ASPP NEWSLETTER

ADELPHI SOCIETY FOR PSYCHOANALYSIS AND PSYCHOTHERAPY

VOL. I No. 1 FALL 1986

ADELPHI AND THE NEW MARKETPLACE

By George D. Goldman

All of us here at Adelphi have become dismayed over the negative effect on the census at the Center and on our private practices of a number of factors: these include cost-consciousness on the part of the insurance carriers, the rise of HMOs (health maintenance organizations), IPAs (independent practice associations), and PPOs (preferred provider organizations), and the general state of the economy. My purpose here is to tell you of one realistic possibility that I have been exploring which would increase the patient pool available to the Center and your private practices. It involves an affiliation with Corporate Health Systems, an already existing PPO. The exact nature of this affiliation has not yet been determined. I want to present what I do know and get some feedback from you so I know whether or not to proceed further in exploring this possibility.

Before describing the possibility of an affiliation with CHS in greater detail, let me tell you how it evolved. Several months ago, I called a meeting of all of the Directors of Adelphi University's professional centers; the goal I had in mind was to find out how we could improve communication with one another and how we could help each other grow. Among the ideas that I proposed was that we here at Adelphi form our own PPO. A PPO at Adelphi could offer a range of health care services including psychotherapy and psychoanalysis, social work services, diagnosis and remediation of speech and hearing problems as well as of reading and learning problems, and training in improved fitness, in better nutrition, and in stress reduction. The Directors of the other Centers responded enthusiastically to the idea of an Adelphi-based PPO. However, at present, there seems to be no one available (willing) to undertake the extensive work that would be involved in the realization of this idea.

I was thus already interested in exploring opportunities for marketing the Postdoctoral Psychotherapy Center and/or the other Centers at Adelphi when, last August, I met with two psychologists, Paul Bender and Lisa Weiss, who are part of CHS. CHS establishes contracts with large firms such as Bloomingdale's, Chemical Bank Goldome, The Daily News, and Xerox. Different contracts provide different services. These covered services range from human resource workshops through in-house employee assistance programs to a preferred provider alternative. CHS offers its subscribers a nationwide network of mental health professionals. Depending on the contract under which a particular subscriber is covered, fees range from $25 to $75 per session.

(cont'd on page 2)

FROM THE PRESIDENT

By Estelle Rapoport

Welcome Back Everyone! By now, I know, the relaxation and warmth of summer are fading memories as we all get back into our busy schedules. I hope that all of you will take some time this year to refresh yourselves and partake of the comraderie and professional enrichment offered by the Society. We have a community that offers long-lasting professional and personal relationships that can be a supportive context for our work as analysts.

The Society is always ready to become involved in the issues important to our members and to the Postdoctoral Program. It is actually through the articulated needs and interests of our members that we have come to define many of the functions of ASPP over the years. Our range of involvements has greatly expanded. Of particular note in our broadening professional scope is the beautiful *Newsletter* you are now reading. This issue marks the first time the *Newsletter* has been professionally published since its inception in 1972. Congratulations to our Editor, Carolida Steiner, for conceiving the new image and executing it so well.

Since this is the beginning of a new year, I thought I would familiarize everyone with our planned activities, ongoing committees and involvements. Our first event of each academic year is a Brunch for first-year Postdoctoral candidates, where they have an opportunity to meet Society members, Postdoctoral Administrators, and each other. This year Marjorie Maltin graciously hosted the Brunch. Concurrent with this welcome, we have initiated an Inter-Class Liaison, where third-and fourth-year candidates individually contact first-year people to help orient them to Adelphi. Holly White-Gotta organized the liaison this year. From all reports, it was very successful.

Each year our program committee, now chaired by Rich Gotta, arranges a Winter Conference and two Friday night speakers. This winter, on Dec. 6, 1986, we will host Dr. Otto Kernberg. Please tell friends and colleagues so that we can have a great turnout. On Friday night, Jan. 9, 1987, Dr. Jay Greenberg will speak. Our spring Friday night speaker will most likely be Dr. Sheldon Bach. The Program Committee is always looking for ideas for conferences and speakers, so feel free to contact Rich. We are researching a program on HMOs, PPOs, etc., since they may very well have an impact on all of us.

(cont'd on page 3)

ASPP NEWSLETTER

Editor (1984-present): CAROLIDA STEINER

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Address Communications to:
CAROLIDA STEINER
99-72 66th Road, Forest Hills, N.Y. 11374

Adelphi And The New Marketplace

(cont'd from page 1)

I want to underscore that accepting patients referred by CHS would, by and large, involve us in a non-psychoanalytic form of treatment. For the most part, the expected form of treatment would be a goal-directed, brief psychotherapy and crisis intervention. The therapist could, on occasion, recommend long-term treatment with the goal of characterological change. However, in most cases, the therapist would be expected to intervene actively and focus on symptom-alleviation.

In addition to the change from our traditional orientation to treatment, CHS has a very firm set of standards and guidelines which preferred providers are expected to follow. The following partial list of provisions from the CHS provider contract should help you evaluate, in a meaningful way, what the impact of our joining would be. Providers are to:

- Be available for orientation and training by CHS. Every effort will be made to complete the training in a timely manner.
- Offer appointments within two working days whenever requested by a covered employee or dependent. If no such request is made, an appointment will be scheduled within a reasonable period of time.
- Call CHS after each initial assessment to review treatment plan and obtain CHS's approval for the implementation of plan as well as outline concurrent review procedures.
- Complete, date, and return, in a timely manner, Report Forms, Termination Forms, and other forms which may be required for the execution of a specific program.
- Complete and submit employees' insurance forms and accept an assignment of insurance benefits. Employees will only be directly responsible for that portion of the fee that is not covered by the employee's insurance.
- Maintain employees' and family members' confidentiality No information will be released to anyone without the written approval of the client. Consult with CHS prior to releasing any information to the employer or to any other individual or agency.
- Be prepared monthly to present to CHS, by telephone, information on all clients in treatment or for whom treatment was suspended or terminated. Such reports shall contain the number of sessions per client during the month, a fully delineated treatment plan including the anticipated number of sessions, changes in existing treatment plans, and terminations.
- Send in quarterly tally sheets identifying each client seen in that quarter.
- Be available to meet quarterly with a CHS representative for an in-depth case consultation. Client's records shall be made available to the CHS representative on such quarterly visits.
- Consult CHS prior to authorizing any psychiatric hospitalization.
- Consult CHS prior to extending outpatient treatment beyond the limit of the insurance benefits.

I am sure that most, if not all, of you share my concern about the long-range survival of the Center and, more generally, of private practice. At the same time, I am aware that the possibility of the Center affiliating with CHS and of the Center's therapists making concomitant changes in how they work is likely to arouse mixed feelings among many of you. That is why it is important to me to have feedback from you. Would you call me directly, leave a message with my secretary at Adelphi (516-228-7939), or fill in and return the form below? I am in my New York office on Monday, Wednesday, and Thursday (212-722-6515); I am in my home office the other days (516-938-6970). I am at Adelphi on Tuesday and Friday afternoons.

1) I am (am not) willing to participate in the Corporate Health Systems program outlined above.

2) I am (am not) willing to meet with Paul Bender and/or Lisa Weiss for an orientation to CHS's program. A convenient time for me to attend such a meeting at Adelphi would be on a

a) Friday evening at 6 P.M. or
b) Sunday morning at 10 A.M.

3) I am (am not) willing to attend a meeting at Adelphi where we could brainstorm around this and other possible responses to the scarcity of patients.

Mail to:

George D. Goldman, Director
Postdoctoral Psychotherapy Center
Adelphi University
Garden City, L.I., N.Y. 11530

Name ______________________________

From The President *(cont'd from page 1)*

Our "Retreat committee" is Many Sanger. Every Fall we plan a weekend away, usually at Jeronimo's in Walker Valley, N.Y. We have tried several Spring Weekends at various resorts, but have never been pleased with the facilities. If there is enough interest, we would be willing to try another Spring Retreat. Manny is always looking for speakers from within the Society for these weekends. It's a great opportunity to share your ideas with fellow analysts in an informal setting.

Every December we host a Chanukah-Christmas Party for the entire Postdoctoral Program. Madeline Hirschfeld, our Hospitality Chairperson, promises that this one, on Dec. 19, 1986, will be the best ever.

For the last several years, in January, we have had a joint conference with the Long Island Institute of Psychoanalysis. This is usually an intimate gathering where a member of ASPP and a member of LIIP present papers on one issue. These conferences have been excellent; the small group makes for lively discussion. Anyone wishing to present a paper at this conference should contact Lyle Greenman.

Around January or February, we sponsor a workshop for those candidates approaching their Postdoctoral case presentation. This seems to be very helpful to the candidates and enjoyable for those who give the workshop.

Our final event of each year is a graduation-end of year celebration. For many years, we had a party at Adelphi. About four years ago, we decided to be innovative and we went on a boatride to Fire Island followed by dinner. This has been great fun and we may do it again this year. If anyone has any other suggestions, we're open to further innovation.

We have two rather new issues for which we have formed active committees. The first is the Legal-Legislative committee which grew out of the Peer-Review crisis and the licensing problems presented by the Seigel Bill. Obviously, there is a need for us to be more aware of legal and political activities as they seem to be directed at our profession more directly than ever before. Michael Zentman and Dave Hescheles, the current committee members, will keep us up to date.

The second is the Legal-Ethical Advisory Committee, chaired by Anna Leifer. This committee is to serve as an advisory body to any member who has a legal question or an ethical dilemma in their private practice. Often, a practitioner may be unsure of the implications of some decision with which she/he is faced. If you call Anna, she and the committee will respond.

An ongoing activity is our Speakers Bureau. Various organizations have contacted the Society asking for Speakers at their meetings. These talks have been a wonderful opportunity to disseminate psychoanalytic understanding and to publicize psychologists as helping professionals. If you would like to speak to an organization on a specific topic, please contact Carolida Steiner (Manhattan, Queens) or Linda Bergman (Nassau, Suffolk).

This year, we will be exploring an active continuing education program, in which our members would offer short-term courses to other professionals on Long Island. While there are many programs like this in Manhattan, there are very few on Long Island. I think this would be a very exciting project and would offer many of us an opportunity to teach courses that we might not otherwise get to do.

Finally, the Society has representatives on every major Postdoctoral Committee. This integral involvement demonstrates our ongoing interest in nurturing and strengthening the program which gave us our identity as analysts.

I hope that all of you will become active in the Society this year. Please send your listing for our Private Practice Directory to Marlene Kasman.

I look forward to seeing you at our functions. If you would like to join a committee or offer suggestions, please call me at 516-621-4815.

CALENDAR OF EVENTS

Saturday, December 6, 1986: ASPP Annual Conference with OTTO F. KERNBERG, M.D., from 9:30 A.M. to 12:30 P.M. The presentation is entitled, "Antisocial Behavior and its Relation to the Narcissistic Personality". The registration fee for the general public will be $40; paid-up ASPP members will pay a reduced fee of $20.

Dr. Kernberg is Associate Chairman and Medical Director of the New York Hospital-Cornell Medical Center, Westchester Division, and Professor of Psychiatry at the Cornell University Medical College. He is also Training and Supervising Analyst of the Columbia University Center for Psychoanalytic Training and Research.

Friday, December 19, 1986: Annual ASPP CHRISTMAS-CHANUKAH PARTY at Alumni House at 9:00 P.M. Postdoctoral classes will be shortened as usual.

Friday, January 9, 1987: ASPP will sponsor a presentation by JAY GREENBERG, Ph.D., at 9:00 P.M. It is entitled, "The Real Relationship in Psychoanalysis: Some New Considerations". Postdoctoral classes will be shortened.

POSTDOCTORAL CLASSES WILL MEET EVERY FRIDAY IN JANUARY. The Spring semester will begin on January 23, 1987; in other words, there will be no break in classes between semesters.

JOURNAL NOTES

By Eric Mendelsohn

With this issue of the Newsletter we introduce a feature called *Journal Notes*. It will include discussions of selected papers from current analytic journals, and comments from readers about previous *JN* pieces. The tone of this section will be informal, with authors' essays reflecting their personal interests and understandings. We invite dialogue with our readers, and hope that you will be moved to agree, disagree, and add your own voices to the discussions appearing in this section. We will print comments received in reply to *JN* pieces as space and editorial judgment permit. Several Society members will contribute to the section on a rotating basis, with one or two writing essays for each issue of the *Newsletter*. Our contributing staff will include Jerry Gold, Jim Hull, Eric Mendelsohn, Teri Schwartz, Elizabeth Sharpless, and Fred Woolverton.

Curtis, J. T. and Silberschatz, G. (1986). Clinical implications of research on brief dynamic psychotherapy I. Formulating the patient's problems and goals. **Psychoanalytic Psychology**, 3, 13-25.

Silberschatz, G. and Curtis, J. T. (1986). Clinical implications of research on brief dynamic psychotherapy II. How the therapist helps or hinders therapeutic progrsss. **Psychoanalytic Psychology**, 3, 27-37.

For practical reasons, if not from choice, psychoanalysts are increasingly interested in the briefer, more focal approaches to psychotherapy. The literature on brief, dynamic psychotherapy is by now extensive. A number of well-described approaches have been developed, and Davenloo, one of the principal proponents of brief therapy, has recently founded a journal devoted to critical discussions of work in this area.

Theorists hoping to distill the effective essence of brief therapy (its "complex secret"), have tried to identify key issues that need to be confronted, or processes that must unfold, for treatment to be helpful. As a result of these efforts to discover where the therapeutic action is, and as a consequence of the tendency to confound relevance with necessity, the literature on brief therapy tends to stress "essentials" of technique and content. Therapists are frequently counseled to use a standard technique and/or focus on certain preselected content areas. (While patients are often screened to determine their suitability for a particular brief therapeutic approach, the usual screening criteria still allow for considerable heterogeneity among patients.)

Another tradition in the field of brief therapy is that of empirical study. Brief therapists, to their credit, tend to study what they do. The yield from a number of outcome studies is informative; several technical approaches, usually designed for specific types of patients, have been shown to be helpful. Follow-up studies fail to condemn improvements as ephemeral. And process studies have, in some cases, been undertaken to identify factors characterizing successful treatments.

In their two-article sequence, recently published in *Psychoanalytic Psychology*, Curtis and Silberschatz make an important, thought-provoking addition to the brief pscyhotherapy literature. Their work is an offshoot of the important studies of therapy process conducted over the past 15 years by Weiss, Sampson, and their associates at the Mt. Zion Hospital in San Francisco. Too little of this work has thus far been published, but several journal articles, and numerous panel presentations have established the Mt. Zion Psychotherapy Group as an important contributor to the empirical study of psychotherapy and psychoanalysis. Their long-awaited book (Weiss, Sampson, and the Mt. Zion Psychotherapy Research Group, in press) should provide a comprehensive presentation of their theoretical and methodological approach, and a review of their research findings.

The Weiss-Sampson thesis is that patients come to treatment in order to solve problems. Accordingly, patients wish for their therapists to succeed where others may have failed. In their view, patients (and others) are capable of elaborate unconscious mentation, including the formulation of self-protective strategies in the face of perceived dangers. Similarly, patients can (unconsciously) imagine circumstances under which defenses could be relaxed. This thesis, based on ego-psychological formulations, emphasizes the cognitive aspects of unconscious experience. While this position may not sound particularly controversial, it must be considered in contrast to another position, widely accepted implicitly or explicitly, by many psychoanalysts. This latter view, referred to as the hypothesis of "automatic functioning", is based upon some of Freud's pre-structural theory formulations. According to this model, patients come to treatment with motivational systems dominated by unconscious impulses pressing for gratification. Complex cognitions, such as plans and anticipations, are viewed as relatively surface, secondary phenomena that arise in response to the need to contend with the impulse life. This view, which has been pitted against the "plan" hypothesis in a number of empirical studies, posits a very different understanding of patients' primary motives, and leads to very different predictions about patients' responses to various therapist interventions (e.g. the prediction that warded off material will emerge under conditions of frustration).

Following Weiss and Sampson, Silberschatz and Curtis view coming to treatment as the patient's attempt at problem solving, and as an opportunity for long-awaited reality testing and mastery in relation to painful pathogenic beliefs. The key elements of their position are summarized as follows:

"1. Patients come into therapy...to get better and they have an unconscious plan for how to do this.

2. If the therapist responds in accord with this plan, the patient will get better; if not, the patient will not improve or may even get worse.

3. Therefore, it should be the patient, not the therapist, who directs the course of brief therapy.

4. There are no universal themes or foci—such as separation or Oedipal conflicts—that should be pursued in brief dynamic therapy.

5. Similarly there are no special or unique techniques for the conduct of brief dynamic therapy." (Curtis and Silberschatz, p. 14)

(cont'd on page 5)

Journal Notes *(cont'd from page 4)*

Several explanatory details: The authors do not say whether their brief therapy model includes a prescription for the number of sessions; however, in several case examples, they refer to a course of 16 sessions and, in some vignettes, they refer to "ending on time." They do not provide details of their research approach, but do say they analyzed audio transcripts of brief psychotherapies conducted by experienced clinicians who had "specialized training" in brief therapy. The therapists were blind to the authors' hypotheses and were unfamiliar with the "plan" concept. The treatments were conducted in the manner favored by the participating therapists. The aim of the data analysis was to determine how well the hypothesis of an unconscious plan that is either facilitated or thwarted by the therapist's interventions explained what happened in the therapy. The first step in data analysis was to formulate patients' central problems and their plans for getting better.

In this day of "therapy manuals", the advice against standardization of technique or preselection of content is encouraging and most welcome. The authors argue against the assumption that an "active" technique is necessary with all brief therapy patients. They also encourage therapists not to worry unduly if patients appear dissatisfied or critical (much of the literature stresses cultivating a "positive" alliance). In a number of their cases, patients seemed to make impressive gains despite dismissive polemics. These patients insisted nothing helpful had occured in the therapy, but the evidence of improvement at the end of treatment was hard to miss. For such patients, blaming, criticizing, or discounting the therapist might represent a "test" of the therapist's mettle; to learn such treatment can be withstood by the therapist, and can be made sense of, (in the view of the authors) might well comprise a patient's "plan" for getting better.

The most interesting and arguable aspect of the Curtis-Silberschatz position is the concept of the unconscious plan. As debatable or incomplete as it may seem to assert that patients enter treatment in order to solve problems, it is going a good deal further to say patients have a plan for their recovery that they attempt to carry out with the help of the therapist.

What is the plan? The authors say it has four components. The first is patients' goals for the therapy, the changes they would like to make. These may or may not coincide with patients' stated goals. Assessment of these goals requires a psychodynamic understanding of the case. The second is referred to as the "obstructions." These derive from "irrational pathogenic beliefs" and the affects associated with them. These are the forces preventing patients from attaining their goals. Presumably patients also "know" something about these "obstructions". The third is called "tests". These are "trial actions carried out unconsciously by the patient in the relationship with the therapist." The purpose of testing is to learn if it is safe to pursue one's goals with the therapist. The fourth component is one initially within the purview of the therapist, not the patient; certain "insights", should they be conveyed to patients, will prove useful in achieving their goals. These "insights" usually pertain to the "obstructions". The idea is that self-actualization is more likely when patients see how and why they hold back.

How is the plan inferred? While the authors do not provide a detailed "how-to", they say therapists learn about patients' plans "from the patient's history, symptoms, and psychopathology, life situation, and behavior with the therapist in the early sessions." In other words, using clinical data, clinicians identify key wishes, anxieties, and resistances, and try to figure out what influence they can bring to bear to increase their patients' freedom and control. What distinguishes the "plan" formulation from most other psychodynamic assessments is its emphasis on the patient's wish for mastery, its problem-solving focus, and its emphasis on "pathogenic irrational beliefs" (e.g. complex unconscious ideas).

In positing unconsciously formulated plans and tests, the authors may make unnecessary and unfounded assumptions. To have a plan means to be able to articulate and anticipate probable outcomes. What type of knowledge is implied? Presumably, at the outset of treatment, patients are not aware of much of what they need to accomplish, nor are they aware of how their behavior is designed to test their therapists. Moreover, patients are portrayed as equally unaware of the outcomes of their tests. When therapists "pass", patients may feel better, become more reflective, or try to relinquish a bothersome sympton or inhibition. When therapists "fail", patients seem to fare poorly. But in neither case are patients aware that what has transpired is "according to plan". At best, in the final sessions of brief therapy, there may be some understanding between patient and therapist that the patient's conduct has been purposeful, and there may be some recognition of how various therapist responses were experienced as reassuring or discouraging. Nevertheless, the authors postulate that patients are able, unconsciously, to devise strategies for inducing therapists to partner them in highly specific ways, and then to critically monitor and evaluate the usefulness of therapists' responses.

In many of the case vignettes, patients improved when therapists responded thoughtfully and pertinently. In all cases, the fulfillment of the plan involved the knowing or unwitting collaboration of the therapist. An example is given of a young man who came to treatment saying he wanted to "overcome his inhibitions about intimate relationships" so that he could marry his girlfriend. Though he professed he wanted marriage, much evidence pointed against this, and the researchers, after reviewing the clinical material, hypothesized the patient really wanted to end the relationship. A pattern of feeling overly responsible for the welfare of various women, and of fearing the consequences of leaving them, emerged from the history. The therapist misread this and, instead, said the patient could not commit to his girlfriend because he feared success with women. The patient reacted negatively to this line of interpretation and soon began saying he needed more time in therapy. The therapist held her ground and ended the treatment in the agreed-upon 16 sessions. The authors said the patient profited from this response. In their view, the patient's gambit of requesting additional sessions was the crucial test of the therapist. They reasoned that the patient entered treatment with the goal of freeing himself from guilt-ridden entanglements with women. When the therapist missed this interpretively, the patient tried to pursue his goal by testing the therapist (illustrating the resilience and resourcefulness of the planning capacity); "would the therapist need to give in to the patient as the patient felt compelled to give in to women?" This time, through action, not interpretation, the therapist passed the test and the patient benefitted.

(cont'd on page 6)

Journal Notes *(cont'd from page 5)*

Referring to this sequence as a "plan" and a "test" may be like confounding the distinction between free recall and recognition memory. We "know" a good deal more when external cues are provided than when we are left to our own devices. In this case, the patient is seen as having an unconscious plan, as recognizing on some level that his protestations of loyalty to girlfriend and therapist are false, and as "knowing" that what he needs is to declare his independence. He than arranges a test to learn if the therapist feels beholden to him, by saying he doesn't feel able to leave. But, isn't it predictable that someone who has so much difficulty moving on would want to linger, especially if things were going poorly? Rather than assume the patient had an unconscious plan for getting better and then arranged a mutative test, wouldn't it be more parsimonious to say this patient apparently has the capacity to profit from the therapist's steadiness and freedom from guilt? What are viewed as unconscious hopes, plans, wishes, and so forth may be so considered because of their effects. It is tempting to say "the patient wanted me to respond this way" when "this" is what the patient's behavior elicited. The conclusion, however, may not be valid. A baby cries. A parent provides comfort. The baby cannot be said to be testing the parent. The baby may not yet even be at the stage of wishing for comforting, at least not until enough repetitions have occurred and the sequence becomes patterned for the child. The reliability and predictability of the response of the other is necessary before a "test" can be formulated.

It becomes useful, then, to distinguish between meeting a need and passing a test. Either type of response can lead to growth, but it stretches the meanings of "plan" and "test" to apply them to instances where patients have not had experiences that would enable them to "know" what their dilemmas are and what responses are needed to resolve them. While the thesis of unconscious plans and testing behavior may aptly characterize certain patients and their mode of operation, it does not apply to cases where a plan cannot yet be formulated and where all that can be done is to unwittingly present a problem. In this latter circumstance, the task of the therapist is to respond to the patient's need (or to "fail" after having established conditions of safety) so the patient can, for the first time, experience the problem in a form that can be verbalized and felt for what it is (c.f. Winnicott's position in his paper "Fear of Breakdown"). One question that arises is whether one can do brief therapy when presented with problems of this sort. The distinction between cases where an unconscious plan can be formulated and ones where the capacity may not exist (in the realm of that particular problem) may correspond to the distinction between neurotic pathology and borderline or psychotic pathology, but this is speculative.

These papers are worth reading closely. The forthcoming book by Weiss, Sampson, and the Mt. Zion group should prove a major contribution and a delight.

References— Weiss, J., Sampson, H. and the Mt. Zion Psychotherapy Research Group. (in press). *The psychoanalytic process: Theory, clinical observation, and empirical research.* New York: Guilford.

Winnicott, D.W. (1974). Fear of breakdown. *International Review of Psychoanalysis*, : 103-107.

THE ROVING REPORTER

By Stephen Zaslow, M.D.

Last May, I chaired a panel at the American Academy of Psychoanalysis meeting in Washington, D.C. Clarice J. Kestenbaum, M.D., presented "Psychoanalytic Interventions with Children and Adolescents with Affective Disorders: A Psychobiological Approach." Adolescents with bipolar disorder tend to have higher verbal than performance IQ's, also traits of exquisitive sensitivity to loss and separation, of grandiosity, and of overtalkativeness. Kestenbaum uses psychopharmacology to treat the biologic dimensions (i.e., excessive mood swings) and analytic psychotherapy for the psychological conflicts. John D. O'Brien, M.D., commented on the need to educate patients and parents about manic-depressive illness, its vicissitudes (especially sensitivity to loss of the familiar and the consistent), and ways of easing stress in its sufferers.

Richard C. Friedman, M.D., in his paper, "Suicide and the Depressed Borderline Adolescent", emphasized the need to combine dynamic psychotherapy and antidepressants. Specific diagnosis is crucial because of the high risk of suicide in severe depression. He advised against splitting such cases between a psychotherapist on the one hand and a medicating psychiatrist on the other. Norman Tabachnik, M.D., Ph.D., agreed with Friedman's point of view.

I was impressed by Kestenbaum's research evidence that bipolar illness is an entity with a strong hereditary component, and that psychological testing and psychiatric history-taking can each provide important diagnostic data. I was equally impressed by Friedman's case examples of management probelms and success in dealing with depressed borderlines. The therapist must be capable of providing a holding environment sufficiently secure to enable use of medication and of psychotherapy. Often this will involve parent guidance as well as hospitalization for the patient. (Extensive bibliographies are available from the presentors.)

Severely depressed and suicidal young people pose a significant challenge to interdisciplinary collaboration. We must be receptive to new findings, able to assimilate new data and face their implications. It is noteworthy that the William Alanson White Institute has added a required course to the first year curriculum in psychoanalysis; it deals with the relationship between Psychoanalysis and Psychopharmacology. Wise Adelphians will create a format in which to grapple with these and related issues.

PLEASE

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YOUR 1986-87

ASPP DUES