this, although there are obviously exceptions and variations to every rule. I call it, "Too Much Mom, Not Enough Dad Syndrome." I proposed this diagnosis to the people responsible for inventing these entities. They weren't too receptive. Seems like my diagnosis wasn't "clinical" enough! Typically, Mom is all over her son, for varying and idiosyncratic reasons, which are best left for another article. There is an inability to confidently set limits, great anxiety about issues of separation and autonomy, a confusion of healthy, independent behavior with disrespect ("freshness"), and in many cases, a need to emasculate the male. So Mom begins a crusade which involves schlepping her son from one doctor to another until, lo, she finds one who's poorly trained enough to give the ADD Blessing. Dad is typically out to lunch; that is to say that he is passive and unassertive with either his wife or his son. He can be a terror at work, be highly successful,

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ADD . . . (Continued from page 10)

but on the home front, he is angry, distant, and frequently feels powerless. He emasculates himself. And his son often acts out his father's anger towards the mother. Father defers to his wife, and is primarily concerned with how to appease this histrionic, terminally dissatisfied mother. He too appreciates the ADD Blessing since he doesn't want to know or understand his responsibilities in this mess either.

More often than not, the boy's ADD symptoms are an adaptation to overcontrol or undercontrol, usually the former. It serves many purposes within the family, the most important of which is as a distraction from his parents' substantial marital difficulties and personal disappointments. He becomes the identified patient, not them (although if he's good at his symptoms, he manages to get his parents in to see the shrink. Also very adaptive!). The behaviors themselves serve to effect some semblance of control and mastery over the boy's life. Mom is too intrusive; Dad is ambivalent (although as I said, there are variations on this theme). The parents are a house divided, each one feeling misunderstood and undermined by the other. It is a rift between the participants of a competitive parent-child triangle. And we haven't even brought in the complications of siblings! When you take the time to get to know these parents, when you can create an atmosphere of alliance and trust, you invariably discover that what is happening is exactly what happened to the parents with their own parents. It's as simple and complicated as that.

Don't get me wrong. It's not that I don't believe in the behavioral symptoms which are collectively called ADD. They do exist, are real, and are quite distressing. There are, of course, many children, particularly boys, who are grossly distractible, poorly organized, forgetful, unable to complete assignments, overactive, restless, and generally a royal pain in the butt! They drive their parents, siblings, and teachers wild. I'll even go as far as to say that in some cases, medication is necessary and helpful. What I refuse to accept is that these symptoms are the result of neurological dysfunction (in the absence of any mental deficiency), biologically or genetically produced, and mainly, that they do NOT result from the same place that all behavior originates from: namely, the family. I suppose it would be nice were it not so. It would certainly make life a lot easier and simpler. Unfortunately, or should I say, fortunately, this is simply not the case. The parents, the family, the blueprint for all future behavior and development, just like their parents and families provided the blueprint for their lives. No one escapes this. It is not good or bad, right or wrong, something to be morally judged. It's just the way it is, for psychologists as well as everyone else. I say fortunately, because if it were genetic or biological, then we'd be stuck with these symptoms forever or until the Ritalin ran out. Not a very pleasant prospect. If, on the other hand, it is PSYCHODYNAMIC; in other words, it is determined in the context of the relationships within the nuclear and extended families, then there is hope. If we can discover how these relationships work, how they came to be, and what purpose they serve, then we can do something about it. If you think about it this way, you can see a logic and reasonableness to it. There's not a damn thing we can do about organic, neurological dysfunction, or retardation.

Unfortunately, ADD is a MISDIAGNOSIS. The symptoms of ADD are more often, and more accurately, a sign of childhood depression. Children express depression very differently than adults do. Adults tend to act depressed; that is, they get lethargic, disorganized, blue, and tend to hide under the covers. Children, however, express depressive feelings paradoxically; that is, they often act the opposite of how they feel. A classic example of childhood and/or adolescent depression is the class clown, who drives his teacher bonkers, makes the other kids laugh at his own expense, but is in reality anything but jovial and happy. There is an edge to this kid's humor, and he is expressing things to his teacher and classmates that are meant for his parents, and family members. The agitation, distractibility, and disorganization of ADD kids are the symptoms of depression: the child's depression AND the depression of his very overwhelmed parents. In fact, it can be theorized that the reason Ritalin, which is an amphetamine based drug, works, is that it produces paradoxical effects on the paradoxical behavior of the child. It slows him down!

It may be more stressful and complicated to look at Attention Deficit Disorder this way, but by golly, it is more hopeful and manageable with the proper assistance. It is solvable the old fashioned way: it is discussed in a family setting, and worked on over time.

President's . . . (Continued from page 9)

relatively little that Division 39 alone, as a separate organization, can do against the dangers and abuses of managed care. Division 39 simply does not have the money and the other resources that would be necessary to launch a major campaign. However, Division 39 members and chapters throughout the country can become active in educating and lobbying legislators and in informing and organizing consumers." DITTO for ASPP!

As we went to press I learned that Lewis Aron, an ASPP member is running for President-Elect of Division 39, APA. I urge ASPP members who also belong to APA to support Lewis Aron and any other ASPP members on the Division 39 Ballot.

REFERENCES

Eagle, M. (1996, Winter). From the president's desk. *Psychologist Psychoanalyst* pp. 1-2.

Goleman, D. (1996, January 24). Critics say managed-care savings are eroding mental care. *New York Times* pp. 22.

Kevles, D. (1995 December 24). The suspect on the couch. A review of (Bollas, C. & Sundelson, D. *The New Informants*) *New York Times Book Review*, p. 9.

Larson, E. (1996, January 22). The soul of an HMO. *Time Magazine*, pp. 44-52.

Milman, D. (1995, December). A powerful response to a MCO. *Newsletter, Suffolk County Psychological Association.*

Saeman, H., (1996, January/February). Psychologists frustrated with managed care, economic issues, but plan to "hang tough," survey reveals. *The National Psychologist*, pp. 1-2

Sherman, W., (1996, February). Mismanaged care. *Vogue Magazine*, pp. 154-156.

Seligman, M., (1995). The effectiveness of psychotherapy - The Consumer Reports Study, *American Psychologist*, 50 (12) 965 - 972.

Slosur, J. R. & Lettieri, R., (1996, Winter). Financing mechanisms in the delivery of mental health care services: widgets or wisdom? *Psychologist Psychoanalyst*, pp. 11-16.

Classified Ads

OFFICE SPACE FOR RENT — Huntington - 600 sq. ft. includes waiting room and a large office attached to private home in quiet neighborhood. Ample parking. $675 per month. Call Chris at 754-6012.

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NEWS AND NOTES

MARK ADAIR announces his article in press: Plato's Lost Theory of Hysteria", *Psychoanalytic Quarterly.*

ELAINE DINITZ led a Psychodynamic Group Process Institute at The American Group Psychotherapy Association. This two day Advanced Level Institute was open to group psychotherapists with 10+ years of group psychotherapy practice.

JACK HERMAN recently published two papers: "Setting Limits While Enabling Self-Expression: Play Therapy with an Aggressive, Controlling Child" with Anne Smith, a graduate of our Child and Adolescent Psychotherapy Program, in the International Journal of Play Therapy, 3 (1),1994; and "Cognitive Ego Psychology and the Psychotherapy of Learning Disorders" with Bob Lane, a former faculty member, in the Journal of Contemporary Psychotherapy, 25 (1), 1995.

LUCIE M. KAY has been named C.E.O. of the Soundview Mental Health Associates, PLLC. SMHA is a group practice specializing in psychotherapy in the home.

MARY ROSE PASTER has been appointed to the Executive Board of the Nassau County Psychological Association and the Managing Board of Cancer Care, Inc. of Long Island.

BILL RYAN had an essay entitled, "At Home in Nature" accepted for publication in the Spring issue of *Pilgramage*. The essay describes the use of time in nature for the healing journey.

CARLA VECCHIONE AND LENNY SAULLE joyfully announce a new addition to their family. Daniel Joseph was born on 12/10/95, 7 lbs. 15 1/2 ozs.

Book Review . . . *(Continued from page 5)*

Stolorow, R. (1993), Thoughts on the nature and therapeutic action of psychoanalytic interpretation. In: *The Widening Scope of Self Psychology, Progress in Psychology.* Vol. 9, ed. A. Goldberg. Hillsdale, NJ: The Analytic Press, pp. 31-43.

_____(1992), Subjectivity and selfpsychology. In: *The Intersubjective Perspective*, ed. R. Stolorow, G. Atwood & B. Brandchaft. Northvale, NJ: Aronson, 1994, pp. 31-39.

Stolorow, R. & Atwood, G. (1992), *Contents of Being: The Intersubjective Foundations of Psychological Life.* Hillsdale, NJ: The Analytic Press.

Stolorow, Atwood & Brandchaft (1994), Self psychology and intersubjectivity theory. In: *The Intersubjective Perspective*, ed. R. Stolorow. G. Atwood & B. Brandchaft. Northvale, NJ: Aronson, pp. 77-91.

_____ (1987), *Psychoanalytic Treatment: An Intersubjective Approach*, Hillsdale, NJ: The Analytic Press.

Winnicott, D.W. (1960), *The Maturational Processes and the Facilitating Environment.* New York: International Universities Press.

SEND US YOUR NEWS

The *ASPP Newsletter* welcomes members' contributions to the News & Notes Column. Let us know of your presentations, publications, awards, honors, professional appointments as well as personal news and significant life events. Send your News & Notes by February 10 to Linda Bergman, Ph.D., 83 Stony Hollow Road, Centerport, New York 11721; Fax (516) 754-4567

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