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Psychoanalysis, Dynamic Psychotherapy and Mental Health Parity: The Need for Advocacy

Susan G. Lazar

Psychotherapy, especially psychoanalysis and dynamic psychotherapy, has historically been poorly supported by insurance benefits. While there are a number of notable exceptions to this generalization (e.g., CHAMPUS, Medicare, Federal Employee Health Benefits Program in past decades), higher co-pays and lower yearly and lifetime limits for mental health care have been widespread discriminatory limitations. After years of advocacy for increasingly comprehensive mental health parity legislation, the Mental Health Parity and Addiction Equity Act (MHPAEA) enacted on Oct. 3, 2008, is the most sweeping national legal mandate to date for parity for mental health care benefits. The Affordable Care and Patient Protection Act of 2010 (ACA) also strengthened mental health parity and its official description explicitly lists psychotherapy as an "Essential Health Benefit."

There are several reasons for the historically discriminatory pattern of under-reimbursement for psychotherapy. Stigma surrounding mental illness, as opposed to physical ailments, is well known and commonplace. There is also a widespread misconception about psychotherapy in particular, describing it as an unnecessary indulgence used by the affluent or the "worried well." To operationalize bias against psychotherapy, insurers have historically resorted to numerous strategies such as coverage exclusions, unequal co-pays, and dubious "medical necessity" reviews. In justifying higher co-pays, for example, insurers have cited "price elasticity" meaning that a higher co-payment from an insured party is needed to reduce its use by patients to the same level as their visits to other medical care. The suppression of patients' access to psychotherapy down to the same rate as use of other medical services by the deliberate increase in patients' cost burden is conceptualized as a necessary correction for an assumed "moral hazard," i.e., the unnecessary use of treatment by those not truly in need (Frank and McGuire, 2000).

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Susan G. Lazar, M.D., *is a training and supervising analyst at the Washington Psychoanalytic Institute, and a clinical professor of psychiatry at Georgetown and George Washington Medical Schools, and at the Uniformed Services University of Health Sciences.*

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A Note from the Editor:

As the second issue of *TAP* under my editorship gets delivered to our members, I want to introduce the Editorial Board's vision for *TAP*. While fulfilling its mandate to report news about goings-on in APsaA, the major focus of *TAP* will be to represent the thinking of our members, and also those outside our Association, about important and compelling issues that contribute to discourse among contemporary analysts. Two- to five- page reports on research, clinical, theoretical and applied psychoanalysis, as well as relevant ideas from adjacent fields, will be presented. Please note the contributions of Michael Slevin as the Special Sections editor, Luba Kessler as Psychoanalytic Education editor, Bob Galatzer-Levy as Science editor, Arlene Kramer Richards and Arnold Richards as Book Review editors, and Bruce Sklarew as Film editor.

We welcome contributions from all. If you have an idea or know of someone who might make an interesting contribution, please contact me and we can talk about implementing it on the pages of *TAP*. Letters to the Editor are also welcome, and can be sent to me at dougchavis@gmail.com.

Thank you for your interest and readership, and we hope you enjoy *TAP*.

Doug Chavis
TAP Editor

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Opportunity and Loss in the Coming Year: Confronting Our Challenges

Harriet Wolfe

Harriet Wolfe

After decades of the same structure and more or less the same identity, APsaA is catapulting toward an immense amount of change. Even when it is long-sought, change brings with it loss and varying levels of grief depending on one's organizational identity. In January 2017, we face a double dose of loss: We come closer to losing our familiar organizational structure and we lose our "home" at the Waldorf. Both of these losses present the important opportunity we have to update and invigorate our organizational mission and claim our sense of place in a changing world. But without attention to where we have been and what we have lost, we will be poorly prepared to define and accomplish what we hope to become.

The changing face of the Waldorf Astoria serves as a metaphor for the challenges we confront as a tradition-bound profession in a rapidly changing culture, one interested in immediate modes of communication and quick fixes for complex problems. The old familiar Waldorf mirrors the Golden Age of psychoanalysis. Its myriad rooms have allowed a stunning number of gilded opportunities for conversation in small, medium and large groups. The enormous arrangement of flowers in the Park Avenue foyer and the centrally located clock have captured the dependable richness of intellectual and social exchange. The clock was still there last year, but the flowers were already gone.

This spring the new Waldorf owners surprised even the current Waldorf staff by suddenly moving their renovation plan up a year, forcing us to reimagine where we might hold our annual winter meetings. After a serious amount of research, our staff located suitable space and negotiated a favorable contract for future National Meetings. The solution required some compromise. We will meet in February rather than January and we will meet (the first year but not the second) in somewhat reduced space. APsaA's new National Meeting location will be the New York Hilton on Sixth Avenue. In 2018 the scientific program dates are February 14-18; in 2019 they are February 6-10.

New Structure

In January 2016, after 70 years with one organizational structure, APsaA members voted to endorse a new one. A supermajority of voting members gave the Executive Council, APsaA's Board of Directors, full responsibility for the activities of the organization. This meant that the Board on Professional Standards (BOPS) was no longer autonomously responsible for educational matters. After decades of focused attention to developing and maintaining educational standards, BOPS itself will be sunsetted and a new Department of Psychoanalytic Education (DPE) will be established. Many herald these developments as immense progress. But unless we take care to honor what BOPS has contributed to our profession and our personal relationships within APsaA, we run the risk of adopting a sense of victory that excludes a balanced appreciation of the challenges inherent in mounting a vibrant, forward-looking program of psychoanalytic training and in achieving a focus on the profession rather than our internal debates.

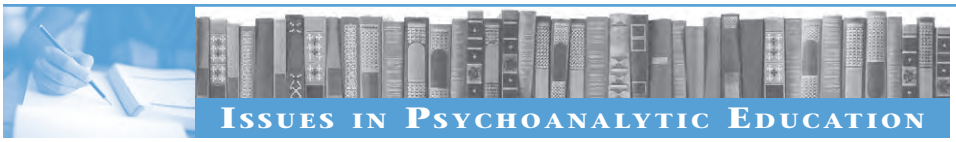
As we know well from analytic work, the more complex a relationship is, the more complicated and necessary a process of mourning is. And many APsaA members have had complex and highly ambivalent relationships with both the structures we are losing, BOPS and the Waldorf. Many of my personal mentors and friends have devoted immense volunteer efforts to BOPS committees and study groups. I think that is true for many of us. We need to honor their constructive work and reduce the risk of losing dedicated colleagues.

The combined leadership of the Executive Committee and Executive Councilors and BOPS Fellows has achieved a vision of One APsaA and created a plan for organizational restructuring: the Six Point Plan. Steps include, in addition to the sunsetting of BOPS, a strengthening of Executive Council, the introduction of the Department of Psychoanalytic Education, institute choice (using IPA requirements as guidelines) regarding TA/SA appointment criteria and training standards, and the externalization of individual analyst certification and institute accreditation (used at the discretion of the individual institutes). These changes require ongoing collaboration across groups within the Association. The tasks are complex and the paths to change are not quick and easy.

Let's come together in January, in our small, medium and large group settings one last time at the Waldorf, and repeatedly recognize what we have been, how we wish to advance, how we will honor our past and correct our course going forward.

As we mourn the loss of organizational configurations and relationships, let's recognize a danger. It would be a form of pathologic mourning to repeat our history of focusing on—even creating—internal conflict rather than focusing on advancing psychoanalysis in modern times. We will never be conflict-free as an organization, nor would we wish to be. If we manage our differences with an open mind to hearing and understanding other points of view, we will have more success facing the future and make more constructive progress.

Harriet Wolfe, M.D., *is president of the American Psychoanalytic Association.*



Today's Future Psychoanalytic Education and DPE

Erik Gann

Erik Gann

In this age of proliferation of psychoanalytic theories ("pluralism"), how are we to do a good job of teaching candidates what psychoanalytic thinking is all about? Are we currently doing a good job? Is psychoanalytic thinking, as taught in our institutes and training centers, in contact and interacting with the important developments and advances in other 21st century scientific and intellectual currents that intersect with our domain? Given that, according to practice surveys over several decades, most graduate analysts spend most of their professional time engaged in treatments and/or activities other than the traditional psychoanalytic method, are we conceptualizing psychoanalytic education in the most relevant, realistic and effective fashion?

I first posed these questions to the Executive Council at the Chicago meeting in preparation for their vote authorizing the creation of the Department of Psychoanalytic Education in APsaA. I now reiterate this inquiry for the readers of this column in order to underscore the decisions before us in the changing APsaA.

Erik Gann, M.D., *is a training and supervising analyst, faculty member and past-president of the San Francisco Center for Psychoanalysis. He is currently task force chair on APsaA's Department of Education. He is also a principal in the Boswell Group.*

Change does not come easily. As psychoanalysts we are immersed in this fact. We know it is difficult for any individual to relinquish well-known, well-hewn patterns of perception and reaction, preferred attitudes and recognizable structures. This is arguably even more the case for groups and organizations than for individuals. Nonetheless, we are currently in the midst of an attempt to transform our own organization in the face of long-standing traditions and practices and some modes of operation many consider outmoded. Furthermore, it is most likely that we do not all agree on the need for these shifts. It is well established that the one matter on which we all agree is that we cannot even muster an agreement on what constitutes an analytic process—or by extension, what is a psychoanalyst? How, then, can we conceptualize the contemporary, psychoanalytic educational task?

Psychoanalytic Evolution

Perhaps it would be more precise to speak of the evolution of our field rather than to focus singularly on the issue of change. I say this because the notion of evolution implies a development in which history is not entirely ignored or refuted, but transformed in nature according to the demands of adaptation. Have the conceptualization and structure of psychoanalytic educational programs adapted to the contemporary scene? In a recent issue of *JAPA*, Otto Kernberg and Robert Michels, along with a number of commentators from within and outside APsaA, suggest different ways in which we must alter our views and activities in these efforts. We are forced to acknowledge that for too long in our more than a century-old discipline, a psychoanalyst was regarded as a person who spent most or all of one's professional time "doing" clinical psychoanalysis. We must also acknowledge that this has been a poorly rationalized but enduring myth. Some of our ranks have followed this path; others have pursued careers in which they have brought their psychoanalytic knowledge into other arenas, often having been dismissed or told privately that their careers would be judged adversely in comparison to the idealized myth.

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From the Psychoanalytic Education Editor

The inauguration of the *TAP* "Issues in Psychoanalytic Education" column corresponds to the formation of the Department of Psychoanalytic Education (DPE) at APsaA. The DPE, which will come into being in June 2017, will aim to secure the delivery of high quality training and education at APsaA through approved institutes in the atmosphere of vigorous institute representation, interdisciplinary enrichment, collegial exchange and mutual edification. A task force, chaired by Erik Gann, has been at work to articulate the functions and define the structures in the service of this mission. In this column, Gann offers his view on what animates, guides and shapes this effort.

—Luba Kessler
Issues in Psychoanalytic Education Editor

Conversations on Psychoanalysis and Race: Part Two

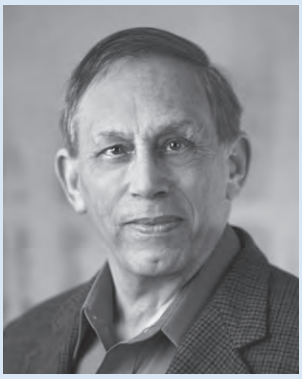
Introduction

Michael Slevin and Beverly J. Stoute
Co-Editors

Race is a core construct and core reality for American individuals and American culture. Believing both that psychoanalysis has much to offer the discussion about race, in and out of the consulting room, and that psychoanalysis has paid too little attention to race in the past, we have edited a three-part special section, "Conversations on Psychoanalysis and Race," for *TAP*, on the subject.

The first part, consisting of our introduction and articles by Annie Lee Jones and Kirkland Vaughans, was published in the Fall 2016 issue. Our authors shared their powerful experiential perspectives on racism for African-Americans.

No conversation can evolve in discussing race in America without lifting the veil of white privilege. Our authors in this second part, tell us of their journeys to come to a deep and lasting understanding of the defensive uses of white privilege with a rare moving, sensitivity and humility. Warren Spielberg, in "Am I the Only Black Kid That Comes Here?," writes about some of the challenges of being a white psychoanalyst working with



Michael Slevin

Beverly J. Stoute

a black male adolescent who challenges the analyst from the outset. Michael Moskowitz and Richard Riechbart write about their personal experiences with white privilege in "How I Came to Understand White Privilege" and "On Racism and Being White: The Journey to Henry's Restaurant," respectively.

"Conversations on Psychoanalysis and Race: Part Three" will be published in the Winter/Spring 2017 issue with articles by Beverly J. Stoute on "Race and Racism in Psychoanalytic Thought: Are There Ghosts in Our Nursery?," Anton Hart on "From Multicultural Competence to Radical Openness: A Psychoanalytic Engagement of Otherness," and Dorothy Holmes on "The Fierce Urgency of Now: Will Institutional Psychoanalysis Answer the Call to Psychoanalytic Understanding and Treatment of Racial Disturbances among Us?"

Michael Slevin, M.S.W., *is in private practice in Baltimore and an emergency psychiatric evaluator of patients in crisis in the Emergency Department of Sinai Hospital. He is co-chair of the Social Issues Department Task Force on Income Inequality and Class.*

Beverly J. Stoute, M.D., *child, adolescent and adult psychiatrist and psychoanalyst, Atlanta; training and supervising analyst, Emory University Psychoanalytic Institute; associate child supervising analyst, New Orleans-Birmingham Psychoanalytic Center; graduate of the New York Psychoanalytic Institute.*

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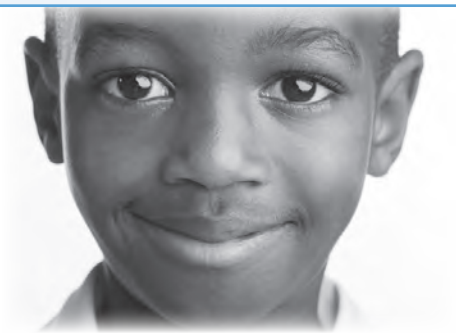
Am I the Only Black Kid That Comes Here?

Warren Spielberg



"Am I the only black kid that comes here?" asked David, an 11-year-old African-American boy who had been referred to me because of behavior problems.

The question caught me off guard and made me anxious. I reverted to the usual, "I am glad to answer your question, but perhaps you can tell me why you are asking?" He answered with silence.

A few minutes later, he said, "I like your chair. Can I sit there?" I thought about it. I liked my chair too. But I was trying to build a relationship with a child who did not trust me.

"OK, you can sit there for a while. But eventually I would like it back." I got up and he settled into my big comfortable leather chair. I sat on the smaller chair that was reserved for the children who came to see me.

"Why do you think your mother brought you here?" Again he did not reply. I waited a minute, long in therapeutic time. Eventually, my annoyance gave way. "Did you hear what I said?"

"Yeah, I heard you. You know why I am here. Now stop bothering me." He moved the chair over to examine my toys.

He had a point. I did know. He had been suspended from his public school for "defiant behavior" and was now enrolled in a private parochial school. Like so many boys of color, David was not thriving in school.

For our two-volume book, *The Psychology of Black Boys and Adolescents*, Kirkland Vaughans and I interviewed over 50 boys and young men about their school lives. Most felt uncomfortable with their teachers. Many reported being singled out for discipline and being asked to sit in the back of the class. However, most were unable to voice their feelings about these experiences. If they do allude to it, it is with much uncertainty and hesitation. Most of the time, they "try not to know" they are the objects of fear or dislike, because this would be unbearably painful to acknowledge. Although they are unable to discuss their feelings and fears about school, they readily enact them. Many use their defiance or their withdrawal to protect themselves from their fear of rejection. Sadly, many blame themselves. By third grade, school participation and achievement among black boys begin to decline, a process that will continue through high school.

I believe the "mentalization" capacity of boys and adolescent males of color becomes compromised in school. Peter Fonagy (1997) has discussed the relationship between the hostility of authority figures and the inability of children to develop self-awareness and advanced cognition. This is an adaptive strategy on the part of a child subjected to deprivation or rejection, as to recognize the hostile thoughts of a meaningful adult would be too frightening and painful. However, as black boys close their minds to important adults like teachers, they also become afraid to think about themselves. They become unable to use what is in their own minds to create and achieve.

The current cultural climate of most schools undermines the developing capacity of the black boy to see himself as cherished in the minds of teachers. In my view, the "achievement gap" reflects a "relational gap" between boys of color and their teachers. Many more white teachers than black teachers describe boys of color as larger physically, less innocent and more delinquent. When some do well in school, they are accused of cheating as their success runs counter to implicit stereotypes. Their positive qualities and selves are "invisible" to others, as A.J. Franklin has noted. They are not seen when they are gifted, intelligent, helpful and decent. Even when they do well they are often accused of cheating or having an unfair advantage. This trauma of non-recognition leads to a lifelong feeling of jeopardy if one tries to be seen.

Jared, a tall handsome young man we met in Montclair, remarked "I stay in the middle. I won't do badly in school, but I don't want to stand out either," echoing a common sentiment we encountered. To stand out or to do too well will lead to some kind of targeting. Black teachers and boys also experience ruptures based on clashes in culture and class. Boys and young men of color are suspended and expelled at six times the rate of their white counterparts. Once suspended, the graduation rates for black boys decline by 30 percent. This sets many of these young men up for a life in the streets and involvement with the criminal justice system.

David could be defiant and uncooperative, but underneath he was frightened of being thought to be stupid and fearful of being punished. And now he was required to be in therapy. In treatment, he seemed to be treating me as one more demeaning authority figure. But now he was in the driver's seat (my chair had wheels) and I was the one in an inferior and more vulnerable position.

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Warren Spielberg, Ph.D., *Fulbright Scholar, psychologist, psychoanalyst, is co-author of* The Psychology of Black Boys and Adolescents. *He consults on issues on boys and men worldwide. In his Brooklyn Heights private practice, he works with children, families and adults.*

How I Came to Understand White Privilege

Michael Moskowitz

"When I call your name, come to the front of the class and form a circle," my first grade teacher Mrs. Wright announced. We were going to learn to read.

I waited anxiously, barely able to sit. I was not called and continued drawing warships in battle. Then the first group returned to their seats and a second group was called. I was not in it. I ran to Mrs. Wright and begged, "I want to learn to read."

"You'll be in the next group," she said.

It soon became clear that the next group was the "gifted" group. I didn't know how this group was chosen. I don't remember any tests, though there may have been one. I do remember that in the third group the girls seemed snootier, and no one wore torn or dirty clothes as some did in the other groups. This is my first memory of privilege, benefiting from an unearned advantage by belonging to a group. Not only was I chosen, I had felt entitled to ask. Not everyone did. It was not exactly white privilege. Everyone in the school was white, and everyone in the town was white. In a way I was less than white. Of the approximately 300 students and 20 or so teachers and staff at the elementary school, I was the only Jew—and I was seldom allowed to forget it.

It was rare to walk the five minutes to school or back home without being taunted, "Dirty Jew," "Christ killer," "Kike." The words were often accompanied by punches and sometimes by beatings. It was the same on the playground. Yet somehow I knew I'd get through it, that this childhood would be escaped, and I would emerge relatively powerful and privileged. Perhaps it was because at some level, even at age six, I knew that my parents, aunts, uncles and cousins had suffered much worse anti-Semitism and had gone on to achieve enough success to garner respect. Perhaps it was because watching television with my parents or relatives always involved calling out, "You know he/she is a Jew." Milton Berle, Phil Silvers, Melvyn Douglas, Lauren Bacall, Shelly Winters, the Marx brothers, Elizabeth Taylor, Peter Lorre, Paul Newman, Sammy Davis Jr, Benny Goodman, Jascha Heifetz, Justice Brandeis, Einstein and Dr. Grawi.

Michael Moskowitz

Dr. Grawi was our neighbor in a grand house on a hill I passed every day on the way to school. He had fled Germany in the '30s and was now a modestly prosperous GP who drove to the city for opera and theater. My parents independently and repeatedly said about him, "They could take away everything, but they couldn't take away his education," which I took to mean, if you do well in school you can always find some place to live well, even if means fleeing thousands of miles to an alien culture to be safe.

I never doubted I would escape the oppressive, often violent place of my childhood. Though the town was only a two-hour drive from New York City, in the '50s it was more an impoverished Appalachian town than an exurb. It still is. In 1828, it become a canal town—rechristened Port Jervis—just before the decline of the canals; then a railroad town before the decline of the railroad. It was a factory town until the flight of the factories. And when the highways came, they passed Port Jervis by.

Because my father was a plumber and owned a small plumbing supply store, we lived in the poorest part of town, and we were poor. But because we were Jewish most neighbors thought we were rich, which bestowed another kind of privilege. Most of my classmates' parents worked in the factories or were laborers. Many were descendants of French Huguenot and Dutch settlers, now poor white. Others were children and grandchildren of Irish and Italian immigrants. Very few expressed any interest in leaving the area, whatever their talents. Diane, my first crush, the smartest student in school—I knew because I looked through the principal's files when I was in detention—got pregnant and left school when she was 14. Some of the Christian kids planned to go to college. Most of those were the children of the professional class, the doctors and lawyers. Of those who left many returned, some to join their father's practice, others to start their own.

My parents made light of local anti-Semitism. It was nothing like they had suffered back home. My father did not come to my defense or teach me how to fight back. "Ignore what they say. It's just words. They're ignorant. They're jealous. This is a country of laws," were some of the things he said. As new citizens my parents knew their rights and their privileges. They taught us not to trust authority. It could be challenged, not flamboyantly, but by the law. "You can always call your lawyer," was an essential part of the talk. I'll say more about the talk later.

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Michael Moskowitz, Ph.D., *a training analyst at IPTAR, has written about psychoanalytic theory, race, ethnicity, and neuroscience. A recipient of the Gradiva Award for his contributions to psychoanalytic publishing, he was an associate producer of the film* Black Psychoanalysts Speak.

On Racism and Being White: The Journey to Henry's Restaurant

Richard Reichbart

> *My schooling gave me no training in seeing myself … as a participant in a damaged culture.*
>
> ***—Peggy McIntosh, "White Privilege: Unpacking the Invisible Knapsack," 1988***


Richard Reichbart

I am sitting at Henry's restaurant on the Upper West Side of Manhattan with the group of psychoanalysts from *Black Psychoanalysts Speak*, the PEP video for which I wrote the grant, and which followed upon two conferences of the same name. (The psychoanalytic conferences were unique because the audiences were predominantly people of color). I am white, as is Michael Moskowitz, who envisioned these conferences, and Alexandra Woods; but everyone else—Kirkland Vaughans, Annie Lee Jones, Craig Polite, Kathy White, Janice Bennett, Anton Hart—is black. There are a number of other black analysts who are not present (Cleonie White, Dolores Morris, Dorothy Holmes, Cheryl Thompson) and subsequently there will be two added to our group (Dionne Powell, Beverly Stoute).

***Richard Reichbart, Ph.D.,** is past president, fellow and training analyst of the Institute for Psychoanalytic Training and Research (IPTAR) in Manhattan; executive director of the PEP video* Black Psychoanalysts Speak; *co-executive director of the PEP video Psychoanalysis in El Barrio.*

I am relatively quiet. In fact, after our dinner, Annie Lee emails me and asks: "Why so quiet?"

I sidestep by saying I have been preoccupied by being president of my institute, IPTAR, but in fact her question gives me pause. Here is my extended answer.

I need to listen. I *have* to listen. Yes, I have a history of being involved, of committing myself to the importance of culture and doing so passionately, of advocating for justice—actually of unknowingly for years metaphorically searching for the black maid who left our family precipitously when I was four years old (a dynamic that I understood as a result of my first psychoanalysis). I was arrested in the Free Speech Movement at Berkeley in 1964 in protest against the University of California's forbidding solicitation by the Congress of Racial Equality (CORE) on campus; I worked for Martin Luther King's Southern Christian Leadership Conference as a civil rights worker in Georgia and Alabama in the summer of 1965; after Yale law school, I lived and worked on the Navajo reservation in Arizona and New Mexico as an Office of Economic Opportunity (OEO) legal services attorney for Dinebeiina Nahilnabe Agaditahe (attorneys who work for the economic revitalization of the Navajo people); and subsequently I represented Native Americans who sat-in at the Bureau of Indian Affairs (BIA) office in Littleton, Colorado, and were accused of trespass. I successfully defended them before an all-white jury by introducing cultural testimony that touched on Native American practices—from the invocation of tribal elders to the preparation of berry soup—showing they had no intent to trespass, were not "wild Indians" but were families who brought food and ceremony to the BIA, which accepted them as guests before their sudden and unexpected arrest.

The fabric of cultures, the texture, the theories of causality that are embedded within them, fascinated me. Thus, I wrote about the nature of Navajo thought as revealed in its healing practices. And as a civil rights worker, I learned the wonders and beliefs of black culture, the back and forth of congregants and preacher at church, the power of gospel music. I applied my knowledge to one of my first clinical psychoanalytic papers, to show that the folk belief system of the Southern mother of a black 12-year-old boy was central to understanding the way in which her child's emotional problems were formed and expressed. It should not be surprising that my early psychoanalytic heroes include George Devereux, Geza Roheim, and Weston La Barre; or that I believe psychoanalysis itself should struggle with the same racial issues as have our great American authors, each in his own way: Ellison, Melville, Faulkner, Twain, Wright.

In a visceral way, I can remember living with Vivian Prater and her family in Fort Valley, Georgia; the safety of being on the unpaved red Georgia clay black side of town; of dinners of collard greens, fried chicken and grits; of learning about the importance of church and song. But the fact is, in all of these situations, my skin offered me a magic protection. I might not be safe on the white side of Fort Valley—it was indeed dangerous back then—but my skin was my passport and permitted me always to leave for home, for a place where I was safe.

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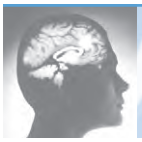
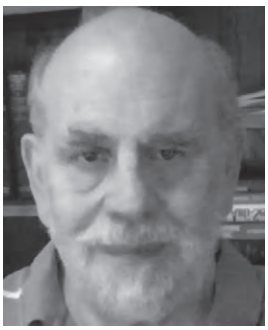


Nonlinearity: New Worldview for Psychoanalysts

Robert M. Galatzer-Levy



Robert M. Galatzer-Levy

An old *New Yorker* cartoon—Two scientists at a blackboard. On the left and right of the blackboard are complex equations. The phrase, "Then the miracle occurs." connects them. One scientist says to the other, "I think you should be more explicit about step two."

Today that "miracle" is often made explicit using the mathematics of nonlinear systems. We psychoanalysts have lots of miracles for which nonlinear dynamics can help.

Pick up a psychoanalytic publication and it is hard not to come across the term "nonlinear." The popularity of the word reflects a sense that something is going on that is not captured well by our common sense vision of orderly interactions, something complicated and perhaps mysterious happens in the complex world of mental function. The term "nonlinear" in mathematics indeed refers to amazing features of the world that were very hard to understand until recent years.

Nonlinearity is a quality of processes seen in virtually all complex systems, a quality that means surprising and unexpected things will happen even though the process follows the laws of cause and effect. This often occurs because in nonlinear systems tiny changes in causes can make huge differences in outcomes. A good way to think about it is to imagine a road dividing: Go a few feet to the right, you end up in New Hampshire, a few feet to the left and your destination is Southern California.

The study of nonlinear systems began in the early 20th century, but serious progress had to wait for developments in mathematics and other theoretical disciplines in the 1960s. A small group of psychoanalysts began to explore their application to our field in the 1970s.

The basic idea is this: When more than two objects interact, even when their interactions are governed by simple rules, the result is not just the sum of their individual interactions. Something new and different occurs.

Let's start with Newton who calculated how individual planets moved around the sun. His solution was exact. He could write an equation for planetary motion and plug in numbers that gave very good but imperfect results. But he knew that, in addition to the gravity between the sun and each planet, the planets exerted a gravitational pull on one another. He could write equations that included these forces but he could not solve them. Nor could anyone else in the succeeding 350 years. The "obvious" solution of making a correction to the equations for the interactions of the individual planets doesn't work as well as one might hope. It improves the solutions but leads to physical impossibilities after a while. The equations were impossible to solve. Even the seemingly simple general problem of predicting the motion of three bodies under the force of gravity remained intractable and yielded predictions that were simply wrong. Such questions as whether the planets would eventually crash into the sun or spin off into space could not be answered clearly. A new kind of math was needed.

That new math, sometimes called chaos theory or nonlinear dynamics systems theory or the theory of nonlinear differential equations, described a new world, a world that expands our notions of what is possible, a world that should reshape our "common sense" and, with that, enlarge our picture of psychological configurations.

Qualitative Changes from (Small) Quantitative Changes

Imagine, for example, that a patient comes to a session with a novel ambition for which you cannot find a convincing antecedent. Using a linear model, you say to yourself, "This must come from somewhere. Maybe some repression was lifted freeing the patient to think a new thought." But the resulting interpretation feels forced. However, in a linearly based model of mental function it or something like it, such flawed interpretations are the only possible ones. Perhaps, you noticed an antecedent for the development, but it seemed too minor to have a profound effect.

In nonlinear systems, however, qualitative changes do emerge from quantitative ones, even small ones. Just as when water cools below 32° Fahrenheit and turns to ice, a substance qualitatively different from liquid water, so too, at the right point tiny quantitative changes in psychological systems can precipitate novel mental configurations, even ones not there in latent or unconscious form. This idea expands our capacities for conceptualizing change and is reason for optimism about the possibilities that can emerge from the psychoanalytic process.

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Robert M. Galatzer-Levy, M.S, M.D., *is University of Chicago clinical professor of psychiatry and behavioral neurosciences and Chicago Institute for Psychoanalysis faculty member. His interest in nonlinear psychoanalysis combines his early mathematics training with his development as a psychoanalyst.*

Nonlinearity

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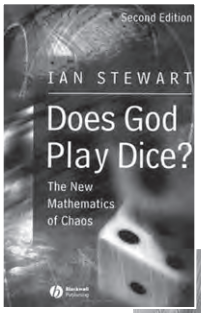
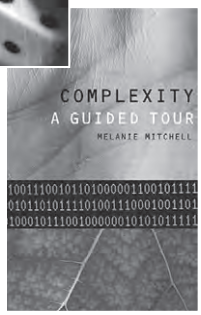
Development

Our picture of development is transformed by a nonlinear worldview. If, as is true of nonlinear systems, small changes can yield big consequences, Robert Frost's image from "The Road Not Taken," where a minimal change "made all the difference," becomes a good metaphor for the reality that tiny changes in the course of development can be life altering. Recognizing this as a possibility in a complex system enlarges the range of our understanding. For example, development may be transformed by seemingly small events. This profound effect of small events might suggest that the latent meaning of an event is greater than is obvious (the standard analytic understanding). Or, it may be that occurring at the right moment, minor events open new pathways leading to the emergence of something new and surprising.

Sophocles vs. Joyce

Analysts love narratives and find them useful explaining psychological events. Convincing narratives often come from mythologies or plausible stories of development. We can think of narratives in terms of the ways characters and elements move through time and space. Unknown to either of them, Oedipus meets his father on the road where the father will not yield right of way. The usefulness of the myth in psychoanalysis is that it describes a path close to those that emerge in many analyses. Mathematicians call such pathways "attractors." For a long time, the study of motion was limited to systems that corresponded to the unfolding of a single story line. But, today, a far larger range of attractors is recognized with properties such as sudden jumps from one pattern of motion to another. These strange attractors suggest new types of narratives, for example narratives that suddenly jump between distinct patterns of change, closer to James Joyce's *Ulysses* than Sophocles' *Oedipus Rex*.





Zoom In—Zoom Out

Analysts have long known that a closely examined bit of analytic process may reveal the structure of the entire analysis. This quality of a tiny portion representing the structure of the whole is typical of "fractals," the beautiful structures seen everywhere in nature from coastlines to snowflakes to plants and the lung. Fractals provide a model for the analytic claim that the study of material at different levels of magnification from an appropriate 15 seconds of interchange to an analysis may yield basically the same information. They provide a rationale for this connection. Since one of the major impediments to researching analysis is the overabundance of process material, this fractal property in which a small part very well represents a whole is a road to simplifying this difficult work.

In Sync

Analytic sessions sometimes feel like a dance. The back and forth between analyst and patient builds something new and curative. A similar process between infant and caretaker is part of normal development. For hundreds of years, physicists have known that when vibrating systems come into contact, new configurations of vibration are likely to appear in each of the systems and in the newly formed dual system. The nonlinear mathematics that describes these processes has only come into being in recent decades. Applying it to the psychoanalytic process suggests how two people moving through their own repetitions again and again may create something new when they come together.

Out of Nowhere, Back to the Miracle—Emergence

The *New Yorker* cartoon's "Then the miracle occurs" refers to "emergence," the appearance of new properties of complex nonlinear systems seemingly out of nowhere. A few examples: the complex hexagonal form of snowflakes, the emergence of new species in Darwin's theory of evolution, the stable configuration of the internet out of millions of individual connections or of elaborate colonies made up of individual ants each of which follows simple rules. So far the main use of this concept in psychoanalysis is to open our eyes to the reality that such things happen. There are emergent properties of analytic processes and psychological function generally. When we see something that seems new in an analysis or in development we neither need to assume that it can be reduced to something that was already there nor do we have to declare it a "miracle," albeit by some other name. It is likely an emergent property of the complex system we call the human mind.

The field of nonlinear mathematics is enormous. It has implications for psychoanalysis ranging from questions about boundaries to the statistical methods appropriate for exploring psychoanalytic data to the way practicing analysts listen to our patients.

Want to know more?

Ian Stewart's *Does God Play Dice?* (2002) remains the best introduction to chaos theory while Melanie Mitchell's *Complexity: A Guided Tour* (2011) is a lively introduction to the broader field of complexity. Both are accessible without an extensive mathematical background to those who do not instantly become anxious when mathematics is mentioned. Applications of nonlinear dynamics to psychoanalysis can be found using PEP with the search terms "nonlinear" and/or "chaos theory." My own book on the subject, *Nonlinear Psychoanalysis: Notes from 40 Years of Chaos* will be published by Routledge in the coming year.

How Do We Help Our Patients?

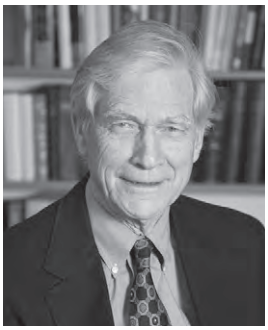
Sherwood Waldron

Most psychoanalytic clinicians and researchers know that psychoanalysis and long-term psychoanalytic therapy work. What remains uncertain is what contributes to that beneficial result. Freud's emphasis on the role of insight has not been sufficiently confirmed in empirical studies, nor has the role of interpretation in bringing about favorable change been easy to demonstrate.

Thirty years ago a group of analysts in New York started tackling the job of connecting the processes of psychoanalytic work with outcomes. We didn't think we had a chance to accomplish this except by studying actual recordings. It was supremely difficult to persuade fellow analysts to record. We had the benefit of groundbreaking efforts by Merton Gill and by a group led by Lester Luborsky in Philadelphia, and I started recording my own work to give us more to study. My background contributed to my making such a culturally unacceptable decision: I had been educated as an undergraduate at the Department of Social Relations at Harvard. This gave me a view of the science of the social sciences (including statistics), and inspired me to do a small research project of my own for my thesis, so that I had the benefit of a somewhat unique perspective as I pursued the goal of becoming a psychoanalyst.

Creating Reliable Measurements

The research group I was able to form 30 years ago continues to this day, with gradually changing membership.



Sherwood Waldron

Our first task was to develop measures of what is going on in the consulting room, viewed from a psychoanalytic point of view. We developed scales and variables to assess core psychoanalytic activities such as the analyst's clarifying, interpreting, addressing transference, conflicts and defenses, along with other aspects of the nature and quality of the analyst's activity and the therapeutic relationship. Also, we assessed the patient's contribution to the process—conveying his/her experiences, reflective functioning, ability to express feelings in an informative way, response to the analyst's contributions and the quality of the patient's own contributions.

To aid in reliability, we developed clinical examples to illustrate the different levels of each variable, from zero to four points, and the resulting APS Coding Manual (with Robert Scharf as first author, unpublished 1993 revised 2010) is helpful as a teaching instrument to students of analysis and analytic therapy. Published results from the ensuing Analytic Process Scales (APS) showed that the strongest influence of the analyst on the patient came from those analyst comments which were of the highest quality (as judged by experienced analyst-raters), irrespective of whether the comments were an interpretation, encouragement to elaborate, addressing the patient's self-esteem or of a similar nature. The analyst-raters used their own best judgment, guided by our APS Coding Manual. The judgments were moderately reliable among the analyst-raters.

What to make of these findings? We realized we had been concentrating most on the technical aspects of the analyst's work, but the relational aspects needed to be more directly evaluated. So back to the drawing board. We developed another set of scales to be applied to each recorded session. We called these the Dynamic Interaction Scales (DIS). As if the 28 scales already described were not sufficient (which they were not). The DIS assesses contributions of the patient, therapist and the interaction between them.

Breakthrough

Then a breakthrough occurred: We began a collaboration with colleagues in Rome, Vittorio Lingiardi and Francesco Gazzillo, of "La Sapienza" University Department of Psychology. They proposed to study what had now become an entire collection of 27 completely recorded psychoanalyses by seven different psychoanalysts. Back in the middle 1980s I had set up the Psychoanalytic Research Consortium (PRC), with help from the Scientific Activities Committee and the Fund for Psychoanalytic Research of APsaA, to collect, safeguard and confidentialize as many psychoanalyses as we could persuade people to make or share with us. Our group included the late Robert Wallerstein as vice-president of the PRC and other members of the Scientific Activities Committee. By the time our Roman collaboration began we had enough cases to make a small study, and received some funding from a private foundation as well as from the research arm of the International Psychoanalytical Association, and the Department of Psychology at La Sapienza University.

We decided to study 20 sessions from each of the recorded analyses, from early, middle and late in each treatment. We were able to find out about what elements contributed to forward movement, once Francesco and his team of colleagues finished applying our 39 process measures to all 540 sessions—a huge accomplishment.

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***Sherwood Waldron, M.D.,** is on the faculty of the New York Psychoanalytic Society and Institute, where he teaches candidates using recorded analytic sessions. A child and adult analyst, private practice and research have together been his primary professional activities.*

How Do We Help

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First we needed to establish whether our patients actually benefitted from their analyses. Using both the Global Assessment of Functioning (GAF) and a new measure we developed called the Personality Health Index (PHI), we found most of them did benefit. While widely used, the GAF is a rather crude measure. The PHI is based upon Jonathan Shedler and Drew Westen's Shedler Westen Assessment Procedure (SWAP). The clinician makes detailed clinical judgments of 200 known aspects of a person's pathology and strength. In 2011, we published the PHI, which provides a percentile score compared to a nationwide sample of other patients in psychoanalysis collected by Rosemary Cogan and John Porcerelli.

Clinicians can evaluate their own patients, or clinician/researchers can rate patients based on listening to eight consecutive sessions to develop sufficient familiarity with the patient to perform the SWAP. The latter was the procedure we followed. The patient who had the most positive change in the course of his analysis went from a PHI of 10, which meant that 90 percent of analytic patients were healthier than he was, to a PHI of 85 at the end of his treatment, meaning he was functioning in the top 15 percent of the reference analytic patients. The chart below (Figure 1) shows how the group as a whole fared from early to late in their treatments (with identifying pseudonyms for each patient). It is clear there was considerable benefit overall, which was also supported by changes in GAF scores that were rated by a different set of raters.

Could we tell what was different about the analyses that did better and those that did do not so well? Here we ran into our biggest problem: our sample size of only 27 cases. We classified 17 as good outcome cases and 10 with limited benefit or deterioration. In view of the importance of the unanswered questions about the efficacy of psychoanalysis under varying conditions (e.g., therapist, patient, techniques used) the number should have been 270 cases. Then we could examine patterns in a way that could give more detailed meaningful conclusions. In this study the only finding we can report about differences between good and poor outcome cases was that all the variables (patient, therapist and interaction) that would be expected to be higher in good outcome cases did indeed average higher in the eight early sessions, compared to the poor outcome cases. This result could scarcely occur by chance. It would be like flipping a coin 39 times and always coming up heads. But because of the low N, we cannot claim to having demonstrated differences between the two groups *on any given variable*. Our field needs the new generation of analysts to have the courage to record their own work to answer many important remaining questions.

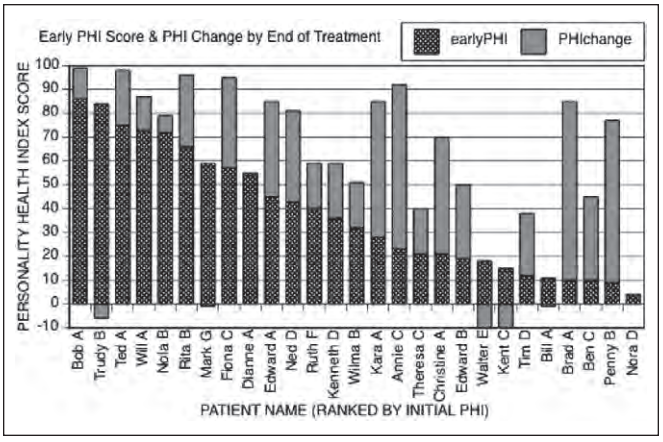

Figure 1

Meanwhile, what can we learn from our process variables, as assessed for all the 540 sessions? First we wanted to know what variables go with each other. Discovering this is a way to simplify to some extent the results from so many measurements and to reveal the structure of these analyses, viewed through the lenses of analytic clinicians. A factor analysis was applied to three domains: contributions of the patient, the analyst, and the interaction between patient and analyst. It turned out the factors we found made clinical sense and could readily be named, although to get a feel for them, one would want to review the individual variables that contributed to each factor. Both the patient and therapist variables reduced to three factors, whereas the interaction only led to one factor. (Figure 2)

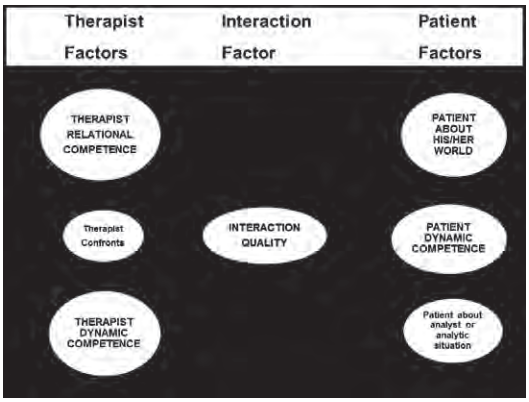

Figure 2

THERAPIST FACTORS: The first, **Therapist Relational Competence**, evaluates the therapist's warmth, amicability, sharing of his/her own subjectivity, expressing feelings, being supportive, straightforward and addressing momentary shifts in the patient's feelings. A second small therapist factor is **Therapist Confronts**, that is, how confrontative the therapist was in the session. The third therapist factor, **Therapist Dynamic Competence**, includes encouraging elaboration, clarifying, interpreting, addressing defenses, transference and conflicts, plus the more general assessment of the quality of the analyst's communication.

INTERACTION FACTOR: Analysis of our interaction variables yielded only one factor, **Interaction Quality**. The variables in this factor include: Therapist helps patient to be more aware of feelings; the patient experiences the

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Mental Health Parity

Continued from page 1

Susan G. Lazar

Since MHPAEA made higher co-pays and discriminatory reimbursement schedules for mental health services illegal, insurance companies have resorted to more indirect means to limit their reimbursement. One such practice consists of flagging patients who exceed a pre-set, "outlier" session cap (e.g., more than 20 or more visits in a given period to trigger concurrent reviews that almost invariably deem continuing treatment "not medically necessary"). This offensive practice lacks both clinical support and an evidentiary basis. For example, with respect to the concern that psychotherapy is an unneeded, at best elective, expense, the Rand Health Experiment documented that even when psychotherapy is free, it is accessed by only 4 percent of an insured population and the average length of care is 11 sessions (Manning, Wells, Duan, et al, 1986). In fact, when insurance benefits for all care is generous, "price elasticity" and higher usage of outpatient mental health benefits tend to disappear. It also turns out that a higher cost burden for outpatient psychiatric care turns away very ill patients who simply forego treatment (Landerman, Burns, Swartz, et al, 1994; Simon, Grothaus, Durham, et al, 1996).

Exploiting a common prejudice that there is little evidence for the value of psychotherapy as part of a rationale not to cover its cost, insurers persistently overlook the robust research base documenting its effectiveness and disregarding in particular the studies of psychodynamic therapies. While psychological treatments are arguably more abstract and harder to conceptualize, to research and to measure than physical ones, we do have a compelling research literature documenting their efficacy and cost-effectiveness, including for psychodynamic treatments. Furthermore, the disparity in "medical necessity" determinations for mental health care compared to other medical care is also evident in the practice of providing insurance coverage for a substantial number of other medical services considered consistent with "standard practice"—and not necessarily supported by rigorous research or anything other than anecdotal or "expert opinion."

Higher Medical Costs Due to Lack of Psychiatric Care

Given decades of stigma and lack of appropriate support for psychotherapy and all mental health care, we now know this lack of sufficient treatment is a significant hidden multiplier of morbidity and disability, as well as greatly expanded overall health care expenses. Compared to patients without psychiatric illness, the increased medical expenses of the psychiatrically ill extend above and beyond the costs of their psychiatric care. Findings from a number of studies document these increased medical expenses, including more primary care visits, higher outpatient charges, and longer hospital stays (Melek and Norris, 2008; Luber, Hollenberg, Williams-Russo, et al, 2000; Deykin, Keane, Kaloupek, et al, 2001). Unfortunately, a high percentage of the psychiatrically ill are never even diagnosed and a majority of those who are receive inadequate treatment (Wang, Berglund, Olfson, et al, 2005; Wang, Lane, Olfson, et al, 2005). Simply put, patients with chronic, complex and/or recurrent psychiatric illness have more medical conditions and higher medical costs. These patients can often be treated with psychotherapy that yields better mental health and overall health outcomes. Yet these facts are unfortunately ignored by many insurance companies intent on minimizing reimbursement and evading the mandate for mental health parity. In addition, despite the preference for lower cost medication treatment, in many situations psychotherapy often provides a higher effect size than medication alone, augments the effect of medication (while the reverse is unclear), has lower dropout rates than medication alone protocols, and obviously lacks the side effects of medication treatments (Levy, Ehrenthal, Yeomans, et al, 2014).

Clearly any claim that a treatment should be covered under insurance must provide evidence for its effectiveness and, ideally, its cost-effectiveness. Cost-effectiveness is not synonymous with effectiveness or efficacy—it refers to the financial cost of a treatment and relates it to specific outcome measures of effectiveness (Cellini and Kee, 2010). It also does not mean cheap but what society is willing to pay for measurable positive outcomes. In essence, it signifies the impact per dollar spent. While many psychiatric patients improve with relatively brief courses of treatment, there are also important groups that are very costly to society if inadequately treated. Studies show that these patients often require more intensive and/or extended psychotherapy than most insurance companies are willing to support, despite the research that suggests the need for more care for these patients to achieve recovery as well as savings that often result from decreased medical expenses and improved productivity which is the even more stringent metric of cost-offset. However, insurance companies tend to focus on controlling short-term immediate costs and not on long-term planning and thorough treatment that might lead to better health outcomes and savings in the budgets of other parties.

Patients Who Need More Psychotherapy

Recent studies have delineated several diagnostic groups of patients who appear to need an intensive and longer duration of psychotherapy and who also often do better with a psychodynamic approach.

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Mental Health Parity

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These groups include those with chronic, debilitating personality disorders, those with chronic, complex disorders such as severe longstanding depression and anxiety, and those with multiple chronic psychiatric disorders. These patients are among the most seriously ill and are frequently not adequately treated with psychotherapy, due to arbitrary limits on reimbursement for psychotherapy by insurance companies (Bendat, 2014).

Treatment Needs of Patients with Personality Disorders

Patients with personality disorders have deeply ingrained, maladaptive, inflexible ways of thinking and behaving that generally lead to impaired relationships with others. Such patients are enormously costly to society. They are among the most chronically impaired groups in psychiatric populations: unemployed for longer periods, have more drug problems, suicide attempts, and interpersonal difficulties (Gabbard, 2000; Linehan and Heard, 1999; Pilkonis, Neighbors and Corbit, 1999; Reich, Yates and Nduaguba, 1989); more criminal behavior, divorce, child abuse, and heavy use of mental and general health care (Skodol, Gunderson, Shea et al, 2005). The lifetime prevalence of personality disorders is between 10 percent and 13.5 percent (P. Casey and Tyrer, 1986; Maier, Lichtermann, Klingler, Heun, and Hallmayer, 1992; Lenzenweger, 2008), affecting at least 30 million Americans of all social classes, races and ethnicities.

Randomized controlled trials of different psychotherapeutic approaches have demonstrated that dialectical behavior therapy (DBT), cognitive-behavioral therapy (CBT), psychodynamic and other specialized treatments for personality disorders are all effective, leading to reduced symptomatology, improved functioning and decreased hospitalization (Hadjipavlou and Ogrodniczuk, 2010, Bateman, 2012, Bateman and Fonagy, 2009; Linehan, Armstrong, Suarez, et al, 1991; McMain, Guimond, Streiner, Cardish, and Links, 2012).

For those who require an extended course of psychotherapy due to their mental illness, both longer duration and higher frequency of psychotherapy have independent positive effects. Together, these factors are associated with the most positive treatment outcomes (Rudolf, Manz, and Ori, 1994; Sandell, Blombert, Lazar, et al, 2000; Grande, Dilg, Jakobsen, et al, 2006; Leichsenring and Rabung, 2008, 2011). The factors that contribute to the cost-effectiveness of extended intensive psychotherapy for those patients who need it include savings from decreased sick leave and decreased medical and hospital costs (Dossmann, Kutter, Heinzel, and Wurmser, 1997; Bateman and Fonagy, 2003, 2008) (Bateman, 2003; Bateman and Fonagy, 2008); Clarkin, Foelsch, Levy, et al, 2001).

For those who require an extended course of psychotherapy due to their mental illness, both longer duration and higher frequency of psychotherapy have independent positive effects.

The disturbed interpersonal relationships of patients with personality disorders and other chronic complex disorders constitute a highly significant risk factor for increased mortality exceeding smoking, alcoholism, obesity and hypertension (Holt-Lunstad, Smith, and Layton, 2010). While psychotherapy of different approaches improves symptoms, a number of studies imply that long-term psychodynamic treatments are significantly superior in improving maladaptive interpersonal relationships (Huber, Zimmerman, Henrich, and Klug, 2012; Levy, Meehan, Kelly, et al, 2006; Levy, Ehrenthal, Yeomans, et al, 2014; Leichsenring and Rabung, 2008, 2011; Shedler, 2010). Shedler also showed that when compared to patients treated with other psychotherapies, patients treated with psychodynamic psychotherapy maintain therapeutic gains better and continue to improve after treatment ends, the "sleeper effect."

Treatment Needs of Patients with Borderline Personality Disorder

With respect to patients with borderline personality disorder (BPD), Van den Bosch, Verheul, Schippers, and van den Brink (2002), found no empirical evidence that the core pathology of patients with BPD (unstable relationships, primitive defenses, identity disorder and boredom) is affected by one year of DBT. They also suggest that intrapsychic elements of this pathology may be more positively affected by psychodynamic psychotherapy. Levy, Meehan, Kelly, et al (2006) and Clarkin, Levy, Lenzenweger, et al (2007), also found that dynamic psychotherapy leads to broader personality changes than supportive psychotherapy or DBT for borderline personality disorder. And with respect to the need for longer term therapy, many studies indicate that patients with BPD in particular take significantly longer to improve (Howard, Kopta, Krause, and Orlinsky, 1986; Hoglend, 1993; Kopta, Howard, Lowry, and Beutler, 1994; Fonagy, 2002; Levy, Meehan, and Yeomans, 2010). In fact, the British Health Service National Institute for Health and Care Excellence (2009) cautions against the use of brief psychological interventions especially for borderline personality disorder stating, "…there is perhaps an even stronger signal that longer treatments with higher doses are of greater benefit. In several studies, significant improvement was only observed after 12 months of active treatment."

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Training Standards: What, Why, and How

Dwarakanath G. Rao and Dionne R. Powell

> *Education is not received. It is achieved.*
>
> ***—Albert Einstein***

As we approach the sunsetting of the Board on Professional Standards and its regulatory functions, APsaA institutes are deep in discussion about standards and external regulation.

The Board on Professional Standards and its regulatory functions will cease activity in June 2017. In preparation, December 31, 2016, is the deadline for suspension of all regulatory activity, waivers, and approvals, with the exception of applications for training and supervising analyst appointments, for which the deadline will be April 30, 2017. Bylaw changes to sunset the Board on Professional Standards will be presented to the Executive Council and the Board on Professional Standards in January 2017 for review, and to the membership in the spring of 2017 for final vote.

The Six-Point Plan gives institutes a choice of standards, of oversight options, and whether or not they want external accreditation. APsaA institutes will have a choice of following APsaA standards using IPA requirements as guidelines, or following the requirements of the American Association for Psychoanalytic Education (AAPE) using existing APsaA standards that meet or exceed IPA standards. Both are subject to future modification: IPA standards by the APsaA Executive Council, and AAPE standards by the AAPE Board of Directors.

Institutes that follow AAPE standards will be nationally accredited through site visits conducted jointly by AAPE and the Accreditation Council for Psychoanalytic Education (ACPE). AAPE is a national standards body; ACPE is a national accrediting agency. A memorandum of understanding between the two organizations brings together external standards and national accreditation for collaboration and efficiency. AAPE requirements for TSA appointment will include certification, as well as vetting via detailed evaluation of clinical work.

Institutes that follow APsaA standards using IPA requirements as guidelines will be self-regulating and not be required to seek external oversight of standards or external accreditation. They may, however, obtain external accreditation through the Accreditation Council for Psychoanalytic Education (ACPE), as well as call upon APsaA's Department of Psychoanalytic Education (DPE) for consultation. The DPE aims to become a broad forum for problem solving in psychoanalytic education, beginning with existing COPE study groups. Requirements for TSA appointments involving immersion standards and certification will be locally determined.

Postgraduate Life and Standards

The single most controversial issue within APsaA has been evaluation of postgraduate expertise in the form of certification and the training analyst system. We now have an opportunity to ponder the purpose of standards, and their meaning and evolution beyond APsaA reorganization. We begin by acknowledging the contributions of APsaA members who have been steadfast in their balanced approach to the education and training of future psychoanalysts. They have worked tirelessly to apply standards to meet the realities of a modern psychoanalytic practice. They teach, supervise, advise, mentor, recruit, work in administration, finance, and on innumerable committees, locally and nationally, all at considerable personal and professional sacrifice of time, energy, and money.

In performing this labor of love, each of these analysts gladly uses consensually validated educational principles. No difficult decision is made without agonizing in the way self-reflective analysts do all over the world. In our observations, such decisions are enriched, not hindered, by clear, thoughtful, aspirational, and externally vetted standards. The key to the thoughtful use of such standards is trust in the intentions and experience of those who establish such standards based on both rigor as well as the complex realities of training and analytic practice. Adherence to a set of national standards, in our opinion, ensures a reliable and sound educational program for consumers and future trainees alike.

AAPE is a standards body that builds on decades of experience and the knowledge of hundreds of educator colleagues. Responsible evolution of standards is a goal of AAPE. In a regulatory landscape that is often rigorous, AAPE's intention is to bring together the best in our traditions and the best in our aspirations. Just as the frame of clinical psychoanalysis is both strong as well as flexible depending on the context, so too we think educational standards ought to be. We don't think it is conceptually possible to be flexible without first building a solid framework, which is why AAPE will begin with existing APsaA standards.

In this time of great change, we invite members to familiarize themselves with the DPE and offer their expertise in building the DPE. Similarly we invite members to familiarize themselves with the AAPE and its philosophy of standards, and the benefits of external standards and accreditation. Together, we believe each member and institute can meet their desired needs, and colleagues with diverse opinions on standards and accreditation can live with a degree of harmony.

Dwarakanath G. Rao, M.D., *is chair of the Board on Professional Standards.*

Dionne R. Powell, M.D., *is secretary of the Board on Professional Standards.*

Welcome to the APsaA 2017 National Meeting in New York

January 18–22

Christine C. Kieffer

As the new year approaches, I suspect you are anticipating APsaA's 2017 National Meeting—thinking about seeing old friends and colleagues, meeting intriguing new ones under the clock. But wait…sadly, this January will mark our last meeting at the grand old Waldorf Astoria, a place that for many of us has come to seem almost like a second home. As you now know, the Waldorf will be shutting down for three years shortly after our meeting, to reemerge as a mix of condos, plus a boutique-style hotel. Thus, our next meeting is likely to be suffused with sadness and an impending sense of loss, even as we gather to reaffirm and celebrate our beloved profession and, of course, deepen our knowledge of our discipline.

As I promised in my last column, I will use this section to highlight some of the other fine programs offered at the January meeting, all of which make unique contributions to the conference.

The University Forum will feature a program on "Racism in America," chaired by Dionne Powell, with speakers, Darryl Pinckney, Lawrence D. Bobo and Jeffrey Prager. The **Meet-the-Author** program, chaired by Henry Friedman, will feature books by Steven Cooper, Margaret Crastnopol and Adrienne Harris. Don't miss this opportunity to join the conversation with these esteemed authors.

There will be two particularly compelling **Symposia** offered at this meeting. The first is "Psychoanalytic Perspectives on Sexual Orientation and Gender Identity in the Orthodox Jewish Community: The Interface between Culture, Religion and Psychoanalysis," chaired by Alison Felt and Alan Slomowitz, with presenters, Mark Blechner and Rabbi Mark Dratch. The second symposium will examine "Poetry and Psychoanalysis," a program chaired by Carol Snow. The presenters for this symposium will be Forrest Hamer, Alice Jones and Susan Kolodny.

Christine C. Kieffer

The Presidential Symposium on Research, chaired, of course, by Harriet Wolfe, will examine "The Scientific Standing of Psychoanalysis." We are delighted that Mark Solms, the new head of APsaA's Science Department, will give this presentation.

As always, we have an exciting group of featured discussants and presenters at the **Two-Day Clinical Workshops**, which afford the opportunity to hear a case in depth. This January, Irene Cairo has invited Navah Kaplan to present to Jorge Canestri her featured discussant. Joseph Lichtenberg has invited Elizabeth Carr to present a case and Frank Lachmann to serve as discussant. Sharon Blum has invited Joseph Wise to present a case to Frank Summers. This year, David Bell will serve as the featured discussant for Donald Moss's clinical workshop. Darlene Ehrenberg will be inaugurating a new two-day clinical workshop. She has invited Lisa Citrin to present a case and Rosemary Balsam to serve as her featured discussant. And for the **Child/Adolescent Clinical Workshop**, chair Monisha Nayar-Akhtar has invited Christie Huddleston to present a case to featured discussant, Norka Malberg. As regulars at these popular programs can attest, there is always plenty of time for participants to add to a lively dialogue inspired by these workshop chairs and their esteemed guests.

As usual, we will have a fine array of **Discussion Groups**, many of which have become hardy perennials, with participants coming back each year to deepen their understanding and share their views of the topic. I would like to call attention to three new discussion groups that will be making their debut at this meeting: "Altered States of Awareness" with Fonya Lord Helm and Maurine Kelber Kelly; "Dreaming, Imagination and Psychoanalytic Process" with Howard M. Katz and "Italian Psychoanalysis and Contemporary Models of Theory and Technique" with Andrea Celenza, John C. Foehl, and Christopher G. Lovett. Be sure to come to one, or several of these new programs.

In closing, I would like to congratulate my colleagues on the Program Committee for their creativity and dedication in organizing what will be a terrific meeting.

Christine C. Kieffer, Ph.D., ABPP, *is chair of the Program Committee.*

Book Review

Examining Patients' Racist Ideologies

Volney Gay
Arlene Kramer Richards and Arnold Richards, Book Review Editors

Volney Gay

Narendra Keval is a psychoanalyst who teaches at the University of Essex in England and conducts a full-time analytic practice. Raised in Zambia, in Southern Africa, he grew up hearing terms like "colored quarters" used by English colonial masters in what was then Northern Rhodesia. Those early experiences of racist ideologies and their entanglement with naked exploitation helped shape his book, *Racist States of Mind: Understanding the Perversion of Curiosity and Concern*. Because these social and political realities persist in most cultures, this book and its exploration of patients willing to share their often taboo thoughts on race are valuable. (A related, recent book is Neil Altman's *Psychoanalysis in an Age of Accelerating Cultural Change: Spiritual Globalization*. Routledge, 2015. See also Narendra Keval's blog posts.)

Patients do not, typically, bring their racist ideologies for therapeutic examination. Rather, Keval discovered "racist states of mind," which generate unconscious convictions of inherent superiority to others and which, if not analyzed, contribute to the deadening of one's personality. In this way, racist states of mind harm both overt victims, the Others and the victimizers. An empathic encounter with these states of mind requires a great deal of analytic tact. Because individual and cultural narcissism are wrapped around core identities of alleged superiority (for example, European, rational, cultured, civilized and, for many in the U.S., Christian), challenging these defenses evokes first anxiety, and then rage. Keval astutely notes Freud's struggles with anti-Semitism and the catastrophe of the Holocaust—manufactured by Europe's "greatest civilization"—have shaped how Jewish and non-Jewish psychoanalysts view the ubiquity of racist ideologies. Beyond these American and European examples of racist states of minds are similar ideologies in caste societies, such as traditional Hinduism. (For example, the Sanskrit word for caste, *varna*, means "color" or "tribe.")

Some therapists may believe the book is less relevant to them because their practice is not as heterogeneous as Keval's. However, even within a seemingly homogeneous culture lay the ingredients of narcissistic pleasures in disdaining others and the inborn propensity to idealize one's tribe, no matter how defined. Among white Americans, for example, one finds income, training, parental status, educational attainment and dozens of other markers of difference sufficient to make invidious comparisons. Alongside racist terms for Africans and Native Americans are terms like "cracker" and "white trash" that are uttered with great disdain for poor whites.

Keval explicates the creative idea of the "racist scene." This is a version of the classical concept of the "primal scene" *(Urszenen)* that Freud first announced in a letter to Wilhelm Fleiss in 1897. The former pertains to fantasies of disruption members of a racially distinct group feel when their pristine sense of home, body and the motherland is "invaded" by foreigners who threaten to ruin what was great, even virginal. Those "M . . . f . . . blacks" (Pakistanis or others) are penetrating and despoiling one's sacred past. Keval's psychoanalytic formulation struck home for many Americans during this election year. Rather than name, experience and mourn the losses that change brings, some Americans respond to these threats with "the additional excitement of hatred and violence."

Keval's case histories, in Part II, are models of analytic brevity and clinical richness. Each merits careful reading and teaching because in each we find a thoughtful analyst struggling to evoke his patients' strongest feelings, especially their sadistic pleasures and their manic-like defenses to keep from recognizing narcissistic wounds against which those primitive defenses are erected. A common countertransference response among white therapists with black patients is guilt; among black therapists with black patients it is unconscious condemnation of those who are "acting white."

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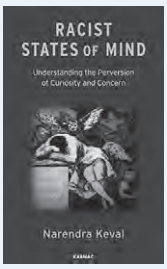

Racist States of Mind: Understanding the Perversion of Curiosity and Concern

By Narendra Keval

141 pages
London: Karnac Books, 2016

***Volney Gay, Ph.D.,** is professor of religious studies, psychiatry and anthropology at Vanderbilt University. His new book is* On the Pleasures of Owning Persons: The Hidden Face of American Slavery, *International Psychoanalytic Books, 2016.*

APsaA's Excellent New Fellows for 2016-2017

The American Psychoanalytic Association Fellowship Program is designed to offer additional knowledge of psychoanalysis to outstanding early-career mental health professionals and academics, the future leaders and educators in their fields. The 15 individuals who are selected as fellows each year have their expenses paid to attend the national meetings of the American Psychoanalytic Association during the fellowship year and to participate in other educational activities. The biographies below introduce this year's excellent group of fellows. We enthusiastically welcome them to APsaA.


Azeesat Babajide

Azeesat Babajide, M.D., M.B.A., is currently a second-year fellow in child and adolescent psychiatry at UCLA. She attended Princeton University where she majored in molecular biology and African-American studies. After college she worked as a curriculum development associate at a charter school in NYC. She attended Tufts University School of Medicine where she obtained both her M.D. and M.B.A. Babajide then completed her adult psychiatry residency training at the New York State Psychiatric Institute–Columbia University. Her interests are in systems of care, psychodynamic and psychoanalytic psychotherapy, education, and child and adolescent psychiatry.


Catherine Boutwell

Catherine Boutwell, Ph.D., is a clinical psychologist at the Women's Program at Columbia University, Department of Psychiatry. Boutwell earned her Ph.D. from The New School for Social Research in 2015, and she completed a postdoctoral fellowship at Columbia University Medical Center in 2016. During graduate school, Boutwell conducted psychotherapy research at Mount Sinai Beth Israel, where she studied shifts in therapists' narratives about the therapeutic alliance before and after psychodynamic supervision. Her current interests include psychoanalysis, psychotherapy process research, women's health and the intersection of development across the lifespan, identity and autobiographical narrative.


Keri O. Brenner

Keri O. Brenner, M.D., M.P.A., is a palliative care physician and a psychiatrist at Massachusetts General Hospital (MGH) and an instructor at Harvard Medical School. She completed psychiatry residency with MGH McLean in 2015 and then the Harvard Palliative Care Fellowship in 2016. Brenner received a dual degree from Yale School of Medicine and Harvard's Kennedy School of Government. Her medical school thesis, "Suffering Transfigured: Phenomenological Personalism in the Doctor-Patient Relationship," received honors recognition. She was a philosophy major at the University of Notre Dame, where she later served on the University's Board of Trustees. Brenner was first inspired to care for patients with terminal illness through her work at Mother Teresa's Home for the Dying in Kolkata, India. Her interests include psychodynamic issues in patients with life-limiting illness, both as a palliative care clinician and as a psychotherapist.

Miguel Caballero is a Ph.D. candidate in the Department of Spanish and Portuguese at Princeton University. His areas of specialization are 20th century literature and culture, particularly architecture and urban planning. His dissertation is tentatively entitled "Negation and Preservation: Buried Monuments in Iberoamerica (1928-1964)," a critique of modern monumentality based on the archival reconstruction of three interventions where iconic monuments of Mexico, Spain and Brazil were buried for different reasons. In fall 2014, he founded the Princeton Psychoanalysis Reading Group and has since organized 14 sessions. In fall 2015, Caballero co-organized the "Freud Today" conference at the Freud Museum in Vienna. He also is an HIV activist and writer, publishing weekly articles on ASS *(Amor, Sexo y Serología)* and HIV Equal.


Miguel Caballero


Kali Cyrus

Kali Cyrus, M.D., is a PGY4 and chief resident in the adult program at the Yale School of Medicine. She graduated with her B.A. in psychology and human biology from Stanford University. She then completed a master's in public health in health policy and management at Emory University's Rollins School of Public Health. Afterwards, she obtained her M.D. from the University of Illinois at Chicago College of Medicine. At Yale, she has completed

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research on doctor-patient communication, designed innovative standardized patient scenarios to test implicit bias, and lectured on privilege, bias and racism for medical students. She has been recognized for her advocacy efforts, clinical care and educational work. She is interested in countertransference and transference stemming from the growing intersectionality of both patients' and doctors' individual identities.


Ksera Dyette

Ksera Dyette, Psy.D., B.C.B., is a first-year fellow at Cambridge Health Alliance, Child and Adolescent Acute Services. She recently received her doctorate from Widener University's Graduate Institute for Clinical Psychology with a board certification in biofeedback. Specializing in work with forensic populations, she maintains clinical focus on issues of sexual trauma, attachment in institutionalized children and intergenerational transmission of trauma. She is also skilled in personality assessment, spending the last three years as a teaching assistant for her program's Rorschach course as well as participating in lectures for advanced differential diagnosis. She presented and volunteered at APsaA's 2014 National Meeting and won the Stuart T. Hauser Memorial Research Prize for her research presentation on her dissertation work with Monisha Nayar-Akhtar, her mentor.


Christopher Flinton

Christopher Flinton, M.D., is a third-year resident in the psychiatry residency program at Walter Reed National Military Medical Center. He received his bachelor's degree at Boston College in Chestnut Hill, Massachusetts. After commissioning in the United States Army, he earned his M.D. degree at the F. Edward Hébert School of Medicine at the Uniformed Services University of the Health Sciences in Bethesda, Maryland. He won the 2016 Anne Alonso Ph.D. Memorial Award, awarded by the American Association of Directors of Psychiatric Residency Training, for his submission: "First Experiences with Psychodynamics." Flinton hopes to use psychoanalytic approaches to treat trauma-related disorders in American service members and their families.


Jennifer Huang Harris

Jennifer Huang Harris, M.D., is a PGY3 psychiatry resident who received her medical school and first two years of residency training at the University of Texas Southwestern and is finishing her residency at Cambridge Health Alliance. Her particular passion is in making complex ideas accessible and relevant through teaching and writing. As an undergraduate at Stanford University studying biology and English, she created a course on the science of cooking. During medical school and residency, she was involved in creating and teaching courses on bioethics, literature and medicine, and a course seeking to synthesize the multiple perspectives in psychiatry. She has also published papers on predicting response to trauma and moral distress. Her clinical interests lie in philosophy of psychiatry, morality and theology, trauma, and conversion disorders. She hopes to make psychoanalytic ideas accessible and relevant in medical education.

Cassie Kaufmann, Ph.D., is a staff psychologist at New York Presbyterian Hospital, where she works with individual patients and groups on a psychiatric inpatient unit. She is also an instructor of clinical psychology at Columbia University Medical Center and maintains a private practice in Manhattan. Her multidisciplinary research incorporates psychoanalytic theory, art and literature, and gender and women's studies. She received her doctorate from the Derner Institute for Advanced Psychological Studies at Adelphi University. Kaufmann's dissertation was a study of visual creative thought that posed a critique of the devaluation of visual thinking within psychoanalytic theory. Prior to studying psychology, she received her B.A. in comparative literature from Yale University and M.S.Ed. in special education from City College.


Cassie Kaufmann


Daniel Kimmel

Daniel Kimmel, M.D., Ph.D., is a fourth-year resident in psychiatry and Leon Levy Neuroscience Fellow at Columbia University. He completed his undergraduate training at Oberlin College, where he double-majored in biology and neurobiology, while studying jazz guitar and flute. After two years as a computer developer in San Francisco, he continued his training in the M.D./Ph.D. program at Stanford University, where he recorded from single neurons in awake behaving monkeys to understand how prefrontal cortex represents and routes information about economic value to make decisions. At Columbia, he developed new statistical tools for examining high-dimensional neural data, while pivoting from animal work to study in humans the relationship between affect and value in decision making. Kimmel hopes to further explore the link between psychoanalytic theory and the physical mechanisms underlying human behavior and emotion.

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2016-2017 Fellows

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Emily Markley

Emily Markley, Psy.D., is a psychologist at Craig Hospital in Colorado where she sees individuals and families as part of a spinal cord injury rehabilitation team. She recently completed her predoctoral internship and postdoctoral fellowship at Yale University where she worked with a range of patients, including those with life-limiting illnesses and college students. She earned her B.A. from Case Western Reserve University, following which she engaged in research on gender violence in Cyprus on a Fulbright grant, and on the biopsychosocial experience of neurodegenerative disease at the Cleveland Clinic. Markley earned her Psy.D. from the University of Denver with her dissertation focusing on implementing the dignity therapy intervention within a hematological oncology population. Markley's interests include the integration of psychodynamic conceptualization and practice in behavioral medicine and end-of-life concerns.


Mayumi Pierce

Mayumi Pierce, M.D., is a PGY4 resident in the adult psychiatric program at the University of California, San Francisco. She is a San Francisco Bay Area native. After graduating with honors in molecular and cell biology from the University of California, Berkeley, Pierce worked at a biotechnology startup in San Francisco. She then attended the David Geffen School of Medicine at UCLA, where she was co-president of their Alpha Omega Alpha chapter and involved in various programs, including the American Medical Women's Association and the Mobile Clinic, a volunteer clinic for homeless individuals in Los Angeles. Pierce was thrilled to return home to UCSF for psychiatric residency, and her professional interests include psychodynamic psychotherapy, community mental health systems, cultural psychiatry and medical education.


Chrysa Prestia

Chrysa Prestia, D.M.A., L.C.S.W., is a fellow in the Program for Psychotherapy, Cambridge Health Alliance. She earned her bachelor's degree from the Peabody Conservatory and doctorate from Stanford University, where she studied music composition, computer music and psychoacoustics. This experience at the intersection of artistic expression and neuroscience led to her study of molecular biology and research on biochemical markers of learning, memory and emotion. Seeking a more direct connection to the passions that drew her to research, she then completed a master's degree in clinical social work and a postgraduate fellowship in psychoanalysis. Her interests concern the neurobiology of emotion and the role of creativity in the process of psychological change. In her practice, she is compelled by the construction or productive disruption of patient narratives in the service of therapeutic action.


Rachel Ross

Rachel Ross M.D., Ph.D., is an instructor in psychiatry at Harvard Medical School. She received her bachelor's degree in biological and environmental engineering at Cornell University, and participated in nanobiotech research. She earned her M.D. and Ph.D. degrees at Albert Einstein College of Medicine where she studied the effects of fatty acid signaling in the hypothalamus on whole body energy metabolism. While in residency at the Massachusetts General Hospital/McLean Hospital Adult Psychiatry Training Program, she began work in the lab of Bradford Lowell, M.D., Ph.D., at Beth Israel Deaconess Medical Center, studying neurocircuitry of the hypothalamus related to metabolism. She has since expanded this study to multiple survival related drives spanning feeding to fertility to stress response pathways. She maintains a small clinical practice at MGH treating patients with anxiety and eating disorders. She hopes to use psychoanalytic insights to relate neural mechanisms of motivational drives and unconscious impulses in the setting of stress.


Lara Sheehi

Lara Sheehi, Psy.D., is a licensed clinical psychologist and a policy analyst with the Department of Health and Human Services in SC. She maintains a private practice and teaches at the George Washington University Professional Psychology Program and Forensic Psychology Program. She received APsaA's Teacher's Academy fellowship as well as the APA, Division 39 Minority Scholars Program award in 2014. Sheehi mentors in the Division 39 Minority Scholars Program, is the secretary of the Multicultural Concerns Committee and is a board member of Section IX (Psychoanalysis for Social Responsibility). Her research addresses cross sections of psychoanalysis and sociopolitics, social justice, race, and her own lived experience as an Arab clinician. Sheehi's publications include a chapter in *Identities in Transition: The Growth and Development of a Multicultural Therapist* (2015) as well as "Enactments of Otherness and Searching for a Third Space in the Palestine-Israel Matrix" in the *Journal of Psychoanalysis, Culture and Society* (2016).

Only Black Kid

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David held my chair hostage for a few months. Often I was "forced" to sit in a smaller chair. I would request the chair back. But he would not relent. Sometimes I would make a mock run for the chair before he could get into it. But he was much faster and more motivated.

Meanwhile I would speak to him of my frustration, longing and helplessness about losing my chair. I wondered aloud, "What have I done to deserve being ripped off in this manner?" Once after a few months, he said, "You don't deserve it."

"Why" I asked. No answer. He went back to building a large Lego structure.

At the end of the session, I commented, "You are very creative, but many people in your life have never noticed." He nodded.

The next session he observed, "You're being nice to me because you want your chair back."

I replied, "I can understand why you think that, but I really do admire you. But yes, it's true I would like my chair back."

"You don't deserve it," he replied, "because you have not been honest with me."

How so," I asked.

"Every time we play checkers, you pick the white pieces. Not the black."

David's comments took me aback. Although he was much softer in his tone and attitude, he put me on the spot. Despite my anxiety, I tried to be reflective. Had I really chosen the white pieces purposefully because of my own racial preference? Further, what did my choice mean to him and why did he focus on it? My thoughts broadened. I remembered a piece of history. There was a time in many Southern states when blacks and whites were not allowed to play checkers together. His mother came from South Carolina. A deeply religious and somewhat distant woman, she was typically deferential. But she could be angry and mistrustful with David and with me. Perhaps he was also expressing her mistrust and doubt about my dedication to David. Perhaps both wondered if I could love him as much as he needed despite my being white.

I also began to think of my own racial history, of my own fights with boys of color who bullied me when I was growing up in a very polarized city. Although I was fortunate to have very close friends from other ethnic and racial backgrounds, I had also experienced the violence that lies in the transitional space between blacks and whites. Was this contributing to our impasse? These reflections penetrated my consciousness, and I began to see our conflict in the context of a larger struggle.

But after six months, David had directly addressed what he felt and feared to be my racist attitudes. I took his directness and courage as a positive sign that the trust between us had grown allowing for new forms of authentic relating. I had begun to feel for some time that there was a growing mutual warmth between us, that the space between us was becoming less charged even though our conflict over the chair had not abated. He had sometimes smiled and began to enter the room on time instead of stalling outside. For my part I had moved off the chair as the essential place of inquiry. Our relationship felt less coercive overall and I became more aware of his other attributes.

I chose to respond to him as honestly as I could. I said, "I was not aware of choosing white pieces, but perhaps it was possible," particularly in that we seemed to be "in some sort of war" most of the time. I also added that I wanted us to be "closer" and I was hoping he could trust me enough to help him.

He listened without comment as he played with Legos. I felt he would continue to wait and see if I would be true to my word.

In therapy, like life, race is difficult to discuss in an intimate fashion. There is a gulf of silence between blacks and whites that affects us both personally and politically. In cross-racial therapeutic encounters both participants can be uncomfortable. The patient fears alienating his therapist and undermining his treatment if he talks about race. The therapist may be afraid to stir up difficult feelings or saying or doing something with racial overtones. And at the same time it is crucial that we try to have these discussions even when they are painful and awkward. In therapy, racial differences can be a barrier to growth and intimacy in both the patient's treatment and in the growth of the therapist. In our communal life the harsh division between blacks and whites underlie deep divisions in policing, education and law enforcement. These issues are front and center today. But the psychological dynamics that propel these conflicts are largely hidden.

The problem of the chair remained between us. He continued to want exclusive control of this prize. Although I was more open to accepting and embracing my own feelings of helplessness to allow him the power and the throne, I was still hoping he would be more generous with me.

Nevertheless, in the following session, I remarked, "We both know I want my chair back. But my relationship with you is more important. Why don't we just agree that it's your chair to use whenever you want from now on."

He did not respond, but over the next weeks the atmosphere continued to change. I had accepted my vulnerability. He in turned seemed more open. Once when he came in, he asked me how I was. Our discussions broadened. We began to talk more about race and about his experiences in school and in his family.

The treatment lasted two years. I never did get my chair back. But I got something more special and rare in our culture: A closer, more real relationship of equality, love and healing.

White Privilege

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Conspiracy of Silence

The first important black person in my life was Malcolm X. I'm not sure how it happened. Maybe because of his "chickens coming home to roost" comment after the Kennedy assassination, saying what no one else dared speak. Maybe it was something my sister-at-college said. Maybe it was by way of Muhammad Ali. I know I heard Malcolm's Oxford Union debates in 1964. I was in awe of how he spoke out against his racist oppressors and by the intellectual precision of his rage, like Moses to the Pharaoh. I wished he were my father. Then in 1965, my first year of high school, he was killed, and I wondered again, as when Kennedy was killed, did heroes have to die?

After leaving home, through college and graduate school, I met, but did not get to know. a few black students. This was in the revolutionary '60s and early '70s and they were most often radical, like me. I assumed, that like Malcolm X, they felt they had the right to speak truth to power, and that they could rely on the law to defend them, as could I. It was not until my second internship and first job at the West Haven VA, working closely with black nurse's aides, and black and brown Vietnam veterans, that I learned how careful and fearful black and brown people often are. Low-keyed at work, the aides never questioned a doctor's or a nurse's decision even when they knew better. It was different outside of work when some talked to me about their anger and discontent. I did not quite get that what I was seeing was institutional racism and white privilege, covered by a conspiracy of silence. At first I attributed it to class and education. Then I saw it in a way I could not deny.

Everyone who was working at the new VA Vietnam Vet Center was attending a training conference in a white suburb of St. Louis. After dinner Dan Campbell and I went for a walk. Dan was a black Vietnam vet with a master's in counseling who worked with me planning the New Haven Vet Center. After walking and talking for a while, he said to me, "I couldn't walk here alone." I asked and Dan explained. It's a screen memory, I'm sure, an après coup, coalescing what I saw and did not want to see because it implicated me among the privileged. Dan did not grow up with his teachers assuming he was smart, with his white neighbors assuming he was rich. Dan, a sweet and mild man, was assumed to be dangerous and was the object of their fear and rage. Maybe I was not the whitest white, but I was white enough to pass, white enough to feel free to walk where I wanted and say what I wanted, and white enough to know if things got rough, I could pick up and leave.

I needed to do something. Around 1984 I started psychoanalytic training at NYU postdoc. I asked for a meeting with the director of the program, Bernie Kalinkowitz. I expressed my concern about the relative absence of black psychoanalysts. He agreed and introduced me to Kirkland Vaughans, a black first-year student, who had expressed similar concerns. We then became co-chairs of the first psychoanalytic diversity committee. As we were getting to know each other, he told me about the racism he had borne in the course of his education to become a psychologist and psychoanalyst. When I said, "You should talk about it. You should tell people," he'd smile and nod. Over the years I heard similar stories from other black psychoanalytic colleagues who often added something like, "I'm used to it. What good would it do?" Then in the light of Barack Obama's presidency, I suggested Black Psychoanalysts Speak, and no one I asked to participate said no.

While reading Ta-Nehisi Coates's *Between the World and Me*, a talk to his son about being a black man in America, and about its dangers, I realized I had received a talk of sorts from my parents as well. Like Coates's it took place over time. The content was different, though like Coates's it did include, "Don't trust police just because they're police." But it did imply you could rely on the law. Also, "Know your lawyer. Bribery is sometimes necessary. Keep your passport current. Have some cash, gold and jewelry in the safe. Get an education you can take with you. It can happen here."

White privilege has shades. Did your mother or father ever give you the talk, the talk about the dangers of a world in which more people have been killed by their own governments than at the hands of the enemy during war? If neither did, then they are either in denial, or they are very white. You are very white if you think it can't happen here, because it happened here and continues to happen right now. It happened to the native people, to those in slavery, to Japanese-Americans. It is happening now to those who have spent years in Guantanamo without trial, to the many thousands who are imprisoned without reason, to the millions too poor to buy decent food or get medical care, to the refugees we turn away. I've told my children. Have you?

Did your mother or father ever give you the talk, the talk about the dangers of a world in which more people have been killed by their own governments than at the hands of the enemy during war? If neither did, then they are either in denial, or they are very white.

Henry's Restaurant

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So, yes, I know about the concept of "white privilege" introduced in the work of Peggy McIntosh, which every psychoanalyst should read, defining racism not as invisible acts of meanness but as an invisible system that confers dominance, and the 50 very simple but poignant examples McIntosh gives of the "daily effects of white privilege," such as "If a traffic cop pulls me over, I can be sure I have not been singled out because of my race" or "I can choose bandages in flesh color and have them more or less match my skin" or "I can arrange to protect my children most of the time from people who do not like them."

Microaggressions

In the video, *Black Psychoanalysts Speak*, Kathy White poignantly asks whether any white person could conceive the effect of or even tolerate the daily "microaggressions" (Janice Bennett has referred to them as "microassaults") to which blacks in this culture are subject, without terrible rage, without in effect "losing it." I would like to suggest that embedded in a culture that favors whites, there is something analogous to microaggressions that blacks encounter that takes place for white people who are aware of the racist structure of our society. I do not mean the obvious discriminations, nor the awareness of different ways in which one is privileged as white that McIntosh reports, but the daily things that happen to each white person that can invoke the commonality of one's white body at a price.

They could be labeled "microchallenges to one's integrity." White people do not talk about how we constantly come across these things. Yet every white person knows them. Let me give some examples: I am having a root canal by a skilled Asian dentist in my suburban largely white town. The dentist expresses fondness for other members of my family he has treated, and I make some remark, just as he is about to drill down, about diversity in the suburbs. It is clear, however, in his reply that he thinks of diversity differently than I do, and places blacks in a different category and—because I am white—he assumes my agreement. Mouth open, vulnerable, I tell myself this is definitely *not* the time, but afterward I am still silent. I think, what is the point? But at what expense do I think that?

Or again: We have dinner with a couple, a friend of mine and his wife to whom I have turned at difficult moments in my life and whose career has brought him into intimate contact with blacks in the music world. To my complete surprise he tells me, despite the fact that he knows I have worked on *Black Psychoanalysts Speak*, that blacks do not have the abstract reasoning power to be psychoanalysts. Stunned, I disagree with him, but this does not reflect fully how I really feel. What I am thinking is that it will be difficult for me to enjoy a social occasion with him again. I probably have lost a dear friend, although he does not realize it. My heart is aching. Should I thrash it out with him? I do not, I let it go. But at what expense?

Close to Home

Let me bring this even closer, to white psychoanalysts at my institute, wonderful analysts from whom I have learned, who in their comments to me sometimes create the same internal sinking feeling I experienced with my friend. Not as obvious sometimes, but still, from my perspective, they too often exhibit a lack of understanding of the pernicious nature of our white privilege. They say such things as "Very few members of our institute have blacks in their practice. How many have applied to our institute? Our focus should be on helping members with their practices and keeping a psychoanalytic stance." They say these things to me as if I should agree as their white president, even when they know something of my personal story, and that I am trying to change the demographics and culture of my institute. And, of course, they are saying, as subtly implied in this construction, that if one is active in trying to change the culture of our institutes, one is not a good analyst; that psychoanalysis is directed toward changing oneself as opposed to society, as if the two are incompatible, and the revolutionary core of Freudian thought, as shown so ably by Elizabeth Danto in *Freud's Free Clinics*, never existed. Are our institutes to remain unaware of the cultural ocean in which we all swim and are we not to say that our white skins lead to our constantly being confronted with these microchallenges to our integrity? On another occasion I will expand this to show how these microchallenges play out in the analyses of our white patients.

…they are saying…if one is active in trying to change the culture of our institutes, one is not a good analyst; that psychoanalysis is directed at attempting to change oneself as opposed to society, as if the two are incompatible and the revolutionary core of Freudian thought…never existed.

Annie Lee Jones, in a prose poem, tells the story of watching a white policeman manhandle a black adolescent at a bus stop, and being paralyzed, not able to do anything, distraught, but for one moment making eye contact with one of the policemen. In that moment, that "crack in time," they shared their humanity, seemed even to understand, and then it was over. As a white man I feel in these

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Racist Ideologies

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Using Enlightenment Ideas to Impose Control

Chapter 9, "Reason and Racism," speaks to the idealization and use of Enlightenment ideas to impose control over "lesser" human beings. Even Immanuel Kant, the greatest European ethicist of the 18th century, began as an ordinary European racist. He altered those views after he wrote his masterpiece, *Groundwork of the Metaphysics of Morals*, in 1785. During the same period Americans were writing the U.S. Constitution. Like them, Kant struggled to disown the common pleasures of racist superiority and in-group narcissism. And like them he faltered until he could purge himself of the anxiety and thrills embodied in racist states of mind.

Issues of race, racism, nationalism, postcolonial theory and similar topics dominate contemporary intellectual circles. Using different names for similar concepts, the same issues dominated Freud's explication of what he called the "psychoneuroses." When he investigated the maladies his female patients brought to him in Vienna, he found they originated in female servitude and oppression.

During that period of discovery, as psychoanalysts see it, Freud also battled against all forms of religiosity. No doubt there were personal, unconscious reasons why he did this. However, there were intellectual and scientific reasons as well. Central to those reasons was Freud's concern that if religiosity were permitted equal footing to psychoanalysis his new science would disappear. Freud designated religion as the great enemy because it alone threatened to displace insight and the critique of self and cultural narcissisms. Freud viewed his parents' religion, Judaism, and Viennese Catholicism in the same light. Within each tradition, numerous people found solace, identity and relief from the anxieties of everyday life. However, for Freud these benefits came at too high a price. Although Keval says little about religion per se, his critique of racist habits extends to many, if not all, forms of religious orthodoxy.

Keval discusses the perversion of Enlightenment principles when it was used to subjugate and conquer other peoples. Freud, of course, saw himself as an heir to the Enlightenment. We, his descendants, cannot escape the universalizing tendency of that intellectual movement. Among its ideals is Immanuel Kant's (post-racialist) demand for ethical self-examination, the categorical imperative: We must act upon rules we wish to see enacted universally and everywhere, regardless of persons' rank or color. That demand is not located in either individual or corporate identity. On the contrary, it is disembodied, desexualized and deidentified. As Keval notes many times, this demand strikes at the heart of traditional forms of group narcissism and group identity. The vast majority of people I know in Tennessee, for example, are rooted in self, family, and religious and national identities that feel permanent to them.

This brings us back to the issue of race and racism. The core values of antiracism and other progressive movements—including psychoanalysis—are Kantian in this sense. We favor diversity, fairness, equal justice, progress and other values. Prior to championing those values, we would do well to look inside ourselves for those hidden pleasures of pomposity and superiority. A natural reaction to those who challenge one's embedded identity is anxiety which in turn evokes anger. Negotiating those strong feelings is the task of good governance and humane political efforts. It appears we cannot escape the search for universals, especially for a universal ethic. Just as other people in other historical epochs struggled with their dichotomous categories of understanding, we do too. Toward that struggle the author's book contributes a great deal.

> *…we would do well to look inside ourselves for those hidden pleasures of pomposity and superiority.*

Henry's Restaurant

Continued from page 23

microchallenges that I—in the white body that has been my protection and that I have in common with the aggressor—am in danger of being like the perpetrator and in danger of being paralyzed as well. All I can think is: if Annie Lee were there, if any of the black psychoanalysts at Henry's restaurant were there, will I prove worthy of their gaze? Or will I use the magic talisman of my white skin and compromise my integrity?

So I *have* to listen to *Black Psychoanalysts Speak* analysts at Henry's restaurant to hear the personal stories they tell: How you protect your black son who wants to drive your red sports car for the first time and *will* be stopped by the police; how the white analyst, knowing nothing about black hair, has no idea why a black woman is reluctant for years to put her large Afro on the analytic pillow and attributes her reasons to be characterological. I need to hear that give and take that occurs at Henry's restaurant, that kidding, that humor and sadness, that insight into the dark heart of our culture, and that daily shared bravery and determination among these black analysts, from which (strangely) I learn about myself.

DPE

Continued from page 4

Even Freud was skeptical about the place of the traditional clinical method in the future of mental health treatments. Many, if not most of us, believe that for selected conditions, it is still and will remain the treatment of choice. But if it is to remain such, we must develop our understanding of psychoanalytic technique and process according to advances from other disciplines in understanding human mental functioning, and acknowledge as equally important the various ways in which psychoanalysis is applied outside the consulting room. The traditional analytic treatment method is, then, just one of the many applications of psychoanalytic thinking.

It, thus, becomes incumbent on us to expand our thinking about what constitutes psychoanalytic education in order to enable students to be prepared for different kinds of psychoanalytic careers. The university model is suggested by this, in which students begin with a core curriculum and then choose different paths of academic specialization. Something of this sort is already appearing on the current scene, such as in Chicago and Emory.

In keeping with this philosophy of current and future needs of and for the field, those of us working on the recommendations for the DPE have tried to develop a model that will take into account the multifold directions and interactions with other domains that will nourish our development as a discipline and overcome our present isolation. In doing so, we are being ever mindful of our rich history, preserving the best of educational practices we have inherited, while creating room for open and creative discourse and courses of action.

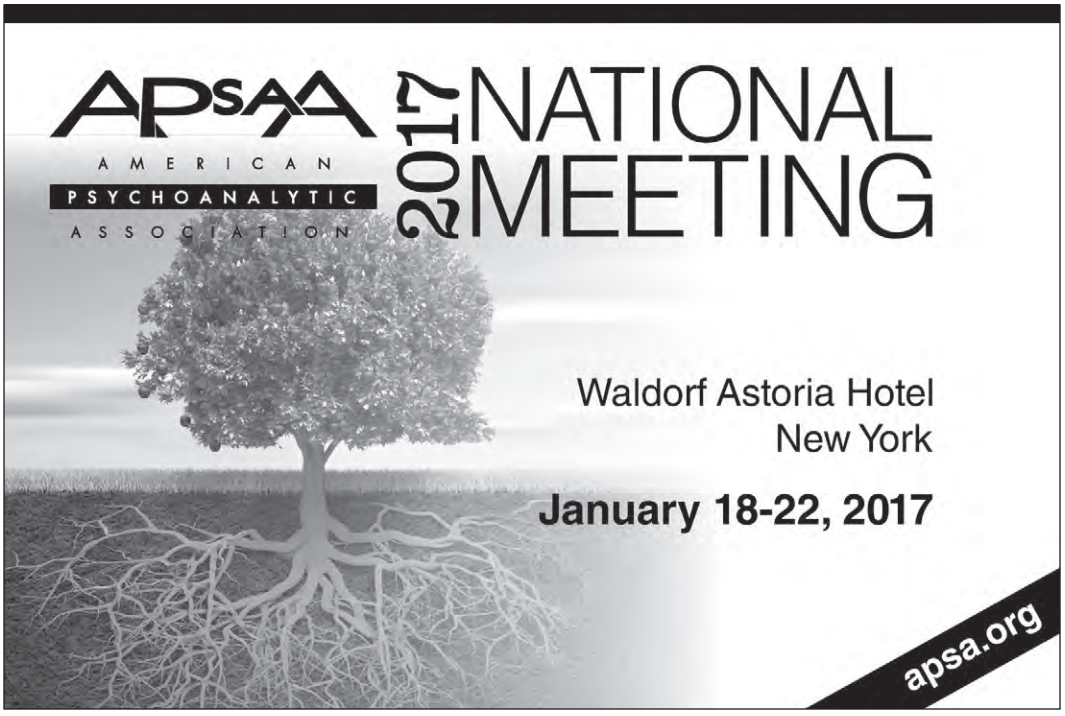
> *This will…lead to increasing diversity in all aspects of APsaA, different paradigms, philosophies, ethnicities and professional backgrounds.*

To this end, the model we have proposed provides for two bodies, the Psychoanalytic Training and Education Forum (PTEF) and the Psychoanalytic Scholarship Forum (PSF). The PTEF will be constituted by institute representatives. It will function as the place of deliberations and exchanges that are most proximal to the consideration and delivery of education and training at the APsaA-approved institutes. The PSF is envisioned as a place for exchange of any ideas pertaining to psychoanalytic inquiry, for continuous enrichment of psychoanalytic thought, dissemination of its relevance to the neighboring scientific and cultural fields, and educational update. Study groups will form according to the proposed areas of inquiry. All interested members and/or institute representatives will be invited to contribute and to participate. There would be ongoing exchange between the PTEF and PSF for mutual feedback and enhancement.

This will, no doubt, lead to increasing diversity in all aspects of APsaA, different paradigms, philosophies, ethnicities and professional backgrounds. It can also provide us the freedom to seek and perhaps even try on new modes of thinking, while respecting the most solid and enduring wisdom and accomplishments of our past.

Diversity will bring disagreement. Disagreement can, and hopefully will, bring freshness to the general discourse. Preserving the important discoveries in the history of our work will provide depth. Then and only then can we feel ensconced in the intellectual flow of the 21st century in all the many applications of psychoanalytic thinking, clinical and otherwise.

May the Force be with us.



How to Grab Public Attention with APsaA's New Blog: *Psychoanalysis Unplugged*

Sue Kolod


Sue Kolod

As chair of APsaA's Committee on Public Information, I am spearheading our effort to launch a new blog, *Psychoanalysis Unplugged*. The blog will be housed on the *Psychology Today* website which will allow for a larger audience and for comments on the posts. The blog will link to the APsaA website as well. We plan to launch the new blog by the end of 2016.

Instead of lamenting how psychoanalysis has been marginalized in the media and the medical profession, we should take action to remedy our PR problem.

It should be an essential part of our careers to educate the public about the good we do and the power of psychoanalytic ideas. This requires us to learn to communicate effectively with those not in the field using clear, direct, accessible language.

Fifteen years ago I started a workshop at the William Alanson White Institute. Each of the 10 group members chose a topic to both write and speak about for the general public. We worked with a communications coach for the first few months. What an eye-opener. No matter how jargon free we thought our writing was, she did not get what we thought we were saying. It required real effort on our part to make our ideas accessible to the coach, but eventually we succeeded. Our group ran successfully for 12 years.

The importance of speaking clearly without jargon was driven home to me during my years as a sign-language interpreter for deaf people. Try to tell a deaf man he has been indicted by a grand jury or a deaf woman that she is HIV positive. The jargon that constitutes communication in ordinary English is utterly useless for this. Psychoanalysts have a common language comprising many terms that are vaguely defined or ambiguous. When we talk to or write for other analysts, we have the illusion we are communicating. That illusion evaporates when we talk to the general public. This becomes obvious when you try to help a layperson understand the meaning of terms such as "projection," "enmeshment" and "interpersonal/relational."

My interests in translating and in communicating with the general public led me from our institute writing group to blog writing for *Contemporary Psychoanalysis in Action*, the blog I established and co-edit with Melissa Ritter and David Braucher at the White Institute.

Blog Authors Needed

Now for APsaA's new blog, we need authors who want to publish posts that will be accessible, relevant and compelling to the general public. As stated above, the blog will be housed on the *Psychology Today* website and posts will be disseminated on social media by our director of public affairs, Wylie Tene, leading people back to our website and attracting the interest of reporters and other people from the media.

Blog posts are short communications—800 words are optimal. A post has to have one main idea. The headline must communicate that idea, but also be catchy. The main point, the "lede," should be spelled out in the first few sentences. The post should show rather than tell—compelling examples and vignettes are preferable to explanations. If you would like to try to write a blog, please check out the Blog Editorial Guidelines on the APsaA website http://www.apsa.org/APsaA_Blog_Guidelines. Submission should be sent to me at this email address: s.kolod@wawhite.org.

Tips From an Active Blogger

Max Belkin, who has contributed many widely read posts to *Contemporary Psychoanalysis in Action*, has given me permission to use this example of blog writing: Belkin's original title was *Vagaries of the Erotic Mind*. Cute, but vague and not catchy. Here was his original first paragraph:

> From Berlusconi and Strauss-Kahn to Roman Catholic clerics, some men continue to behave badly. In puritan America, the media scrupulously chronicles extramarital escapades of politicians and celebrities.

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Sue Kolod, Ph.D., *chair of APsaA's Public Information Committee, is supervising and training analyst and faculty at the White Institute and co-editor of the blog,* Contemporary Psychoanalysis in Action. *Kolod has written about the impact of hormones on the psyche.*

> No wonder the cover stories of American newspapers often resemble a hit parade of erotic tableaux that depict statesmen of different political and sexual persuasions: Schwarzenegger and the housekeeper, McGreevey and the Israeli dude, Spitzer and the call girl, Sanford and the Argentine belle, to name just a few. Millions of TV watchers and *New York Post* readers regularly consume the salacious details of sex scandals as if they were made of popcorn. Who needs the Kardashians in the era of CNN?

Erudite and clever, but this expressed no central idea.

Max and his editor re-titled the post *Erotic Fantasies: The Good, the Bad and the Ugly*. This catchy allusion to Clint Eastwood echoed the theme of the newly focused first paragraph:

> A vibrant erotic life requires synergy and tensions among our *good, bad* and *ugly* fantasies and desires. Our sexual fantasies provide a window into our inner lives: who we want to be, as well as who we are afraid to be.

This post used Sullivan's concept of dissociation, which Sullivan himself described without jargon as "The good me, the bad me and the not me." Max's jargon-free post illustrated this concept in action in the realm of erotic fantasies. His post has been very popular, so far garnering 12,000 hits on the *Psychology Today* website. Here is the link to the post: https://www.psychologytoday.com/blog/contemporary-psychoanalysis-in-action/201305/erotic-fantasies-the-good-the-bad-and-the-ugly.

Give blog writing a try. It is an excellent way to communicate with the public, and it will also help you clarify and articulate your ideas about psychoanalysis.

How Do We Help

Continued from page 12

therapist as empathic; the therapeutic couple make connections between what is happening in the consulting room and the rest of the patient's life; the patient responds productively to the analyst's communications; and the therapeutic couple are rated as engaged with one another.

PATIENT FACTORS: The first patient factor is **Patient [Communicates] About His/Her World** (meaning outside the consulting room). The second, **Patient Dynamic Competence**, includes shifting flexibly between experiencing and reflecting, overall productivity (defined and illustrated in the APS Coding Manual), and addressing troubling patterns in his/her life. The third is **Patient [Communicates] About the Analyst or Analytic Situation**. All the component variables are rated on a five-point scale.

Once the factor analysis is completed, the seven factors identified become variables in our study, so we can examine how they are related to one another.

New Insights

The most important result from our assessment of these variables is that we can say *what aspects affected the progress of these analyses* by studying changes from session to session. There are 405 pairs of sessions adjacent to one another in our database (that is, two consecutive sessions on successive days or within a few days of each other). This gives us the opportunity to find out what activities or characteristics, among our variables, influence the psychoanalytic process favorably or unfavorably in the following session. Using this approach, we have very strong evidence of the impact of a psychoanalytic approach in enhancing those features of the experience that have been shown by many other studies in psychodynamic therapy to be beneficial to patients.

Figure 3 illustrates that therapist relational competence and therapist dynamic competence both contribute to heightened interaction quality in the next session. And higher interaction quality in the previous session contributes to enhanced patient dynamic competence in the next session. In addition, therapist dynamic competence contributes to patient dynamic competence directly.

There are other interesting interactions. Figure 3 summarizes the findings by looking at how one factor influences the other in the next session. Arrows are shown only where the results are statistically significant. The origin of each arrow is the score in the previous session, and the point of the arrow is the result in the next session (in 405 pairs of sessions).

It is of interest that there are two adjacent arrows going in opposite directions, between Therapist Dynamic Competence and Interaction Quality. This means that therapist dynamic competence in the previous session increases interaction quality in the next session, and interaction quality in the previous session increases therapist dynamic competence in the following session. This is the kind of core finding to indicate that indeed, what we communicate to our patients and how well we communicate it (tactfully, with appropriate timing and consideration for self-esteem) demonstrably makes a difference in the psychoanalytic process.

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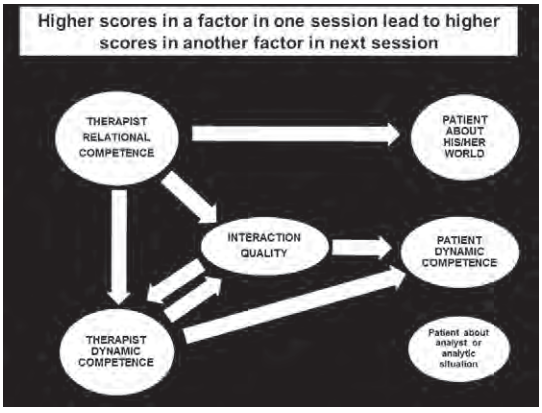

Figure 3

How Do We Help

Continued from page 27

Almost all of the factors are composed of multiple individual variables. We have checked the correlations between the variables in each factor and the variables in the other factor in the next session, and the majority of the underlying variables are correlated significantly.

Figure 4 is a detailed chart showing the variables underlying one arrow. As is apparent in this chart, the therapist addressing transference and conflicts leads to increases in the three patient dynamic competence variables (The other four therapist dynamic competence variable correlations are not high enough to reach statistical significance.). The first of these two findings validates that, when used with sufficient understanding of the patient, and of his or her state of mind at the particular moment, *addressing the patient's reactions to the analyst or analytic situation* can be most helpful in psychoanalysis, as other studies in psychodynamic therapy have found, for instance the groundbreaking study by Per Høglend and his colleagues from Norway (2007). The second finding, the role of addressing the patient's conflicts in leading to forward movement, validates this classical psychoanalytic tenet perhaps most elegantly expressed by Charles Brenner in *The Mind in Conflict* (1982).

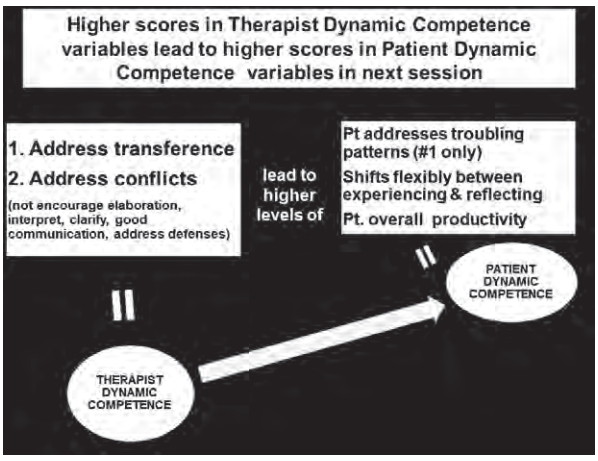

Figure 4

Psychoanalysis is a complex undertaking, and no two patient-analyst pairs are going to turn out alike. Figures 3 and 4 bring us in the direction of capturing that complexity. At the same time, they stimulate ideas that might not have emerged without such analysis of the data. For instance, as shown in Figure 3, the sheer fact that the patient was talking about or expressing feelings about his/her analyst did not prove to have a significant direct impact, by itself, on other dimensions of the work in the next session, nor was it impacted by previous therapist relational competence, therapist dynamic competence or interaction quality. In listening to the material, we sometimes had the impression that some patients could talk a good game in this respect, but it did not necessarily correlate with positive results.

There is one additional finding from looking at Figure 3 that is noteworthy. The third analyst factor was Analyst Confronts. It happened that higher scores on almost all the therapist relational competence variables in the previous session were predictive of increased confrontation in the next session, although this increased confrontation was not predictive of any of the other factors in the session following. We do not imply that confrontation is not useful; rather we believe the clinical material needs to be studied by clinicians to ascertain what impact such confrontation might have, not just in the next session but going forward. This is a new finding worth pursuing by further detailed study of the recorded sessions in which confrontation occurred, and the consequences. There is much room for more work, and we welcome help from interested colleagues. It is clear that, to advance psychoanalytic understanding, one needs to study the qualitative as well as quantitative.

As previously described, it may be seen from Figure 3 that therapist dynamic competence and interaction quality directly impacted patient dynamic competence, and that therapist relational competence also played an important enhancing role by enhancing interaction quality. This is consistent with the development in our field of the "relational turn." At the same time, the "classical" analytic values appear to be well supported in our study. It is not "either-or."

An important goal for the future is to compare the results of psychoanalysis and long-term psychoanalytic psychotherapy (LTPP). Studies such as the one by Falk Leichsenring and Sven Rabung (2008) have shown convincing evidence for the superiority of LTPP over other forms of therapy for what they call "complex mental disorders," but we need to clarify further what difference in value there may be between LTPP and psychoanalysis for longstanding limitations in character or ways of relating to others. Here the new generation of analysts could make a great contribution by recording both cases of psychoanalysis and of LTPP. We owe it to our patients, and to the health of our practices, to investigate when and to what degree a substantially more intensive treatment effort works to the patient's benefit, even though as psychoanalysts most of us are convinced that for some patients the more intensive form of therapy is essential. A systematic comparison of such recorded cases would be beneficial to our field. There are descriptive materials about making recordings on our website—http://www.psychoanalyticresearch.org/—and I will be glad to help and advise anyone who would consider joining in this work. You may also contact me at woodywald@earthlink.net for other detailed graphs not included in this article.

My thanks to our U.S. research team, which includes currently Robert Scharf, Seymour Moscovitz, Fonya Helm and Karl Stukenberg, and to the Italian team led by Francesco Gazzillo.

Mental Health Parity

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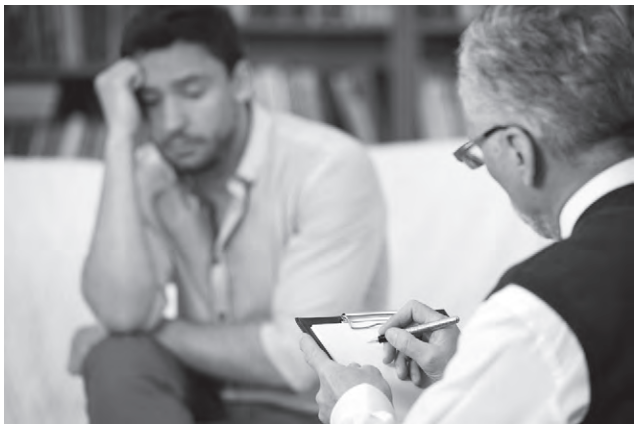
Treatment Needs of Patients with Depression

While depression is the most common diagnosis made in primary care, Katon and Sullivan (1990) found that primary care physicians miss the diagnosis 50 percent of the time. It is experienced by one-fifth of all Americans at some point during their lifetimes (Kessler, Berglund, Demler, et al, 2003) and is extremely costly to society in increased medical costs, suicide-related mortality costs, and disability. A World Health Organization study (2008) found unipolar depressive disorders to be the greatest cause of worldwide disability. Compared to other depressed patients, the 20 percent who are treatment resistant have significantly greater health care costs, are twice as likely to be hospitalized both for depression and general medical admissions, have 12 percent more outpatient visits, 1.4 to 3 times more psychotropic medications, over six times the mean total medical costs, and 19 times greater total depression-related costs (Crown, Finkelstein, Berndt, et al, 2002).



For patients with unipolar depression, both a psychodynamic approach and the greater intensity of a psychoanalytic schedule appear to add benefit. A comparison of long-term cognitive-behavioral, psychoanalytic and psychodynamic therapy for these patients yielded similar improvements in depressive symptoms for all three approaches immediately post-treatment. While the CBT and psychodynamic therapy patients also had similar levels of depressive symptoms at three-year follow-up, patients treated with the more intensive psychoanalytic treatment had sustained greater improvement. Both the psychoanalytically treated and psychodynamic therapy groups had fewer interpersonal problems than the CBT group at both post-treatment measurement points. The improvement in interpersonal problems was the only detectable superiority of psychodynamic therapy over CBT, while the more intensively psychoanalytically treated group had significantly greater improvement both in general distress and interpersonal problems immediately after treatment, and in depressive symptoms, general distress, interpersonal problems and self-schema than the CBT group at three-year follow-up (Huber, Zimmermann, Henrich, et al, 2012).

It seems increasingly clear that certain character traits complicate the treatment needs of depressed patients. For example, Blatt (1992) and Blatt, Quinlan, Pilkonis, et al (1995) found that perfectionistic patients do poorly in all brief treatments and fare better in more intensive, extended psychoanalytic treatment than in less intensive long-term therapies.

Also, seemingly successful treatment of depression is often accompanied by residual symptoms that can progress to become prodromal symptoms of recurrence. Residual symptoms have a strong prognostic value of relapse and are likely its most consistent predictors. Here again we find that dysfunctional social and interpersonal patterns in particular are positively correlated with persistent depression, relapse and poor long-term outcome. Accordingly, the fact that a patient no longer meets syndromal criteria is insufficient to designate full recovery despite the fact that the number and quality of sub-syndromal symptoms are often not specified in treatments judged to be successful. Therefore, treatments are needed that address ongoing characterological traits that put patients at risk for recurring illness (Fava, Ruini, and Belaise, 2007).

As noted above, a number of studies point to psychodynamic treatments as having greater efficacy with these traits (Levy, Meehan, Kelly, et al, 2006; Clarkin Levy, Lenzenweger, and Kernberg, et al, 2007; Leichsenrung and Rabung, 2008; Shedler, 2010; Huber, Zimmermann, Henrich, et al, 2012). Of note, demonstrating the impact of long-term psychodynamic psychotherapy on the brain, Buchheim, Viviani, Kessler, et al, (2012) published the first study documenting its treatment-specific changes in the limbic system and regulatory regions in the prefrontal cortex associated with improvement in depression after therapy.

Comorbid Outcomes: Patients with Personality Disorders and Depression

Several researchers specifically link personality disorders with treatment resistant, persistent and recurrent depression and note that these patients with both major depressive disorder and personality disorder have significantly more role limitations due to emotional problems, impaired social functioning and general health perceptions than patients with major depressive disorder alone.

Poor psychosocial functioning compounds the impairments of major depressive disorder and affects the course of the illness. Furthermore, subjects whose personality disorders remit show improvement in social functioning and are more likely to achieve remittance of their depression than those with major depression and persisting personality disorders—the group that functions the poorest. These authors conclude that both personality and mood disorders need to be treated in

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Mental Health Parity

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comorbid patients, since the course of personality psychopathology influences depressive outcome as well as psychosocial functioning (Skodol, Grilo, Pagano, et al, 2005; Markowitz, Skodol, Petkova, et al, 2007). Depressed patients with comorbid personality disorders also have significantly longer time to remission than depressed patients without personality disorders. In fact, borderline and obsessive-compulsive personality disorders at baseline are robust predictors of accelerated relapse after remission from an episode of major depressive disorder, even when controlling for other negative prognostic predictors.

In sum, personality disorders are negative prognostic indicators for the course of major depressive disorder. Borderline personality disorder emerges as a particularly robust independent predictor of chronicity (accounting for approximately 57 percent of persistent cases) and also as the strongest predictor of persistence of major depressive disorder, followed by schizoid and schizotypal personality disorder, any anxiety disorder (the strongest Axis I predictor) and dysthymic disorder (Grilo, Stout, Markowitz, et al, 2010; Skodol, Grilo, Keyes, et al, 2011.) Taking the long view from a cost-effective perspective, it would seem clear that patients with major depression and a comorbid personality disorder need both illnesses treated to avoid recurrent and persistent depressive illness even when the treatment of the personality disorder may require a longer and more intensive treatment.

Patients with Varied Diagnoses Treated with LTPP or Psychoanalysis

Other studies have examined outcome and cost-effectiveness for over 5000 outpatients with a variety of common DSM4 Axis 1 and 2 diagnoses who were treated with either long-term psychodynamic psychotherapy (LTPP) or psychoanalytic treatment. Both LTPP and psychoanalysis yield large effect sizes for symptom reduction, personality change, and improvement in moderate pathology both at termination and follow-up as well as reduced health care use and sick leave (DeMaat , Philipszoon, Schoevers, et al, 2007; DeMaat, de Jonghe, Schoevers, et al, 2009). Psychoanalysis, with its greater frequency, is more costly but more cost-effective than LTPP from a health-related quality perspective (Berghout, Zevalkink, and Haakaart-van Roijen, 2010a and b) and both treatments yield significantly reduced work absenteeism and lowered hospitalization at seven-year follow-up (Beutel, Rasting, Stuhr, et al, 2004.)

In addition, psychodynamic psychotherapies have been found to be effective for anxiety disorders, eating disorders, substance abuse, somatic symptoms and marital discord (Levy, Ehrenthal, Yeomans, et al, 2014).

Mental Health Parity and Continued Disparity of Insurance Coverage

In a succinct and accessible account of insurance coverage for mental health benefits in the context of MHPAEA and the ACA, Bendat (2014) describes both what these laws require as well as how they are circumvented and often fail to be enforced. Actual "parity" or equality for mental health benefits is mandated for insurance coverage for most medical insurance plans in both self-funded and fully-insured private employer plans if mental health benefits are offered and in both self-funded and fully-insured ACA plans with respect to essential mental health benefits with the exception of those "grandfathered" under the ACA. Recently, parity has also been expanded to mental health benefits in managed Medicaid and CHIP programs.

Parity regulations are meant to apply both to "quantitative" (number of services) and "non-quantitative" (describing protocols) limitations on the scope and duration of treatment eligible for coverage. Examples of non-quantitative treatment limitations include medical management standards, standards for provider admission to insurance networks and reimbursement rates, methods for determining usual, customary and reasonable charges, and "fail-first policies" that insist on lower-cost therapies prior to authorizing coverage for more expensive treatments. While an incomplete list, these standards and a number of others are prohibited from being applied in a more restrictive manner for mental health services than for other medical care.

Perhaps most frequently, however, the mandate for parity is being observed essentially in the breach. The evasions include the insurers rationing mental health care based on sub-standard and inappropriately restrictive medical necessity guidelines that are not developed by recognized mental health specialty groups, while adjudicating benefits for other medical conditions based on more generally recognized standards. To authorize more than a set minimum of mental health services, other illegal practices include, for example, a more restrictive insistence on fail-first treatment protocols and on much more severe and immediately life-threatening conditions (e.g., ongoing risk of imminent suicide) by which to evaluate requests for non-hospital levels of care. And in lieu of the older annual visit limitations and higher co-pays for mental health services commonly in use prior to MHPAEA, which the law has now proscribed, and in a hidden violation of the demand for parity in quantitative measures (number of services), insurers now use concealed algorithms to flag "outlier" patients who require more than a minimal, "normative" amount of treatment. These cases trigger the ostensibly "non-quantitative" protocol of insurer reviews described as "quality control" to uncover "fraud and abuse" and limit care under the guise of "medical necessity" (Bendat, 2014).

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To date, the processes meant to provide avenues for insured patients' challenges to inappropriate denial of mental health benefits have been deeply flawed. Under Department of Labor rules, self-funded health plans (which cover nearly half of the country's health benefits) are permitted to contract (generally through managed behavioral health care organizations) with "independent" review organizations (IROs) to adjudicate such consumer appeals with respect to benefit denials. IROs, however, routinely overlook parity and due process violations and very rarely reverse benefit denials since exercising actual independence and finding legal violations could compromise their contracts.

The CGRI is available to our members to aid with obtaining insurance reimbursement for our patients.

While the states have primary responsibility to enforce parity compliance of fully insured insurance plans, the states do not routinely scrutinize denials with respect to parity requirements and also routinely employ the same IROs who service the self-funded insurance companies, leading essentially to the same result. In practice, for-profit insurance companies put up a stiff resistance not only to covering the most expensive mental health benefits of hospitalization and residential treatment but also work vigorously to limit access to outpatient psychotherapy, particularly that which exceeds a brief course per year (Bendat, 2014).

Aside from these systemic obstacles inherent in the current system provided for appeals, in theory there always remains the potential remedy of litigation, however costly, financially and emotionally, for insurance consumers facing wrongful denial of coverage for needed mental health services. Individuals with employer-sponsored mental health benefits can exercise a private right to enforce parity and due process remedies conferred by MHPAEA. However, even though the parity requirements apply also to individual and non-federal governmental health plans regulated by the states, these subscribers lack a right to private legal action to enforce their entitlement to mental health care parity, thus limiting recourse to approximately 30 million insured subscribers (Bendat, 2014).

Among other measures, what is clearly needed are policy and regulatory revisions, the right of private legal action to all insurance subscribers, and establishment of true independence for "independent review organizations" adjudicating appeals of claim denials. What have been encouraging to date are large class action suits against offending insurance companies and managed care organizations successfully pressed by Meiram Bendat, among others. It is also important that national professional organizations such as APsaA join with other professional associations in policy statements and amicus briefs supporting genuine compliance with the requirements of the parity and affordable care act laws with respect to mental health care.

Both to protect our own patients and to arrive at a consensus within our own national organization to support parity officially, it behooves us as APsaA members to become familiar with the law and the many specific ways it is being evaded. In short, we need to get down a bit into the weeds about insurance practices such as inappropriate non-quantitative treatment limitations and spurious proprietary insurance company "medical necessity" guidelines not consistent with our own professional standards. According to Herbert Gross, chair of APsaA's Committee on Government Relations and Insurance, the CGRI is available to our members to aid with specific problems encountered in obtaining appropriate insurance reimbursement for their patients. APsaA members may contact him at hgross@herbertgross.com. In addition, on behalf of APsaA, the CGRI will work vigorously to support existing legal mandates for true mental health parity and to join in appropriate advocacy efforts to advance this cause on behalf of our patients.

We must insist on the recognition of our accumulated professional experience and wisdom, of the actual existent research base validating our crucial work, and of our patients' suffering and financial burden from the lack of support for appropriate care.

Editor's Note

Much of the above material was also referenced in two volumes written by The Committee on Psychotherapy, Group for the Advancement of Psychiatry (GAP): Psychotherapy Is Worth It: A Comprehensive Review of Its Cost-Effectiveness, *ed., Lazar, SG, APPI, 2010, a systematically searched, comprehensive review of 23 years (1984–2007) of the medical literature relevant to the cost-effectiveness of all varieties of psychotherapy and a more recent survey of the research base, training, and practice issues in* Psychodynamic Psychiatry Fall Special Issue: *"Psychotherapy, The Affordable Care Act, and Mental Health Parity: Obstacles to Implementation," Vol. 42, Number 3, Fall 2014 , eds. Lazar, SG and Yeomans, FE. Details of the references cited can be found in these publications.*

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